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Section 1

Introduction to the BlueCard® Program

As a contracted provider of Blue Shield of California (Blue Shield), you may render services to patients who are insured by other states' Blue plans, and who travel in or live within California.

This section describes the advantages of the BlueCard Program and provides information to make filing claims easy. You will find helpful information about:

- Identifying out-of-state Blue plan members
- Verifying eligibility and benefits
- Locating other states' Blue plan medical policies and pre-certification requirements
- Requesting and obtaining authorizations
- Submitting BlueCard claims and requesting medical records
- Accessing BlueCard resources and contact information

Definition of the BlueCard Program

BlueCard® is a national program that enables Blue Cross and Blue Shield (BCBS) plan members to obtain healthcare services while traveling or living in another Blue Cross and/or Blue Shield plan's service area. The program links participating healthcare providers with all the independent Blue Cross and Blue Shield plans across the country through a single electronic network for claims processing and reimbursement. Additionally, the program links providers in more than 200 countries and territories worldwide.

BlueCard Program Advantages to Providers

The program allows you to conveniently submit claims for patients from out-of-state Blue plans, either domestic or international, directly to Blue Shield.

Blue Shield is your primary contact for BlueCard claim submission, claims processing, and provider inquiries.

Blue Shield, a mission-driven and nonprofit health plan established in 1939, continues to experience growth in out-of-area membership because of our partnership with you. That is why we are committed to meeting your needs and expectations and creating a sustainably affordable healthcare system that's worthy of our family and friends. In doing so, your patients will have a positive experience with each visit.

The BlueCard® Program

Services Processed Through the BlueCard Program

Claims for all inpatient, outpatient and professional services generated for out-of-state Blue plan members are processed through the BlueCard Program.

Products Included in the BlueCard Program

A variety of products and claim types are eligible to be delivered via BlueCard, however not all Blue plans offer all the products listed below to their members.

- Traditional (indemnity insurance)
- PPO (Preferred Provider Organization)
- EPO (Exclusive Provider Organization), including Blue High Performance NetworkSM (Blue HPNSM)
- POS (Point of Service)
- HMO (Health Maintenance Organization)
 - HMO claims are eligible to be processed under the BlueCard Program or through the Away From Home Care Program.
- Blue Cross Blue Shield Global® Core
- GeoBlue Expat claims
- Medigap – Medicare Complementary/Supplemental
- Standalone vision
- Standalone prescription drugs

Note: Standalone vision and standalone self-administered prescription drugs programs are eligible to be processed through BlueCard when such products are not delivered using a vendor. Consult claim filing instructions on the back of the ID cards.

Note: Definitions of the above products are available in the Glossary of Terms section of this manual

Products Excluded from the BlueCard Program

The following claims are excluded from the BlueCard Program:

- Stand-alone dental
- Self-administered prescription drugs delivered through an intermediary model (using a vendor)
- Vision claims delivered through an intermediary model (using a vendor)
- Federal Employee Program (FEP) member claims
- Medicaid and SCHIP that is part of the Medicaid program
- Medicare Advantage*

*Medicare Advantage is a separate program from BlueCard and delivered through its own centrally administered platform. However, since you might see members of other Blue plans who have Medicare Advantage coverage there is a section on Medicare Advantage claims processing in this manual.

Section 2

How Does the BlueCard Program Work?

How to Identify Members

Member ID Cards

When members of other state Blue plans arrive at your office or facility, be sure to ask them for their current Blue plan membership identification card. The main identifier for other state Blue plan members is the three-character prefix. The ID cards may also have:

- PPO in a suitcase logo, for eligible PPO members
- Blank suitcase log, for eligible Traditional, HMO, POS or indemnity members
- PPOB in a suitcase logo, for PPO members with access to the BlueCard PPO Basic network
- A BlueHPN in a suitcase logo with the Blue High Performance NetworkSM (BlueHPNSM) name in the upper right or lower left corner, for BlueHPN EPO members

The PPO in a suitcase logo indicates that the member is enrolled in either a PPO product or an EPO product. In either case, you will be reimbursed according to Blue Shield's PPO provider contract. Please note that EPO products may have limited benefits out-of-area. The potential for such benefit limitations are indicated on the reverse side of an EPO ID card.

The PPOB in a suitcase logo indicates that the member has selected a PPO or EPO product, from a Blue Plan, and the member has access to a new PPO network, referred to as BlueCard PPO Basic.

For members having traditional or HMO coverage, you will be reimbursed according to Blue Shield's traditional provider contract. For members who have POS coverage, you will be reimbursed according to Blue Shield's POS provider contract, if you participate in the BlueCard POS voluntary program or you will be reimbursed according to Blue Shield's Traditional provider contract, if you don't participate in the BlueCard POS voluntary program.

How to Identify Members *(cont'd.)*

Member ID Cards *(cont'd.)*

The BlueHPN EPO product includes a BlueHPN in a suitcase logo on the ID card. Members must obtain services from BlueHPN providers to receive full benefits. If you are a BlueHPN provider, you will be reimbursed for covered services in accordance with your contract with Blue Shield of California. If you are not a BlueHPN provider, it is important to note that benefits for services incurred with non-BlueHPN providers are limited to emergent care within BlueHPN product areas, and to urgent and emergent care outside of BlueHPN product areas. For these limited benefits, if you are a PPO provider, you will be reimbursed according to Blue Shield of California PPO provider contract, just like you are for other EPO products.

Some Blue ID cards do not have any suitcase logo on them. Those ID cards include Medicaid, State Children's Health Insurance Programs (SCHIP) if administered as part of State's Medicaid, and Medicare Complementary and Supplemental products, also known as Medigap. Government-determined reimbursement levels apply to these products. While Blue Shield routes these claims for out-of-area members to the member's Blue Plan, most of the Medicare Complementary or Medigap claims are sent directly from the Medicare intermediary to the member's Blue Plan via the established electronic crossover process.

The BlueCard® Program

How to Identify Members *(cont'd.)*

Member ID Cards *(cont'd.)*

Important facts concerning member IDs:

- A correct member ID includes the three-character prefix (first three positions) and all subsequent characters, up to a total of 17 positions. This means that you may see cards with IDs between 6 and 14 numbers or letters following the prefix.
- Do not add or delete characters or numbers within the member ID.
- Do not change the sequence of the characters following the prefix.
- The three-character prefix is critical for the electronic routing of specific HIPAA-compliant transactions to the appropriate Blue plan.
- Members who are part of the Federal Employee Program (FEP) will have the letter "R" in front of their member ID. FEP claims are not processed by the BlueCard Program. Instead, FEP professional claims that require medical records should be sent to the FEP Claims Unit at P.O. Box 272510, Chico, CA 95927-2510.
- Note that most out-of-state Blue plan member ID cards have plan names that begin with "Blue Cross Blue Shield" brand names and identifies the state where members receive coverage. However, some Blue plans have unique plan names that do not begin with "Blue Cross Blue Shield" branding and do not identify the state where the member receives coverage. Nevertheless, you can submit BlueCard claims to Blue Shield for members whose ID cards have unique Blue plan names. For a current list of the unique Blue plan names, email BlueCardMarketing@blueshieldca.com.

Examples of member IDs:

A2A1234567


Prefix

ABC1234H567


Prefix

2A212345678901234


Prefix

How to Identify Members *(cont'd.)*

Three-Character Prefix

The three-character prefix at the beginning of the member's identification number is the key element used to identify and correctly route claims. The prefix identifies the Blue plan or National Account to which the member belongs. It is critical for confirming a patient's membership and coverage.

To ensure accurate claim processing, it is critical to capture all ID card data. If the information is not captured correctly, you may experience a delay with the claim processing. Please make copies of the front and back of the ID card and pass this key information to your billing staff. Do not make up prefixes.

Do not assume that the member's ID is the Social Security number. All Blue plans have replaced Social Security numbers on member ID cards with a unique, alternative identifier.

As a provider serving other state Blue plan members, you may find the following tips helpful:

- Ask the member for his or her most current Blue ID card at every visit. Since new ID cards may be issued to members throughout the year, this will ensure you have the most up-to-date information in your patient's file.
- Verify with the member that the ID on the card is not his or her Social Security number. If it is, call the BlueCard® *Eligibility* line at (800) 676-BLUE to verify the ID.
- Member IDs must be reported exactly as shown on the ID card and must not be changed or altered. Do not add or omit any characters from the member ID.
- Blue plan member ID cards are formatted to reflect brand guidelines established by the Blue Cross and Blue Shield Association. The ID cards are designed to make it easier for members and providers to find information they need. Design elements include:
 - Easier-to-read member information featured on the front of the card.
 - A single toll-free provider phone number for provider customer service, hospital pre-admission or pre-authorization information and prescription processing information for pharmacists, listed together on the back of the card.
 - The Blue plan's Web URL located on the back of the card.
 - The mailing instructions for medical claims included on the back of the card.



The three-character prefix.

The "PPO in a suitcase" logo may appear anywhere on the card, but in this example, it appears in the lower right corner of the I.D. card.



Note: ID card samples are not the actual depiction of cards; they show the general look and feel for the brand guidelines from the Association.

The BlueCard® Program

How to Identify Members *(cont'd.)*

BlueCard PPO Basic ID Cards

Verifying Blue patients' benefits and eligibility is now more important than ever since new products and benefit types have entered the market, due to the Affordable Care Act. In addition to patients who have traditional Blue PPO, HMO, POS, or other coverage, you may now see patients who have a BlueCard PPO Basic product.

When you see the "PPOB in a suitcase" logo on the front of the member's ID card, it means the member has selected a PPO or EPO product, from a Blue Plan, and the member has access to a new PPO network, referred to as BlueCard PPO Basic.

Currently, Blue Shield does not offer a BlueCard PPO Basic network to local Blue Shield members. However, you may see patients with BlueCard PPO Basic coverage by an out-of-state Blue Plan. Providers will be reimbursed for covered services in accordance with your PPO contract with Blue Shield of California.

Sample ID Card

	BlueCross BlueShield of Geography	Blue Product	ALPHA <small>Employer Group</small>
Member Name Member Name	Dependents Dependent One		
Member ID XYZ123456789	Dependent Two		
	Dependent Three		
Group No. 023457	Plan PPO		
BIN 987654	Office Visit \$15		
Benefit Plan HIOPT	Specialist Copay \$15		
Effective Date 00/00/00	Emergency \$75		
Plan Code 123	Deductible \$50		
 			

How to Identify Members (cont'd.)

How to Identify BLUEHPN Members

The Blue High Performance NetworkSM (BlueHPNSM) is a new network that is available to members that live in key metropolitan areas. BlueHPN members must access BlueHPN providers in order to receive full benefits. If you are a BlueHPN provider, you will be reimbursed for services provided to BlueHPN members according to your contract with Blue Shield of California. If you are not a BlueHPN provider, it is important to note that benefits for services incurred with non-BlueHPN providers are limited to emergent care within Blue HPN product areas, and to urgent and emergent care outside of BlueHPN product areas.

You can recognize BlueHPN members by the following:

- The Blue High Performance Network name on the front of the member ID card
- The BlueHPN in a suitcase logo in the bottom right-hand corner of the member ID card

Those BlueHPN products offered may include fully insured and self-insured Blue plan members. Language regarding benefit limitations is also included on the back of the BlueHPN EPO member ID card. For these limited benefits, if you are not a BlueHPN provider but are a PPO provider, you will be reimbursed according to Blue Shield of California PPO provider contract, just like you are for other EPO products.

Sample ID Card

 BlueCross BlueShield Geography		
Member Name Member Name Member ID XYZ123456789		Dependents Dependent One Dependent Two Dependent Three
Group No. 023457 BIN 987654 Benefit Plan HIOPT Effective Date 00/00/00	Plan EPO Office Visit \$15 Specialist Copay \$15 Emergency \$75 Deductible \$50	
		

 BlueCross BlueShield Geography		
Member Name Member Name Member ID XYZ123456789		Dependents Dependent One Dependent Two Dependent Three
Group No. 023457 BIN 987654 Benefit Plan HIOPT Effective Date 00/00/00	Plan EPO Office Visit \$15 Specialist Copay \$15 Emergency \$75 Deductible \$50	
		

 BlueCross BlueShield Geography		www.BluePlan.com Customer Service: 1-800-234-5678 Outside of Area: 1-800-610-2583 Eligibility: 1-800-676-2583 Pharmacy Benefits: 1-800-123-4567 Gamma Vision*: 1-800-987-6543
Members: See your benefit booklet for covered services. Possession of this card does not guarantee eligibility for benefits. Hospital or physicians: file claims with local BlueCross and/or BlueShield Plan. BlueCross and BlueShield of Geography provides administrative services only and does not assume any financial risk for claims.		*ALPHA contracts directly with Gamma Vision. BlueCross and BlueShield of Geography P.O. Box 01234 City, State 01234-1234 An independent licensee of the BlueCross and BlueShield Association.
Benefits limited to emergent care at non-Blue HPN providers within Blue HPN product areas. Benefits limited to urgent and emergent care at non-Blue HPN providers outside of Blue HPN product areas.		Pharmacy benefits administrator

 BlueCross BlueShield Geography		www.BluePlan.com Customer Service: 1-800-234-5678 Outside of Area: 1-800-610-2583 Eligibility: 1-800-676-2583 Pharmacy Benefits: 1-800-123-4567 Gamma Vision*: 1-800-987-6543
Members: See your benefit booklet for covered services. Possession of this card does not guarantee eligibility for benefits. Hospital or physicians: file claims with local BlueCross and/or BlueShield Plan. BlueCross and BlueShield of Geography provides administrative services only and does not assume any financial risk for claims.		*ALPHA contracts directly with Gamma Vision. BlueCross and BlueShield of Geography P.O. Box 01234 City, State 01234-1234 An independent licensee of the BlueCross and BlueShield Association.
Benefits limited to emergent care at non-Blue HPN providers within Blue HPN product areas. Benefits limited to urgent and emergent care at non-Blue HPN providers outside of Blue HPN product areas.		Pharmacy benefits administrator

The BlueCard® Program

How to Identify Members *(cont'd.)*

How to Identify International Blue Plan Members

Occasionally, you may see identification cards that are from members of International Licensees or that are for international-based products. Currently those Licensees include Blue Cross Blue Shield of the U.S. Virgin Islands, BlueCross & BlueShield of Uruguay, Blue Cross and Blue Shield of Panama, and Blue Cross Blue Shield of Costa Rica, and those products include those provided through Blue Shield Global Core and the Blue Cross Blue Shield Global™ portfolio. Always check with Blue Shield of California as the list of International Licensees and products may change. ID cards from these Licensees and for these products will also contain three-character prefixes and may or may not have one of the benefit product logos referenced in the following sections. Please treat these members the same as you would domestic Blue Plan members (e.g., do not collect any payment from the member beyond cost-sharing amounts such as deductible, coinsurance and co-payment) and file their claims to Blue Shield of California. See below for sample ID cards for international members and products.

Illustration A - Sample ID Card

 BlueCross & BlueShield de Uruguay		www.bcbssu.com.uy
MEMBER NAME	Plan	
Member Name	1400	
MEMBER ID	RPA PREMIUM	
XYZ 0123456789	Expiration Date: May. 31, 2011	
Plan	PPO	
GROUP	URU038	
BC/BS Plan Codes: 154/654		
CREDENCIAL PARA USO EXCLUSIVO FUERA DE URUGUAY		
		BlueCross & BlueShield de Uruguay
		Uruguay
		Atención al Cliente: (598-2) 707-7575
		United States (E.E.U.U.)
		Customer Service: (598-2) 707-7575
		Provider Finder: 1-800-810-2583
		Eligibility: 1-800-676-2583
		BlueCross & BlueShield de Uruguay
		Lord Ponsonby 2456
		11600 Montevideo, Uruguay
		An Independent Licensee of the BlueCross and BlueShield Association.

Sample ID cards for International Products

Illustration B – Blue Cross Blue Shield Global portfolio:

How to Identify Members (cont'd.)

How to Identify International Blue Plan Members (cont'd.)

Illustration C – Shield-only ID Card

Please Note: In certain territories, including Hong Kong and the United Arab Emirates, Blue Cross branded products are not available. The ID cards of members in these territories will display the Blue Shield Global Core logo (see example below):

			
Member Name:	Employer Group Name:	www.bupaglobalaccess.com	
Member ID:	Employer Group No.	U.S. Customer Service +1 786-257-4741	U.S. Customer Service Toll Free +1 844-369-3797
Rx Group No.		Providers Inquiries & Precertification +1 844-369-3099	Evacuation/Repatriation (if included); +44 1273 333911
BIN		Prescription/Pharmacy Information and Pharmacy Help Desk +1 855-767-1864	Process claims through Pharmacy Data Management (PDM)
PCN:		Underwritten by Bupa or its Designated Affiliate, independent licensees of the Blue Cross Blue Shield Association.	U.S. Service Center Palmetto Bay Village Center 17901 Old Cutler Road, Suite#400 Palmetto Bay, FL 33157 Email: info@bupaglobalaccess.com
		 Pharmacy benefits administrator.	

Canadian ID Cards

Please Note: The Canadian Association of Blue Cross plans and its member plans are separate and distinct from the Blue Cross and Blue Shield Association (BCBSA) and its member plans in the United States.

You may occasionally see ID cards for people who are covered by a Canadian Blue Cross plan. Claims for Canadian Blue Cross plan members are not processed through the BlueCard® Program.

Please follow the instructions of the Blue Cross plans in Canada and those, if any, on the ID cards for servicing their members. The Blue Cross plans in Canada are:

- | | | |
|---------------------|--------------------|-------------------------|
| Alberta Blue Cross | Ontario Blue Cross | Quebec Blue Cross |
| Manitoba Blue Cross | Pacific Blue Cross | Saskatchewan Blue Cross |
| Medavie Blue Cross | | |

Source: <http://www.bluecross.ca/en/contact.html>

The BlueCard® Program

How to Identify Members *(cont'd.)*

Consumer Directed Health Care and Healthcare Debit Cards

Consumer Directed Health Care (CDHC) is a term that refers to a movement in the healthcare industry to empower members, reduce employer costs and change consumer healthcare purchasing behavior. Health plans that offer CDHC plans provide the member with additional information to make an informed and appropriate healthcare decision using member support tools, provider and network information, and financial incentives.

Members who have CDHC plans often carry healthcare debit cards that allow them to pay for out-of-pocket costs using funds from their Health Reimbursement Arrangements (HRA), Health Savings Accounts (HSA) or Flexible Spending Accounts (FSA). All three are types of tax favored accounts offered by the member's employer to pay for eligible expenses not covered by the health plan.

Some cards are "stand-alone" debit cards to cover out-of-pocket costs, while others also serve as a member ID card with the member ID number. These debit cards can help you simplify your administration process and can potentially help:

- Reduce bad debt
- Reduce paperwork for billing statements
- Minimize bookkeeping and patient-account functions for handling cash and checks
- Avoid unnecessary claim payment delays

In some cases, the card will have the nationally recognized Blue logos, along with the logo from a major debit card organization such as MasterCard® or Visa®.

Sample of Stand-Alone Healthcare Debit Card



How to Identify Members (cont'd.)

Consumer Directed Health Care and Healthcare Debit Cards (cont'd.)

Sample of Combined Healthcare Debit Card and Member ID Card



The cards include a magnetic strip so providers can swipe the card at the point of service to collect the member copayment. With the healthcare debit cards members can pay for copayments and other out-of-pocket expenses by swiping the card through any provider's debit card swipe terminal. The funds will be deducted automatically from the member's appropriate HRA, HSA or FSA account.

Combining a healthcare ID card with a source of payment is an added convenience to members and providers. Members can use their cards to pay outstanding balances on billing statements. They can also use their cards via phone to process payments. In addition, members are more likely to carry their *current* ID cards, because of the payment capabilities. If your office currently accepts credit card payments, there is no additional cost or equipment necessary beyond what you already pay to swipe other signature debit cards.

Limited Benefit Products

Another new product and benefit type in the healthcare market is the limited benefit products for Blue plan patients whose annual benefits are limited to \$50,000 or less.

Currently, Blue Shield does not offer such limited benefit plans to our local Blue Shield members. However, you may see patients with limited benefits who are covered by an out-of-state Blue plan.

How to recognize members with limited benefits products

Members with Blue limited benefits coverage (that is, annual benefits limited to \$50,000 or less) carry ID cards that may have one or more of the following indicators:

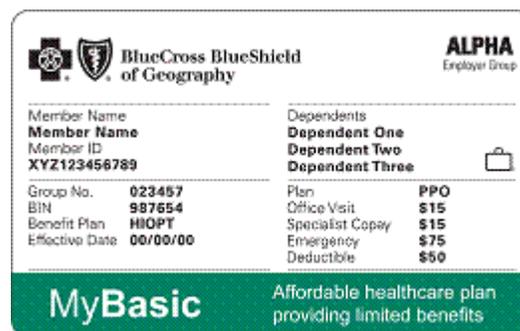
- Product name will be listed such as **InReach** or **MyBasic**
- A **green stripe** at the bottom of the card
- A statement either on the front or the back of the ID card stating this is a limited benefits product
- A **black cross and/or shield** to help differentiate it from other identification cards

The BlueCard® Program

How to Identify Members (cont'd.)

Limited Benefit Products (cont'd.)

These ID cards may look like this:



How to find out if the patient has limited benefit coverage

In addition to obtaining a copy of the patient's ID card and regardless of the benefit product type, we recommend that you verify patient's benefits and eligibility and collect any patient liability or copayment only. You may do so electronically by submitting an eligibility inquiry to Blue Shield at blueshieldca.com/provider or by calling BlueCard® *Eligibility* at (800) 676-BLUE (2583).

You will receive the patient's accumulated benefits to help you understand the remaining benefits left for the member. If the cost of services extends beyond the patient's benefit coverage limit, inform the patient of any additional liability he or she might have.

What to do if the patient's benefits are exhausted before the end of their treatment

Annual benefit limits should be handled in the same manner as any other limits on the medical coverage. Any services beyond the covered amounts or the number of treatments might be member's liability. We recommend that you inform patients of any potential liability they might have as soon as possible.

How to Identify Members *(cont'd.)*

Helpful Tips

- Carefully determine the member's financial responsibility before processing payment. You can access the member's accumulated deductible by logging on to blueshieldca.com/provider or by calling the BlueCard® *Eligibility* line at (800) 676-BLUE (2583).
- Ask members for their current member ID card and regularly obtain new photocopies (front and back) of the member ID card. Having the current card will enable you to submit claims with the appropriate member information (including three-character prefix) and avoid unnecessary claims payment delays.
- If the member presents a debit card (stand-alone or combined), be sure to verify the out-of-pocket amounts before processing payment:
 - Many plans offer well care services that are payable under the basic healthcare program. If you have any questions about the member's benefits or to request accumulated deductible information, please log onto blueshieldca.com/provider or call the BlueCard® *Eligibility* line at (800) 676-BLUE (2583).
 - You may use the debit card for member responsibility for medical services provided in your office.
 - You may choose to forego using the debit card and submit the claims to Blue Shield for processing. The Remittance Advice will inform you of member responsibilities.
 - All services, regardless of whether or not you've collected the member responsibility at the time of service, must be filed to Blue Shield for proper benefit determination and to update the members' claim history.
- Check eligibility and benefits electronically by logging onto Provider Connection at blueshieldca.com/provider or by calling (800) 676-BLUE (2583) and providing the three-character prefix. Online eligibility and benefits results for out-of-state Blue plan members include the following elements:
 - Other payor information, if the member has other insurance
 - An authorization indicator, if authorization or referral is required
 - Pre-existing condition information, if applicable
 - Accumulated year-to-date deductible amounts
 - Accumulated year-to-date out-of-pocket costs
 - Accumulated year-to-date benefit maximum amounts
 - Accumulated year-to-date individual lifetime maximum amounts
- Please do not use the debit card to process full payment up front. If you have any questions about the member's benefits, log onto blueshieldca.com/provider to perform a BlueCard eligibility and benefits search, or call (800) 676-BLUE (2583). For questions about the debit card processing instructions or payment issues, please contact the toll-free debit card administrator's number on the back of the card.

The BlueCard® Program

Coverage and Eligibility Verification

Provider Connection, our provider website at blueshieldca.com/provider, gives you direct access to current, reliable information for out-of-state Blue plan members' eligibility, benefits, claims mailing address, and share of cost. You can receive more detailed benefit information when searching for out-of-state Blue plan members' benefits online. Submit an online inquiry about certain benefits you would like more information on, and the benefit information will be returned to you onscreen or sent to the Provider Connection Message Center.

You can also verify out-of-state Blue plan member eligibility, benefits coverage and share of cost information by calling BlueCard *Eligibility*® at (800) 676-BLUE (2583). This automated Voice Response Unit (VRU) will prompt you to provide the three-character prefix and will route your call to the member's Blue plan.

Keep in mind that Blue plans are located throughout the country and may operate on a different time zone than Blue Shield. You may be transferred to a voice response system linked to customer enrollment and benefits.

The BlueCard *Eligibility*® line is for eligibility, benefit and pre-certification/referral authorization inquiries only. It should not be used for determining where to submit your BlueCard claims or for claim status. See the Claim Filing section in this manual for claim filing information.

Eligibility and Benefits for BlueHPN EPO Members:

BlueHPN EPO members will be identified as such within the eligibility and benefits result response. If you are a Blue Shield of California contracted provider within BlueHPN network, submit your claim to Blue Shield. If you are not a contracted BlueHPN provider with Blue Shield of California, you should be aware that the only services that are covered for BlueHPN EPO members are urgent and emergent care outside of BlueHPN product areas. Benefits are determined by Blue plan the member is insured with.

Coordination of Benefits (COB) Information on Blue Plan Members

Coordination of Benefits (COB) refers to how the Blue System ensures that Blue plan members receive full benefits and prevent double payment for services when a Blue plan member has coverage from two or more sources. The member's contract language explains the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.

Blue plan member benefit structures vary and state requirements around the collection of other insurance information differ across the country. To reduce the number of BlueCard claims being denied for lack of COB information, processing standard requirements are in place to limit instances when Blue plans can reject claims for COB investigations.

When you see Blue plan patients who you are aware might have other health insurance coverage (i.e., Medicare, other Blue plan), please keep in mind the following:

- If Blue Shield of California or any other Blue plan is the primary payor, submit the other carrier's name and address with the claim to Blue Shield of California. If you do not include the COB information with the claim, the member's Blue plan will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment, which will increase your volume of bookkeeping.
- If another non-Blue health plan is primary and Blue Shield of California or any other Blue plan is secondary, submit the claim to Blue Shield of California only after receiving payment from the primary payor, including the explanation of payment from the primary carrier. If you do not include the COB information with the claim, the member's Blue plan will have to investigate the claim, which may result in a payment delay or post-payment adjustment.

Carefully review the payment information from all payors involved on the remittance advice before balance billing the patient for any potential liability. The information listed on the Blue Shield of California remittance advice as "patient liability" might be different from the actual amount the patient owes you, due to the combination of the primary insurer payment and your negotiated amount with Blue Shield of California.

If you have any questions regarding COB claims processing or payments in relation to Blue plan members, please contact the BlueCard Program Customer Service unit at (800) 622-0632.

Your involvement is needed to assist in collecting other insurance information from Blue plan members. To avoid claim rejections due to lack of COB information, use the COB Questionnaire to collect information from any Blue plan member who has insurance coverage in addition to his/her out-of-state Blue plan coverage.

The BlueCard® Program

Coordination of Benefits (COB) Information on Blue Plan Members (cont'd.)

When out-of-state Blue plan members state they have other insurance coverage in addition to their out-of-state Blue plan coverage, please perform one of the following:

1. During the patient's visit, request the patient complete and return the COB Questionnaire to you, then mail the completed form on behalf of the patient to Blue Shield to:

Blue Shield of California, BlueCard Program, P.O. Box 1505, Red Bluff CA 96080
2. During the patient's visit, give the patient a COB Questionnaire with instructions to complete and submit the form to his or her out-of-state Blue plan as soon as possible.

Refer to the COB Questionnaire on the following pages or on blueshieldca.com/provider under *Guidelines & resources*, then *Forms*, then *Patient care forms*.

Coordination of Benefits Questionnaire

Coordination of Benefits Questionnaire



Blue Cross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

Provider: After the policy holder has completed and signed, please forward this form to your local Blue Cross and/or Blue Shield Plan immediately. Do not hold to submit with the claim.

Check here if you will be electronically submitting this to your local BC and/or BS Plan and you have the Policy Holders signature on file.

Member: Your Blue Cross and/or Blue Shield contract may contain a Coordination of Benefits (COB) provision. Your Plan depends upon your help in order to process your claims correctly and appreciates your prompt and accurate reply. If any of the information below changes, please contact your Blue Cross and/or Blue Shield Plan immediately.

Provider Name:	NPI (Give Tax ID if no NPI Number):
----------------	-------------------------------------

Policyholder Name:	
Group Number:	Member ID Number with Three Letter Prefix:

Section A Other Insurance

Are you or any other member of this Blue Cross and/or Blue Shield policy covered by another medical or dental insurance policy, any other Blue Cross and/or Blue Shield policy or Medicare?

- No If No, please complete Section D, sign, date and return this questionnaire to us, indicating "No other insurance."
- Yes If Yes, please complete all the fields below that pertain to the member(s) that has the other coverage.

Mark those that apply: Other Health Insurance Other Dental Insurance

What type of policy is this? Group Individual Policy Student Policy Medicare Supplemental

Other Insurance Carrier's Name

Address

Address State Zip Phone Number

Dependent(s) listed on the other Insurance

Other Insurance Policyholder's Name Policyholder's Date of Birth ID Number

Effective Date of Other Insurance If Cancelled, Cancellation Date

Is the policy holder: Actively working for the group Inactive
 Retired, retirement date: _____ On COBRA, which began: _____

Policyholder's Employer

Address

City State Zip Phone Number

The BlueCard® Program

Section B	Medicare Information
Do the policyholder and/or dependent(s) have Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of person(s) with Medicare _____	
Medicare Number, including alpha character(s) _____	
Effective Date of Medicare Part A: _____ Effective date of Medicare Part B: _____	
Medicare Entitlement: <input type="checkbox"/> Yes <input type="checkbox"/> Disability* <input type="checkbox"/> Yes <input type="checkbox"/> End Stage Renal Disease (ESRD)*	
If the reason is for Disability or ESRD, please provide the following:	
1 st Date of Disability: _____	
1 st Date of Dialysis for ESRD: _____	
Was ESRD started in a facility? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was ESRD started as Self Dialysis of Home Dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has a transplant been performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please provide the date of the transplant: _____	

Section C	Court Order Information
Is there a Court Order specifying a person(s) to maintain health coverage for any of your dependent(s)?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
List the name(s) of the dependent(s) that this applies to: _____	
If yes, who is the person(s) listed to maintain health coverage? _____	
What is the relation to the child(ren)? _____	Who has custody of the child(ren) more than 50% of the time? _____
<i>Documentation of the court order may be requested from your Blue Cross and/or Blue Shield Plan</i>	

Section D	Names of Dependent(s) on Blue Cross and/or Blue Shield Policy			
Name	Relationship	Date of Birth	Sex	Social Security Number (Optional)
Name	Relationship	Date of Birth	Sex	Social Security Number (Optional)
Name	Relationship	Date of Birth	Sex	Social Security Number (Optional)
Policy Holder Signature		Date		

WB-07-071

Other -State Blue Plan Members' Medical Policies and Pre-Certification/Prior Authorization Requirements

On Provider Connection, our provider website, you can now find information to help you treat other state Blue plan members. You can view medical policies and general pre-certification/prior authorization requirements applicable to other state Blue plan members, along with contact information to initiate the pre-certification/prior authorization process.

To access the medical policy and pre-certification/prior authorization requirements, follow the steps below:

1. Log onto blueshieldca.com/provider.
2. Click on the *Pre-service review for out-of-area members* link within the *Authorizations* section of Provider Connection.
3. Enter the other state Blue plan member's three-character prefix, select either the medical policy or the prior authorization button, and then click on "Search."

This online functionality gives providers easy access to information and provides a valuable supplement to the information you currently receive when verifying other state Blue plan members' benefits, eligibility and share of costs, directly from the member's Blue plan.

Prior Authorization

Prior authorization of medical services for other state Blue plan members is provided by the member's Blue plan. Providers can request authorization for an otherstate Blue plan member online by using the Electronic Provider Access (EPA) tool. The EPA tool will enable you to use Blue Shield's provider website to gain secured access to another Blue plan's provider website to request authorization.

To access the EPA tool, log onto Provider Connection at blueshieldca.com/provider, click on the *Pre-service review for out-of-area members* link within the *Authorizations* section.

Choose from the available options to assist in obtaining the necessary information:

- Medical Policy Information – Select this option to obtain medical policy for a service.
- Prior Authorization Information – Select this option to determine if pre-service and pre-authorization is required for a service.
- Electronic Provider Access – Select this option to submit a pre-certification and prior authorization request.

Providers will need the member's three-character prefix to complete each search. The prefix is the first three characters that precede the member identification number.

The BlueCard® Program

Prior Authorization *(cont'd.)*

By entering a valid prefix, you will then be automatically routed to the member's Blue plan provider portal to begin an authorization request. Please note that each Blue plan's website is customized to their authorization services they offer.

Providers can also contact the member's Blue plan by calling the designated telephone number of the Health Care Services department located on the back of the member's ID card.

Electronic, online, and phone inquiries regarding authorizations for Blue plan members needing for clinical lab, DME/HME, and specialty pharmacy services should be directed to the member's Blue plan as defined in the Ancillary Claims Filing Guidelines section of this appendix. The member's Blue plan may contact you directly related to clinical information or to request medical records prior to treatment or for concurrent review or chronic condition management for a specific member.

Note: Failure to obtain required prior authorization or admission review may result in partial or total benefit denial and/or greater out-of-pocket expenses for Blue plan members. However, obtaining approval is not a guarantee of payment.

Utilization Review

You should remind patients that they are responsible for obtaining pre-certification/authorization for outpatient services from their Blue plan. Participating providers are responsible for obtaining pre-service review for inpatient facility services when the services are required by the account or member contract (see section entitled Provider Financial Responsibility). In addition, members are held harmless when pre-service review is required and not received for inpatient facility services (unless an account receives an approved exception).

General information on pre-certification/preauthorization information can be found by clicking on the *Pre-service review for out-of-area members* within the *Authorization* section of blueshieldca.com/provider.

When obtaining pre-certification/preauthorization, please provide as much information as possible, to minimize potential claims issues. Providers are encouraged to communicate immediately with a member's Blue Plan if any changes in treatment or setting occur to ensure an existing authorization is modified or a new one is obtained, if needed. Failure to obtain approval for additional days may result in claims processing delays and potential payment denials.

When the length of an inpatient hospital stay extends past the previously approved length of stay, any additional days must be approved. Failure to obtain approval for the additional days may result in claim processing delays and potential payment denials.

Electronic Provider Access

Electronic Provider Access (EPA) gives providers the ability to access out-of-area member's Blue plan provider portals to conduct electronic pre-service review. The term pre-service review is used to refer to pre-notification, pre-certification, pre-authorization and prior approval, amongst other pre-claim processes. EPA enables providers to use their local Blue plan provider portal to gain access to an out-of-area member's Blue plan provider portal, through a secure routing mechanism. Once in the Blue plan provider portal, the out-of-area provider has the same access to electronic pre-service review capabilities as the Blue plan's local providers.

The availability of EPA varies depending on the capabilities of each Blue plan. Some Blue plans have electronic pre-service review for many services, while others do not. The following describes how to use EPA and what to expect when attempting to contact other Blue plans.

Using the EPA Tool

Log onto blueshieldca.com/provider, click on *Pre-service review for out-of-area members* link within the *Authorizations* section. Choose the *Electronic Provider Access* option. You will be asked to enter the three-character prefix from the member's ID card, which is the first three characters that precede the member subscriber identification number. The NPI and location of requesting provider are also required, as is whether or not you are a Blue Shield of California contracted provider. Once those fields have been filled out, click the "Submit" button.

After submitting, you are routed to the member's Blue plan EPA landing page. This page welcomes you to the out-of-state Blue plan's portal and indicates that you have left Blue Shield of California's provider portal. The landing page allows you to connect to the available electronic pre-service review processes. Because the screens and functionality of out-of-state Blue plan pre-service review processes vary widely, other Blue plans may include instructional documents or e-learning tools on their Blue plan landing page to provide instruction on how to conduct an electronic pre-service review. The page may also include instructions for conducting pre-service review for services where the electronic function is not available.

The out-of-state Blue plan landing page looks similar across the Blue plan system but will be customized to the particular Blue plan based on the electronic pre-service review services they offer.

The BlueCard® Program

Provider Financial Responsibility for Pre-Service Review for Blue Plan Members

Blue Shield's participating providers are responsible for obtaining pre-service review for inpatient facility services for BlueCard members and holding the member harmless when pre-service review is required by the account or member contract and not received for inpatient services. Participating providers must also:

- Notify the member's Blue plan within 48 hours when a change or modifications to the original pre-service review occurs.
- Obtain pre-service review for emergency and/or urgent admissions within 72 hours.

Failure to contact the member's Blue plan for pre-service review or for a change or modification of the pre-service review will result in claim processing delays and potential payment denials for inpatient facility services. The Blue plan member must be held harmless and cannot be balance-billed if pre-service review has not occurred.*

Pre-service review contact information for a member's Blue plan is provided on the member's identification card. Pre-service review requirements can also be determined by:

- Using the Electronic Provider Access (EPA) tool available at Blue Shield's provider portal at blueshieldca.com/provider.
- Submitting an ANSI 278 electronic transaction to Blue Shield.
- Calling the BlueCard Eligibility toll-free phone number at (800) 676-BLUE.

Services that deny as not medically necessary remain the member's liability.

If you have any questions on Provider Financial Responsibility or general questions, please call Blue Shield at (800) 622-0632.

**Unless the member signed a written consent to be billed prior to rendering service.*

Medical Records Requests and Processing

Blue Shield is dedicated to achieving a seamless delivery of medical records requests and processing for otherstate Blue plan members and the providers who serve them.

Medical records related to your otherstate Blue plan patients may be requested as part of the pre-claim experience, as part of a concurrent review or as part of the BlueCard claim appeal process. It is Blue Shield's responsibility to obtain medical records from our providers at the request of the member's Blue plan. However, in pre-claim situations, the member's Blue plan may directly contact you to request medical records if the member's Blue plan needs the records to make a determination as part of the prior authorization or pre-certification process or in situations that are deemed as an urgent medical need. Please note that when requesting medical records for DME/HME services, the ordering provider's information is required to process the request.

Blue Shield performs the following steps to ensure delivery of medical record requests and processing:

- When receiving a medical records request from the member's Blue plan, we verify whether or not the provider has already submitted the records.
- When a member's Blue plans requests medical records, we send the request to our providers within two business days of receipt of the out-of-state Blue plan's request.
- When requesting medical records from a provider, we strive to send concise and specific details to fulfill the request.
- We send medical record requests to the address and department indicated in your provider demographics profile.
- When providers respond to requests and submit medical records to us, we ensure that all records are sent electronically to the member's Blue plan within three business days on their receipt.
- We follow up with the member's Blue plan to ensure that records are reviewed and adjusted in a timely manner.
- We maintain copies or images of all medical records received from providers.

To make the medical records process more efficient, please respond to medical record requests within 10 days of the request.

Section 3

Claim Filing

Processing BlueCard Claims

Blue Shield processes BlueCard claims for inpatient, outpatient, professional, and ancillary* services rendered to other state Blue plan members. Be sure to include the member's complete identification number when you submit the claim. The complete identification number includes the three-character prefix. Claims with incorrect or missing prefixes and member identification numbers cannot be filed correctly.

**Ancillary providers who Blue Shield categorizes them in their contract as Independent Clinical Laboratory, Durable/Home Medical Equipment, orthotic and prosthetics and Supplies, and Specialty Pharmacy providers should file their claims according to the Ancillary Claims Filing Requirements listed further in this document.*

Providers are required to submit BlueCard claims electronically to Blue Shield that do not have a medical record attached. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected. Please indicate the member's subscriber ID number, including the three-character prefix, on each electronically submitted claim. If you have any questions about the process or require additional information on electronic claim submission, contact our EDI Help Desk by calling (800) 480-1221 or emailing EDI_BSC@blueshieldca.com.

You may now submit claims online through clearinghouse vendor Office Ally. Once at the EDI clearinghouse's website, you will have the option to review the claim submission services offered. To visit Office Ally and for detailed information about electronic submissions, go to Provider Connection at blueshieldca.com/provider, click on *Claims*, then click on the *Submit claims for free* box in the claims tool area.

Mail hard-copy BlueCard claims that require medical records to:

Blue Shield of California
BlueCard Program
P. O. Box 272630
Chico, CA 95927-2630

BlueCard Claim Tips

After the member of another Blue Plan receives services from you, you should submit the claim to Blue Shield of California. We will work with the member's Blue plan to process the claim and the member's Blue plan will send an explanation of benefit (EOB) to the member. We will send you an explanation of payment or remittance advice and applicable payment to you under the terms of our contract with you based on the member's benefits and coverage.

Following these helpful tips will improve your claim experience:

- Ask members for their current member ID card and regularly obtain new photocopies of the (front and back). Having the current card enables you to submit claims with the appropriate member information (including the three-character prefix) and avoid unnecessary claims payment delays.
- Check eligibility and benefits electronically at blueshieldca.com/provider or by calling (800) 676-BLUE (2583). Be sure to provide the member's three-character prefix.
- Verify the member's cost sharing amount before processing payment. Please do not process full payment upfront as Blue plan members are responsible for their share of cost, deductible, co-insurance, and non-covered services.
- Indicate any payment you collected from the patient on the claim. Submit all BlueCard claims to Blue Shield of California. Be sure to include the member's complete subscriber identification number when you submit the claim. This includes the three-character prefix. Submit claims with only valid prefixes; claims with incorrect or missing prefixes and member identification numbers cannot be processed.
- Reduce claim adjustments by double-checking to ensure you have indicated the correct provider Tax ID Number (TIN), Provider Identification Number (PIN) and/or the National Provider Identifier (NPI) number.
- In cases where there is more than one payor and a Blue plan is a primary payor, submit Other Party Liability (OPL) information with the BlueCard claim. Upon receipt, Blue Shield of California will electronically route the claim to the member's Blue plan.
- Do not send duplicate claims. Sending another claim, or having your billing agency resubmit claims automatically, slows down the claims payment process and creates confusion for the member. Go to Provider Connection at blueshieldca.com/provider for direct access, 24 hours a day, seven days a week, for current, reliable information on BlueCard claims, payment status and claim reporting tools.
- To avoid denials as duplicates when submitting corrected BlueCard claims, file them after the original claim has finalized. After the original claim is finalized, you may submit the corrected claim electronically by identifying the claim as Type of Bill (XX7).

The BlueCard® Program

BlueCard Claim Tips *(cont'd.)*

- If medical records are requested, send them to either the claims address listed on the request letter you received from Blue Shield or to the address that appears in the search results of the Claims Routing Tool or the eligibility and benefits inquiry.
- Check claims status by contacting Blue Shield of California at blueshieldca.com/provider, contact Blue Shield's dedicated BlueCard Customer Service Unit at (800) 622-0632, or submit an electronic HIPAA 276 transaction to Blue Shield of California.

Send BlueCard claims electronically. However, when medical records must be attached with paper BlueCard claims, please consider these paper claim tips:

- Applying a stamp on the paper claims with clear messages is acceptable to Blue Shield; however, **do not** cover key information with the stamp. Attaching a cover sheet to the claim is an acceptable alternative to applying a stamp to the claim form.
- Please type or write in a font size that is large enough so that your message can be clearly read.
- When medical records must be attached, mail BlueCard claims to:

Blue Shield of California
BlueCard Program
P.O. Box 272630
Chico, CA 95927-2630

After you have submitted BlueCard claims to Blue Shield, you may obtain status and verify payment information on your BlueCard claims by accessing the *Claims* section on our website at blueshieldca.com/provider. Use this tool as your primary resource for requesting and receiving details and status of BlueCard claim.

If you have remaining questions about your BlueCard claims after accessing the *Claims* section on our website, access additional information within Resources section of BlueCard Program or contact Blue Shield's dedicated BlueCard Customer Service Unit at (800) 622-0632.

Submitting BlueCard Claims

Providers are required to submit BlueCard claims electronically to Blue Shield that do not have a medical record attached. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected. The following are tips on how to submit claims:

- 1) Access our Claims Routing Tool on Provider Connection at blueshieldca.com/provider by clicking on the *Claims Routing Tool* link within the *Claims* section. Simply enter the member's three-character prefix and date of service to immediately learn where to send the BlueCard claim.
- 2) Note the claim address and patient benefit information added to the online verification of Eligibility and Benefits search results returned by blueshieldca.com/provider. You will find the information you need to correctly send BlueCard claims, as well as local Blue Shield commercial and FEP claims. On the right-hand side of your search results, refer to the appropriate payor information, claims mailing address, claims unit's toll-free telephone number and member eligibility toll-free telephone number.
- 3) If and for so long as your independent physician practice is not contracted with another licensee of the Blue Cross Blue Shield Association in the State of California, providers shall submit to Blue Shield for processing all claims for medical services furnished by your independent physician practice and process through the BlueCard Program, unless the member receiving such services is enrolled in a benefit plan having an exclusive arrangement with such other licensee of the Association.
- 4) If and for so long as your independent physician practice is contracted with both Blue Shield and another licensee of the Blue Cross Blue Shield Association in the State of California, and there is no exclusive arrangement with either Blue Shield nor the other license of the Association, your independent physician practice shall increase the number of claims for medical services process through the BlueCard Program (as defined in the Provider Manual) sent to Blue Shield for processing.

The BlueCard® Program

Submitting BlueCard Claims *(cont'd.)*

- 5) To facilitate the obligation outlined in 4) above, Blue Shield provides clearinghouses and EDI partners* with tools that improve claims processing accuracy and reduce turnaround time. These are collectively known as the BlueCard Prefix Code Routing Table Edit (“BlueCard Edit” or simply, “Edit”). Unless otherwise noted in the Provider Contract; the provider has authorized the implementation and use of these tools for their BlueCard claims in all transmission formats.

The purpose and functionality of the BlueCard Edit is to direct and route all BlueCard transactions where Blue Shield is eligible to process said claims. This includes all BlueCard transactions that are related to a healthcare member whose healthcare payer is a licensed affiliate of the Blue Cross Blue Shield Association (“BCBSA”). It does not include transactions from prefixes noted in the tables that are (i) exclusive to another licensee of the Blue Cross Blue Shield Association in the State of California,; or (ii) from those licensed affiliates of BCBSA that designates another licensee of the Blue Cross Blue Shield Association in the State of California exclusively to process transactions for its members.

Other state independent licensee(s) of the Blue Cross Blue Shield Association may select Blue Shield of California or another licensee of the Blue Cross Blue Shield Association in the State of California as the preferred processor of their BlueCard claims in California for particular accounts, groups, procedures and/or other circumstances. Submitting claims to the wrong processor or payor can cause substantial delays in processing. Blue Shield and its agents will provide best effort to review claims submitted to California processor(s). In the event a claim is submitted to a non-preferred processor, Blue Shield may re-route claims as needed. Re-routing of BlueCard claims may occur in accordance to Blue Shield’s agreement(s) with another licensee of the Blue Cross Blue Shield Association. Where other state independent licensee(s) of the Blue Cross Blue Shield Association has selected another independent Blue Cross and Blue Shield licensee in California, as their processor for accounts or groups, Blue Shield will provide best effort to re-route claims to that licensee. This claim review process is integral to our claims processing and claims routing systems and cannot be selectively enabled by Provider. While Blue Shield and its agents will provide best effort; we cannot ensure that 100% of all claims are reviewed prior to Payor delivery. Blue Shield is not responsible for any delays or liability from the provision or non-provision of this service or subsequent re-routing or non re-routing.

- 6) If submitting a claim for ancillary services (independent clinical lab, DME/HME, or specialty pharmacy), please refer to the Ancillary Claims Filing Guidelines section of this appendix.

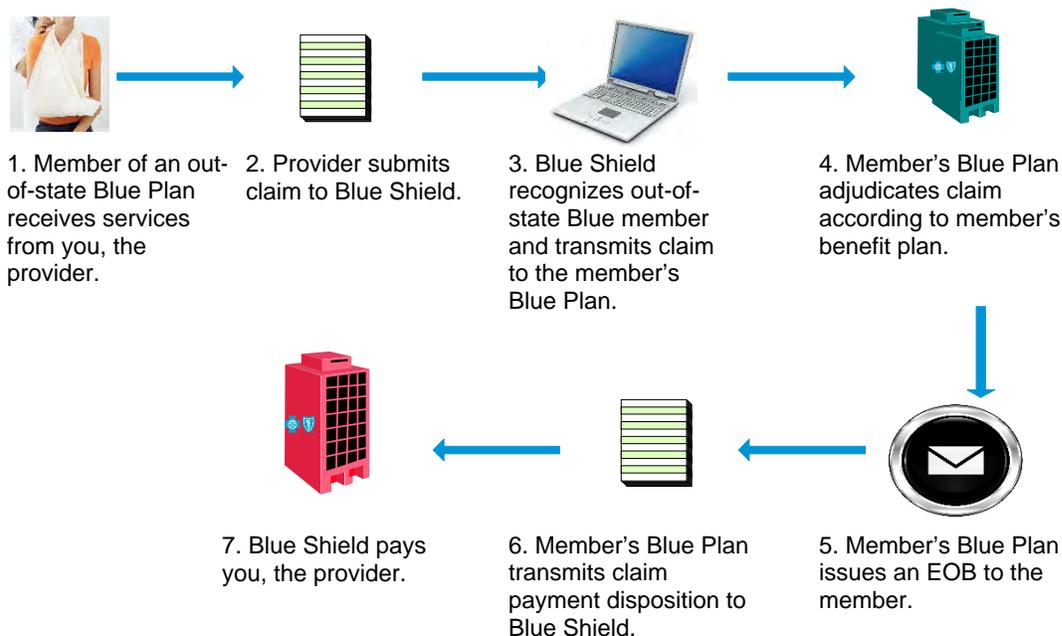
Submitting BlueCard Claims (cont'd.)

- 7) If you have any questions about electronic claims submission, contact our EDI Help Desk at (800) 480-1221, email EDI_BSC@blueshieldca.com or submit an EDI inquiry online on Provider Connection.

In cases where there is more than one payor and Blue Cross and/or Blue Shield is a primary payor, submit Other Party Liability (OPL) information with the Blue Cross and/or Blue Shield claim. Upon receipt, Blue Shield will electronically route the claim to the member's Blue plan. The member's Blue plan then processes the claim and applicable payment. Blue Shield will reimburse you for services.

*If requested, Blue Shield will provide to the provider or their agents or claims clearinghouse (collectively known as the "SUBMITTER") its proprietary BlueCard Prefix Code (also known as the Interplan Teleprocessing System, or "ITS") tables ("Tables") which shall at all times remain the Confidential Information of Blue Shield. Upon provision of the Tables, the Submitter shall develop, implement, and maintain in production the software functionality or program known as the BlueCard Prefix Code Routing Table edit ("BlueCard Edit" or simply, "Edit"). Where such capability currently exists, the provider hereby authorizes and directs their Submitter to make use of said Edit or similar capability. To inquire about the BlueCard Edit, email BlueCardMarketing@blueshieldca.com.

Below is an example of how claims flow through BlueCard



The BlueCard® Program

Traditional Medicare-Related Claims

The following are guidelines for the processing of traditional Medicare-related claims:

- When Medicare is primary payor, submit claims to your local Medicare intermediary.
- All Blue claims are set up to automatically cross-over to the member's Blue plan after being adjudicated by the Medicare intermediary.

How do I submit Medicare primary/Blue plan secondary claims?

- For members with Medicare primary coverage and Blue plan secondary coverage, submit the claim first to your Medicare intermediary.
- Be certain that you include the exact name of the secondary plan and the complete subscriber number. The member's Blue plan subscriber number will include the three-character prefix followed by alpha-numeric values.
- When you receive the remittance advice from the Medicare intermediary, verify whether the claim has been automatically forwarded (crossed over) to the secondary payor (Blue plan). If the Medicare remittance advice indicates the claim has been crossed over, it means that Medicare has forwarded the claim, on your behalf, to the appropriate secondary plan for processing. There is no need for you to resubmit the claim to the Blue plan.

When should I expect to receive payment?

The Medicare intermediary will process and cross over the claim within about 14 business days. This means that the Medicare intermediary will be forwarding the claim to the secondary Blue plan on approximately the same date you receive the Medicare remittance advice. Please allow up to 30 additional calendar days before expecting payment or instructions regarding the secondary processing of the claim.

What should I do if I have not received a Medicare remittance advice and/or payment for the claim?

If you submitted the claim to the Medicare intermediary and you have not received a response to your initial claim submission, do not automatically submit another claim to the secondary Blue plan. Instead, please take the following steps:

- Confirm that the Medicare intermediary received the claim and resend it to the Medicare intermediary only if it was not initially received.
- Wait until you receive the Medicare remittance advice for the claim.

Traditional Medicare-Related Claims *(cont'd.)*

- Wait an additional 30 calendar days after you receive the remittance advice to receive payment or instructions from the Blue plan regarding secondary coverage processing.
- If, after 30 calendar days, you have not received payment or instructions from the Blue plan regarding secondary claim processing, we recommend that you submit a secondary claim, including complete Medicare adjudication information, to the local Blue plan, as appropriate.

To avoid having your claim denied by the Blue plan as a duplicate, do not submit a secondary claim to the local Blue plan before taking each of the steps described above.

Whom should I contact if I have questions?

If Blue Shield is the secondary healthcare coverage carrier for the patient, please contact us using the following information:

- Online at blueshieldca.com/provider
- Provider Customer Service, by telephone at (800) 541-6652
- By postal mail at Blue Shield of California, P.O. Box 272540, Chico, CA 95927-2540

If the patient's secondary plan is a Blue plan in a state other than California, please contact us using the following information:

- BlueCard Provider Customer Service, by telephone at (800) 622-0632
- By postal mail at BlueCard Claims, P.O. Box 272630, Chico, CA 95927-2630

The BlueCard® Program

Ancillary Claims Filing Requirements

Ancillary providers include Independent Clinical Laboratory, Durable/Home Medical Equipment and Supplies (D/HME), Orthotics & Prosthetics (O&P), and Specialty Pharmacy providers. File claims for these providers as follows:

- Independent Clinical Laboratory (Lab)
 - File to the BCBS Plan in whose service area the referring provider is located.
- Durable/Home Medical Equipment and Supplies (D/HME) and Orthotics & Prosthetics (O&P)
 - File to the Plan in whose service area the equipment/supplies was shipped to or purchased at a retail store.
- Specialty Pharmacy
 - File to the Plan in whose service area the ordering physician is located.

If you contract with more than one Plan in a state for the same product type (i.e., PPO or Traditional), you may file the claim with either Plan.

Provider Type	How to File (Required Fields)	Where to File	Example
Independent Clinical Laboratory (any type of non-hospital based laboratory) Types of Service include, but are not limited to: blood, urine, samples, analysis, etc.	Referring Provider: <ul style="list-style-type: none"> – Field 17B on CMS 1500 Health Insurance Claim Form or – Loop 2310A (claim level) on the 837 Professional Electronic 	File the claim to the Plan in whose service area the referring provider is located . Note: <ul style="list-style-type: none"> • Claim must be processed based on information submitted on the claim. • The referring provider NPI, as submitted on the claim, must be used to determine where service was rendered. • Claims for the analysis of a lab must be filed to the Plan in whose service area the referring provider is located. • BlueCard rules for claims incurred in an overlapping service area and contiguous county apply. 	Blood is drawn in lab or office setting at the request of a referring provider located in [enter Plan X service area] . Blood analysis is done in [enter Plan Y service area] . <i>File both portions of the claim to: [enter Plan X service area].</i>

Ancillary Claims Filing Requirements *(cont'd.)*

Provider Type	How to File (Required Fields)	Where to File	Example
<p>Durable/Home Medical Equipment and Supplies (D/HME) and Orthotics/Prosthetics</p> <p>Types of Service include, but are not limited to: Hospital beds, oxygen tanks, crutches, equipment to correct deformities or to preserve and restore the function of the skeletal system, etc.</p>	<p>Patient's Address:</p> <ul style="list-style-type: none"> - Field 5 on CMS 1500 Health Insurance Claim Form or - Loop 2010CA on the 837 Professional Electronic Submission. <p>Ordering Provider:</p> <ul style="list-style-type: none"> - Field 17B on CMS 1500 Health Insurance Claim Form or - Loop 2420E (line level) on the 837 Professional Electronic Submission. <p>Place of Service:</p> <ul style="list-style-type: none"> - Field 24B on the CMS 1500 Health Insurance Claim Form or - Loop 2300, CLM05-1 on the 837 Professional Electronic Submissions. <p>Service Facility Location Information:</p> <ul style="list-style-type: none"> - Field 32 on CMS 1500 Health Insurance Form or - Loop 2310C (claim level) on the 837 Professional Electronic Submission. 	<p>File the claim to the Plan in whose service area the equipment was <i>shipped to or purchased in a retail store</i>.</p> <p>Note:</p> <ul style="list-style-type: none"> • Claim must be processed based on information submitted on the claim. • The Place of Service code, as submitted on the claim, must be used to determine where service was rendered (e.g. member home/equivalent setting, retail, office, etc.). • BlueCard rules for claims incurred in an overlapping service area and contiguous county apply. 	<p>A. Wheelchair, Ankle foot orthotic, etc, is purchased at a retail store in [enter Plan Y service area].</p> <p style="text-align: right;"><i>File to: [enter Plan Y service area]</i></p> <p>B. Wheelchair, Ankle foot orthotic, etc, is purchased on the internet from an online retail supplier in [enter Plan X service area] and shipped to [enter Plan Y service area].</p> <p style="text-align: right;"><i>File to: [enter Plan Y service area]</i></p> <p>C. Wheelchair, Ankle foot orthotic, etc, is purchased at a retail store in [enter Plan X service area] and shipped to [enter Plan Y service area].</p> <p style="text-align: right;"><i>File to: [enter Plan Y service area]</i></p>

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Ancillary Claims Filing Requirements *(cont'd.)*

Provider Type	How to File (Required Fields)	Where to File	Example
<p>Specialty Pharmacy Types of Service: Non-routine, biological therapeutics ordered by a healthcare professional as a covered medical benefit as defined by the member's Plan's Specialty Pharmacy formulary. Include, but are not limited to: injectable, infusion therapies, etc.</p>	<p>Referring Provider:</p> <ul style="list-style-type: none"> - Field 17B on CMS 1500 Health Insurance Claim Form or - Loop 2310A (claim level) on the 837 Professional Electronic Submission. 	<p>File the claim to the Plan whose state the <i>Ordering Physician is located.</i></p> <p>Note:</p> <ul style="list-style-type: none"> • Claim must be processed based on information submitted on the claim. • The ordering physician NPI, as submitted on the claim, must be used to determine where service was rendered. • BlueCard rules for claims incurred in an overlapping service area and contiguous county apply. 	<p>Patient is seen by a physician in [enter Plan X service area] who orders a specialty pharmacy injectable for this patient. Patient will receive the injections in [enter Plan Y service area] where the member lives for 6 months of the year. <i>File to:</i> [enter Plan X service area]</p>

Ancillary Claims Filing Requirements *(cont'd.)*

- The ancillary claim filing rules apply regardless of the provider's contracting status with the Blue plan where the claim is filed.
- Providers are encouraged to verify member eligibility and benefits by contacting the phone number on the back of the member ID card or call (800) 676-BLUE prior to providing any ancillary service.
- Providers that utilize outside vendors to provide services (e.g., sending blood specimen for special analysis that cannot be done by the Lab where the specimen was drawn) should utilize in-network participating ancillary providers to reduce the possibility of additional member liability for covered benefits. A list of in-network participating providers may be obtained by contacting Blue Shield's Provider Information & Enrollment unit at (800) 258-3091 or logging onto blueshieldca.com/provider.
- Members are financially liable for ancillary services not covered under their benefit plan. It is the provider's responsibility to request payment directly from the member for non-covered services.
- Providers who wish to establish Trading Partner Agreements with other Blue plans should contact the other Blue plans to obtain additional information.
- If you have questions about the Ancillary Claims Filing Requirements, please contact Blue Shield's BlueCard Customer Service Unit at (800) 622-0632 or log onto Provider Connection at blueshieldca.com/provider, click on the *Claims* section, click on the *Policies and guidelines* and then select the *Ancillary claims filing* box.

The BlueCard® Program

Claims Filing for Air Ambulance Services for BlueCard Patients

Generally, as a healthcare provider you should file claims for your Blue Cross and Blue Shield patients to the local Blue Plan. However, there are unique circumstances when claims filing directions will differ based on the type of service rendered.

Claims for air ambulance services must be filed to the Blue plan in whose service area the point of pickup ZIP code is located.

Note: If you contract with more than one Blue plan in a state for the same product type (i.e., PPO or Traditional), you may file the claim with either Blue plan.

Service Rendered	How to File (Required Fields)	Where to File	Example
Air Ambulance Services	<p>Point of Pickup ZIP Code:</p> <ul style="list-style-type: none"> – Populate item 23 on CMS 1500 Health Insurance Claim Form, with the 5-digit ZIP code of the point of pickup <ul style="list-style-type: none"> – For electronic billers, populate the origin information (ZIP code of the point of pickup), in the Ambulance Pick-Up Location Loop in the ASC X12N Health Care Claim (837) Professional. – Where Form CMS-1450 (UB-04) is used for air ambulance service not included with local hospital charges, populate Form Locators 39-41, with the 5-digit ZIP code of the point of pickup. The Form Locator must be populated with the approved Code and Value specified by the National Uniform Billing Committee in the UB-04 Data Specifications Manual. <ul style="list-style-type: none"> – Form Locators (FL) 39-41 – Code: A0 (Special ZIP code reporting), or its successor code specified by the National Uniform Billing Committee. – Value: Five-digit ZIP code of the location from which the beneficiary is initially placed on board the ambulance. – For electronic claims, populate the origin information (ZIP code of the point of pickup) in the Value Information Segment in the ASC X12N Health Care Claim (837) Institutional. 	<p>File the claim to the Blue plan in whose service area the point of pickup ZIP code is located*.</p> <p>*BlueCard rules for claims incurred in an overlapping service area and contiguous county apply.</p>	<ul style="list-style-type: none"> • The point of pick up ZIP code is in Blue plan A service area. • The claim must be filed to Blue plan A, based on the point of pickup ZIP code.

If you have questions about the claims filing for Air Ambulance Services for other state Blue plan member, please contact Blue Shield’s BlueCard Customer Service Unit at (800) 622-0632.

Medical Records

Blue plans around the country have made improvements to the medical records process to make it more efficient. We now are able to send and receive medical records electronically among each other. This new method significantly reduces the time it takes to transmit supporting documentation for BlueCard claims, reduces the need to request records multiple times and significantly reduces lost or misrouted records.

Under what circumstances may the provider get requests for medical records for other Blue plan members?

- **As part of the pre-authorization process** - If you receive request for medical records from the member's Blue plan prior to rendering services, as part of the pre-authorization process, you will be instructed to submit the records directly to the member's Blue plan that requested them. This is the only circumstance where you would not submit them to Blue Shield.
- **As part of claim review and adjudication** - These requests will come from Blue Shield in a form of a letter requesting specific medical records and including instructions for submission.

Note: When requesting medical records for DME/HME services, the ordering provider's information is required to process the request.

BlueCard Medical Record Process for Claim Review

- An initial communication, generally in the form of a letter, should be received by your office requesting the needed information.
- A remittance may be received by your office indicating the claim is being denied pending receipt and review of records. Occasionally, the medical records you submit might cross in the mail with the remittance advice for the claim indicating a need for medical records. A remittance advice is not a duplicate request for medical records. If you submitted medical records previously but received a remittance advice indicating records were still needed, please contact Blue Shield's dedicated BlueCard Customer Service team at (800) 622-0632 to ensure your original submission has been received and processed. This will prevent duplicate records being sent unnecessarily.
- If you received only a remittance advice indicating records are needed, but you did not receive a medical records request letter, contact Blue Shield's dedicated BlueCard Customer Service team at (800) 622-0632 to determine if the records are needed from your office.
- Upon receipt of the information, the claim will be reviewed to determine the benefits.

The BlueCard® Program

Medical Records *(cont'd.)*

Helpful Ways You Can Assist in Timely Processing of Medical Records

- If the records are requested following submission of the claim, forward all requested medical records to Blue Shield's dedicated BlueCard Customer Service team at: Blue Shield of California, BlueCard Program, P.O. Box 272630, Chico, CA 95927-2630
- Follow the submission instructions given on the request, using the specified address, email address or fax number. The address or fax number for medical records may be different than the address you use to submit claims.
- Include the cover letter you received with the request when submitting the medical records. This is necessary to make sure the records are routed properly once received by Blue Shield.
- Please submit the information to Blue Shield within 10 days of the request to avoid further delay.
- Only send the information specifically requested. Frequently, complete medical records are not necessary.
- Please do not proactively send medical records with the claim. Unsolicited claim attachments may cause claim payment delays.

Claims Coding

Code claims as you would for local Blue Shield claims. Please refer to Section 4: Billing and Payment for further claim billing information and requirements.

Claim Payment and Claim Status Inquiries

Blue Shield processes BlueCard claims in accordance with our contract agreement with you. Go to Provider Connection at blueshieldca.com/provider 24 hours a day, seven days a week for current, reliable information on BlueCard claims, payment status, and claim reporting tools.

To obtain status and verify payment information on your BlueCard claims, access the *Claims* section on blueshieldca.com/provider. Use this tool as your primary resource for requesting and receiving details on BlueCard claims. If you have remaining questions about your BlueCard claims after accessing the *Claims* section on our website, contact Blue Shield's dedicated BlueCard Customer Service Unit at (800) 622-0632.

Calls from Members and Others with Claim Questions

If Blue plan members contact you, advise them to contact their Blue plan and refer them to their ID card for a customer service number.

The member's Blue plan should not contact you directly regarding claims issues, but if the member's Blue plan contacts you and asks you to submit the claim to them, refer them to Blue Shield of California.

Value Based Provider Arrangements

Blue plans have value-based care delivery arrangements in place with their providers. Each Blue plan has created their own arrangement with their provider(s), including reimbursement arrangements. Due to the unique nature of each Blue plan/provider arrangement, there is no common provider education template for value-based care delivery arrangements that can be created and distributed for use by all Blue plans.

Claim Adjustments

Contact the Blue Shield's BlueCard Customer Service Unit at (800) 622-0632 if an adjustment is required.

Provider Claim Appeals

Provider claim appeals for all BlueCard claims processed by Blue Shield are handled through Blue Shield. BlueCard claim appeals must be resolved within a 30-day timeframe. We will coordinate the appeal process with the member's Blue plan, if needed. For more information on the BlueCard claim appeal process, contact our BlueCard Customer Service Unit at (800) 622-0632.

Section 4

BlueCard Resources

Claims Routing Tool

Determining where to submit BlueCard claims is the number one question providers ask about BlueCard claims. To find out which California Blue plan can process your BlueCard claim, access our Claims Routing Tool on Provider Connection at blueshieldca.com/provider within claims section. Simply enter the member's three-character prefix and date of service to instantly learn where to send your BlueCard claim.

BlueCard Videos

Blue Shield offers two short videos online at our Provider Connection website that describe the core processes of the BlueCard Program.

Our **BlueCard Basics video** makes it easy to learn how to verify eligibility and benefits, request authorizations, and submit claims for out-of-state Blue plan members.

Our **Claims Routing Tool video** will help you identify where to send your BlueCard claims for Blue plan members with healthcare coverage from out-of-state Blue Cross and Blue Shield plans.

Access our online BlueCard videos by logging onto blueshieldca.com/provider, clicking on the *Find BlueCard Program resources* link within the BlueCard section, then selecting either video on the webpage that appears.

BlueCard Program Tutorials

Access our online BlueCard Program tutorials and quickly learn about our online tools. BlueCard tutorials are available anytime, 24 hours a day, 7 days a week. Select the topics you want to learn about, whenever it's convenient for you.

The tutorials will help you learn how to:

- Verify eligibility and benefits
- Access other Blue plans' medical policies, pre-certification guidelines and request medical authorizations
- Instantly determine where to submit claims with the Claims Routing Tool
- Check claims status, payment details and EOB's

Log onto Provider Connection at blueshieldca.com/provider and click on the *BlueCard Program home page* link within the BlueCard Program section on the opening landing page and select the *Tutorials* link. Then choose from a variety of tutorial modules offered.

BlueCard Program Webinars

We offer complimentary online BlueCard Program training sessions to give providers detailed information about serving other states' Blue plan members and processing BlueCard claims.

To attend one of our monthly webinars, access our *Webinars* link on the BlueCard Program webpage on Provider Connection for the date and time. You can also register for available BlueCard webinars by accessing *News & education* section within Provider. To receive notification about BlueCard webinars, request more information by emailing BlueCardMarketing@blueshieldca.com.

BlueCard Frequently Asked Questions (FAQ) Page

Visit our expanded BlueCard FAQ page to see the most asked questions from providers about the BlueCard Program and their detailed answers. To access this informative page, log onto blueshieldca.com/provider, click on the *BlueCard Program* home page link, select the *Resources* link, and then choose the *BlueCard Program FAQs* box.

BlueCard Program Educational Resources

A wide variety of BlueCard educational flyers, brochures, and other resources are available on the BlueCard Program webpage on Provider Connection. The BlueCard educational materials are also available in the *News & education* section.

Section 5

Medicare Advantage

Medicare Advantage Overview

“Medicare Advantage” (MA) is the program alternative to standard Medicare Part A and Part B fee-for-service coverage (generally referred to as “traditional Medicare”). It offers Medicare beneficiaries several product options (similar to those available in the commercial market), including health maintenance organization (HMO), preferred provider organization (PPO), point-of-service (POS) and private fee-for-service (PFFS) plans. All Medicare Advantage plans must offer beneficiaries at least the standard Medicare Part A and B benefits, but many offer additional covered services as well (e.g., enhanced vision and dental benefits).

In addition to these products, Medicare Advantage organizations may also offer a Special Needs Plan (SNP) which can limit enrollment to subgroups of the Medicare population in order to focus on ensuring that their special needs are met as effectively as possible.

Medicare Advantage plans may allow in-and out-of-network benefits, depending on the type of product selected. Providers should confirm the level of coverage by calling 1.800.676.BLUE (2583) or submitting an electronic inquiry for all Medicare Advantage members prior to providing service since the level of benefits, and coverage rules may vary depending on the Medicare Advantage plan.

Types of Medicare Advantage Plans

Medicare Advantage HMO

A Medicare Advantage HMO is a Medicare managed care option in which members typically receive a set of predetermined and prepaid services provided by a network of physicians and hospitals. Generally (except in urgent or emergency care situations), medical services are only covered when provided by in-network providers. The level of benefits, and the coverage rules, may vary by Medicare Advantage plan.

Medicare Advantage POS

A Medicare Advantage POS program is an option available through some Medicare HMO programs. It allows members to determine—at the point of service—whether they want to receive certain designated services within the HMO system or seek such services outside the HMO’s provider network (usually at greater cost to the member). The Medicare Advantage POS plan may specify which services will be available outside of the HMO’s provider network.

Types of Medicare Advantage Plans *(cont'd.)*

Medicare Advantage PPO

A Medicare Advantage PPO is a plan that has a network of providers, but unlike traditional HMO products, it allows members who enroll access to services provided outside the contracted network of providers. Required member cost-sharing may be greater when covered services are obtained out-of-network. Medicare Advantage PPO plans may be offered on a local or regional (frequently multi-state) basis. Special payment and other rules apply to regional PPOs.

Medicare Advantage PFFS

A Medicare Advantage PFFS plan is a plan in which the member may go to any Medicare-approved doctor or hospital that accepts the plan's terms and conditions of participation. Acceptance is "deemed" to occur where the provider is aware, in advance of furnishing services, that the member is enrolled in a PFFS product and where the provider has reasonable access to the terms and conditions of participation.

The Medicare Advantage organization, rather than the Medicare program, pays physicians and providers on a fee-for-services basis for services rendered to such members. Members are responsible for cost-sharing, as specified in the plan, and balance billing may be permitted in limited instance where the provider is a network provider and the plan expressly allows for balance billing.

Medicare Advantage PFFS varies from the other Blue products you might currently participate in:

- You can see and treat any Medicare Advantage PFFS member without having a contract with Blue Shield.
- If you do provide services, you will do so under the Terms and Conditions of that member's Blue plan.
- Please refer to the back of the member's ID card for information on accessing the Blue plan's Terms and Conditions. You may choose to render services to a MA PFFS member on an episode of care (claim-by-claim) basis.
- MA PFFS Terms and Conditions might vary for each Blue Cross and/or Blue Shield plan and we advise that you review them before servicing MA PFFS members.
- Submit your MA PFFS claims to Blue Shield.

The BlueCard® Program

Types of Medicare Advantage Plans *(cont'd.)*

Medicare Advantage Medical Savings Account (MSA)

A Medicare Advantage MSA plan is made up of two parts. One part is a Medicare MSA Health Insurance Policy with a high deductible. The other part is a special savings account where Medicare deposits money to help members pay their medical bills.

Medicare Advantage PPO Network Sharing

What is BCBS Medicare Advantage PPO Network Sharing?

All BCBS MA PPO Plans participate in reciprocal network sharing. This network sharing allows all BCBS MA PPO members to obtain in-network benefits when traveling or living in the service area of any other BCBS MA PPO Plan as long as the member sees a contracted MA PPO provider.

What does the BCBS Medicare Advantage (MA) PPO Network Sharing mean to me?

If you are a contracted MA PPO provider with Blue Shield and you see MA PPO members from other BCBS Plans, these members will be extended the same contractual access to care and will be reimbursed in accordance with your negotiated rate with your Blue Shield contract. These members will receive in-network benefits in accordance with their member contract.

If you are not a contracted MA PPO provider with Blue Shield of California and you provide services for any BCBS MA members, you will receive the Medicare allowed amount for covered services. For urgent or emergency care, you will be reimbursed at the member's in-network benefit level. Other services will be reimbursed at the out-of-network benefit level.

How do I recognize an out-of-area member from one of these Plans participating in the BCBS MA PPO network sharing?

You can recognize a MA PPO member when their member ID card has the following logo.



The "MA" in the suitcase indicates a member who is covered under the MA PPO network sharing program. Members have been asked not to show their standard Medicare ID card when receiving services; instead, members should provide their Blue Cross and/or Blue Shield member ID.

Types of Medicare Advantage Plans *(cont'd.)*

Do I have to provide services to Medicare Advantage PPO members from other Blue Cross Blue Shield Plans?

If you are a contracted Medicare Advantage PPO provider with Blue Shield of California, you must provide the same access to care as you do for Blue Shield MA PPO members. You can expect to receive the same contracted rates for such services.

If you are not a Medicare Advantage PPO contracted provider, you may see Medicare Advantage members from other BCBS Plans but you are not required to do so. Should you decide to provide services to BCBS Medicare Advantage members, you will be reimbursed for covered services at the Medicare allowed amount based on where the services were rendered and under the member's out-of-network benefits. For urgent or emergency care, you will be reimbursed at the in-network benefit level.

What if my practice is closed to new local Blue Cross Blue Shield Medicare Advantage PPO members?

If your practice is closed to new local BCBS MA PPO members, you do not have to provide care for BCBS MA PPO out-of-area members. The same contractual arrangements apply to these out-of-area network sharing members as your local MA PPO members.

What will I be paid for providing services to these out-of-area Medicare Advantage PPO network sharing members?

If you are a MA PPO contracted provider with Blue Shield, benefits will be based on your contracted MA PPO rate for providing covered services to MA PPO members from any MA PPO Plan. Once you submit the MA claim, Blue Shield will work with the other Plan to determine benefits and send you the payment.

What will I be paid for providing services to Medicare Advantage out-of-area members not participating in the Medicare Advantage PPO Network Sharing?

When you provide covered services to other BCBS MA out-of-area members', benefits will be based on the Medicare allowed amount. Once you submit the claim, Blue Shield will send you the payment. However, these services will be paid under the member's out-of-network benefits unless for urgent or emergency care.

The BlueCard® Program

Types of Medicare Advantage Plans *(cont'd.)*

May I request payment upfront?

Generally, once the member receives care, you should not ask for full payment up front other than out-of-pocket expenses (deductible, co-payment, coinsurance and non-covered services).

Under certain circumstances when the member has been notified in advance that a service will not be covered, you may request payment from the member before services are rendered or billed to the member. The member should sign an Advance Benefit Notification (ABN) form before services are rendered in these situations.

What is the member cost sharing level and co-payments?

Member cost sharing level and co-payment is based on the member's health plan. You may collect the co-payment amounts from the member at the time of service. To determine the cost sharing and/or co-payment amounts, you should call the Eligibility Line at 1.800.676.BLUE (2583).

May I balance bill the member the difference in my charge and the allowance?

No, you may not balance bill the member for this difference. Members may be billed for any deductibles, co-insurance, and/or co-pays.

What if I disagree with the reimbursement amount I received?

If there is a question concerning the reimbursement amount, contact Blue Shield at 1.800.622.0632.

What is BCBS Medicare Advantage PPO Network Sharing?

Network sharing allows MA PPO members from MA PPO BCBS Plans to obtain in-network benefits when traveling or living in the service areas of the MA PPO Plans as long as the member sees a contracted MA PPO provider. MA PPO shared networks are available in 39 states and one territory:

Alabama	Kentucky	Nebraska	Puerto Rico
California	Kansas	Nevada	Rhode Island
Colorado	Louisiana	New Hampshire	South Carolina
Connecticut	Maine	New Jersey	Tennessee
Florida	Massachusetts	New Mexico	Texas
Georgia	Michigan	New York	Utah
Hawaii	Minnesota	Ohio	Virginia
Idaho	Missouri	Oklahoma	Washington
Illinois	Montana	Oregon	Wisconsin
Indiana	North Carolina	Pennsylvania	West Virginia

How to Recognize Medicare Advantage Members

Members of Medicare Advantage plans will not have a standard Medicare card; instead, a Blue Cross and/or Blue Shield logo will be visible on the ID card. The following examples illustrate how the different products associated with the Medicare Advantage program will be designated on the front of the member ID cards:

<p><i>Member ID cards for Medicare Advantage products will display one of the benefit product logos shown here:</i></p>		Health Maintenance Organization
		Medical Savings Account
		Private Fee-For-Service
		Point of Service
		Network Sharing Preferred Provider Organization

When these logos are displayed on the front of a member's ID card, it indicates the coverage type the member has in his/her Blue plan service area or region. However, when the member receives services outside his/her Blue plan service area or region, provider reimbursement for covered services is based on the Medicare allowed amount, except for PPO network sharing arrangements.

Blue Shield of California participates in Medicare Advantage PPO Network Sharing arrangements, and contracted provider reimbursement is based on the contracted rate with Blue Shield of California. Non-contracted provider reimbursement is the Medicare allowed amount based on where services are rendered.

Tip: While all MA PPO members have suitcases on their ID cards, some have limited benefits outside of their primary carrier's service area. Providers should refer to the back the member's ID card for language indicating such restrictions apply.

The BlueCard® Program

Eligibility Verification

Verify eligibility by contacting Medicare Member Services at (800) 676-BLUE (2583) and providing the member's prefix or by submitting an electronic inquiry to Blue Shield and providing the prefix. Be sure to ask if Medicare Advantage benefits apply. If you experience difficulty obtaining eligibility information, please record the prefix and report it to Blue Shield.

Medicare Advantage Claims Submission

Submit all Medicare Advantage claims to Blue Shield. Do not bill Medicare directly for any services rendered to a Medicare Advantage member. Payment will be made directly by a Blue plan.

Reimbursement for Medicare Advantage PPO, HMO and POS

No Plan Contract: Services for out-of-area and local Medicare Advantage members

Based upon the Centers for Medicare & Medicaid Services (CMS) regulations, if you are a provider who accepts Medicare assignment and you render services to a Medicare Advantage member for whom you have no obligation to provide services under your contract with a Blue plan, you will generally be considered a non-contracted provider and be reimbursed the equivalent of the current Medicare allowed amount for all covered services (i.e., the amount you would collect if the beneficiary were enrolled in traditional Medicare). Special payment rules apply to hospitals and certain other entities (such as skilled nursing facilities) that are non-contracted providers.

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules. Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue plan or its branded affiliate. In general, you may collect only the applicable cost sharing (e.g., copayment) amounts from the member at the time of service and may not otherwise charge or balance bill the member.

Note: Enrollee payment responsibilities can include more than copayments (e.g., deductibles). Please review the remittance notice concerning Medicare Advantage plan payment, member's payment responsibility, and balance billing limitations.

Plan Contract: Services for local Blue Medicare Advantage members

If you are a provider who accepts Medicare assignment and you render services to a local Medicare Advantage member for whom you have an obligation to provide services under your contract with a Blue plan, you will be considered a contracted provider and be reimbursed per the contractual agreement.

Reimbursement for Medicare Advantage PPO, HMO and POS *(cont'd.)*

If you are a provider who accepts Medicare assignment, has a Blue plan contract to provide services for all Medicare Advantage enrollees, and you render services to out-of-area Blue Medicare Advantage members, you will be reimbursed at the contracted rate.

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules and their individual Blue plan contractual arrangements. Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue plan. In general, you may collect only the applicable cost sharing (e.g., copayment) amounts from the member at the time of service and may not otherwise charge or balance bill the member.

Please review the remittance notice concerning Medicare Advantage plan payment, member's payment responsibility, and balance billing limitations.

Plan Contract: Services for out-of-area Medicare Advantage Blue members

If you are a provider who accepts Medicare assignment, has a Blue plan contract to provide services for local Medicare Advantage enrollees only, and you render services to out-of-area Blue Medicare Advantage members, you will be reimbursed at the Medicare allowed amount (i.e., the amount you would collect if the beneficiary were enrolled in traditional Medicare).

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules and their individual Plan contractual arrangements. Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue plan. In general, you may collect only the applicable cost sharing (e.g., copayment) amounts from the member at the time of service and may not otherwise charge or balance bill the member.

Please review the remittance notice concerning Medicare Advantage plan payment, member's payment responsibility and balance billing limitations.

The BlueCard® Program

Reimbursement for Medicare Advantage Private Fee-For-Service (PFFS)

Plan Contract: Services for local Medicare Advantage PFFS member

If you are a provider who accepts Medicare assignment and you render services to a PFFS local Medicare Advantage member for whom you have an obligation to provide services under your contract with a Blue plan, you will generally be considered a contracted provider and be reimbursed per the contractual agreement. This amount may be less than your charge amount.

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules and their individual Plan contractual arrangements. Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue plan. In general, you may collect only the applicable cost sharing (e.g., copayment) amounts from the member at the time of service but may be able to balance bill the member in certain limited instances where the Blue plan with which you contract expressly allows for balancing billing of PFFS members.

Please review the remittance notice concerning Medicare Advantage plan payment, member's payment responsibility and balance billing limitations.

Services for out-of-area Blue Medicare Advantage PFFS members

If you have rendered services for a Blue out-of-area Medicare Advantage PFFS member, but are not obligated to provide services to such member under a contract with a Blue plan, you will generally be reimbursed the Medicare allowed amount for all covered services (i.e., the amount you would collect if the beneficiary were enrolled in traditional Medicare).

If you have rendered services for a Blue out-of-area Medicare Advantage PFFS member and you are obligated to provide services to such member under a contract with a Blue plan, you will generally be reimbursed at your contracted rate.

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules. Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue plan. In general, you may collect only the applicable cost sharing (e.g., copayment) amounts from the member at the time of service and may not otherwise charge or balance bill the member.

Please review the remittance notice concerning Medicare Advantage plan payment, member's payment responsibility and balance billing limitations.

Reimbursement for Medicare Advantage Private Fee-For-Service (PFFS) *(cont'd.)*

Medicare Advantage Coordination of Care Program

A new national Coordination of Care program to support Blue MA members was launched on January 1, 2020. The program aims to increase the quality of members' care by enabling Blue MA PPO group members to receive appropriate care, wherever they access care.

To better support all Blue MA PPO group members residing in California, Blue Shield is working with providers to improve these members' care through:

- Supporting providers with additional information about open gaps in care
- Requesting medical records to give Plans a complete understanding of member health status

MA PPO group members participating into this program can be identified as having a member address in California and based on the following logo included on their Blue Cross and/or Blue Shield ID Cards:



What does this new program to support Blue Medicare Advantage members mean to me?

This program will result in some changes, including a number that will be beneficial to you, your practice and your patients. The program serves all MA PPO group members that reside in Blue Shield's service area, and some of the benefits that you may see include:

- You will receive consolidated information on gaps in care and risk adjustment gaps, as well as medical record requests for all Blue MA PPO members enrolled with Blue Shield and other Blue Plans and residing in California through local communication practices.
- The MA PPO group members that you see may come into your practice setting more frequently for care due to Blue Shield's requesting care gap closures, allowing for greater continuity in care.

Reminder: As outlined in your contract with Blue Shield, you are required to respond to requests in support of risk adjustment, HEDIS and other government required activities within the requested timeframe. This includes requests from Blue Shield related to this program.

Section 6

Health Insurance Marketplaces (Exchanges)

Health Insurance Marketplaces Overview

The Patient Protection and Affordable Care Act of 2010 provides for the establishment of Health Insurance Marketplaces (i.e. Exchanges), in each state, where individuals and small businesses can purchase qualified insurance coverage through internet websites. The intent of the Marketplace is to:

Create a more organized and competitive health insurance marketplace by offering consumers a choice of health insurance plans,

- Establish common rules regarding insurance offerings and pricing,
- Provide information to help consumers better understand the options available to them and,
- Allow individual and small businesses to have the purchasing power comparable to that of large businesses.

The Marketplaces makes it easier for consumers to compare health insurance plans by providing transparent information about health insurance plan provisions such as product information, premium costs, and covered benefits, as well as a plan's performance in encouraging wellness, managing chronic illnesses, and improving consumer satisfaction.

Each state is given the option to set-up its own "state-based" Marketplace approved by HHS for marketing products to individual consumers and small businesses. If states do not set up a state-based marketplace, the Department of Health and Human Services (HHS) establishes a federally-facilitated Marketplace, federally-supported Marketplace, or a state-partnership Marketplace in the state. Blue plans that offer products on the Marketplaces collaborate with the state and federal governments for eligibility, enrollment, reconciliation, and other operations to ensure that consumers can seamlessly enroll in individual and small business health insurance products. Blue Shield of California has on-Exchange state-subsidized plans available for purchase through Covered California. Information on Covered California plans offered by Blue Shield can be accessed through Provider Connection at blueshieldca.com/provider. Click on *Guidelines & resources* at the top of the landing page, then *Healthcare reform* in the top right.

Health Insurance Marketplaces Overview *(cont'd.)*

Exchange-Purchased Plans - Individual Grace Period

The Patient Protection and Affordable Care Act (PPACA) mandates a three month grace period for individual members who receive a premium subsidy from the government and are delinquent in paying their portion of premiums. The grace period applies as long as the individual has previously paid at least one month's premium within the benefit year. The health insurance plan is only obligated to pay claims for services rendered during the first month of the grace period. PPACA clarifies that the health insurance plan may pend claims during the second and third months of the grace period.

Blue plans are required to either pay or pend claims for services rendered during the second and third month of the grace period. Consequently, if a member is within the last two months of the federally mandated individual grace period, providers may receive a notification from Blue Shield of California indicating that the member is in the grace period.

Exchange Individual Grace Period – Post Service Notification Letter to Provider

Communication to providers will include the following information:

1. Notice-unique identification number (claim includes member information):

Claim #: _____

2. Name of the QHP and affiliated issuer (Blue plan name):

3. Explanation of the three month grace period:

Under the Patient Protection and Affordable Care Act (PPACA), there is a three month grace period under Exchange-purchased individual insurance policies, when a premium due is not received for members eligible for premium subsidies. During this grace period, carriers may not disenroll members and, during the second and third months of the grace period, are required to notify providers about the possibility that claims may be denied in the event that the premium is not paid.

4. Purpose of the notice, applicable dates of whether the enrollee is in the second or third month of the grace period & individuals affected under the policy and possibly under care of the provider:

Please be advised that a premium due has not been received for this subsidy eligible member and that the member and any eligible dependents are and at the time that your care was provided, were in the second or third month of the Exchange individual health insurance grace period. The above-referenced claim thus was pended due to non-payment of premium and will be denied if the premium is not paid by the end of the grace period.

The BlueCard® Program

Health Insurance Marketplaces Overview *(cont'd.)*

5. Consequences:

If the premium is paid in full by the end of the grace period, any pended claims will be processed in accordance with the terms of the contract. If the premium is not paid in full by the end of the grace period, any claims incurred in the second and third months may be denied.

6. QHP customer service telephone number:

Please feel free to contact Blue Shield of California Monday through Friday, at our Provider Customer Service Unit at (800) 541-6652 if you have any questions regarding this claim.

Health Insurance Marketplaces Claims

The products offered on the Marketplaces will follow local business practices for processing and servicing claims. Providers should continue to follow current practices with Blue Shield of California for claims processing and handling such as outlined below.

1. Eligibility and Benefits
2. Care Management
 1. Pre-Service Review
 2. Medical Policy
3. Claim Pricing and Processing
 1. Contracting
 2. Claim Filing
 3. Pricing
 4. Claim Processing
 5. Medical Records
 6. Payment
 7. Customer Service

Health Insurance Marketplaces Overview *(cont'd.)*

How can I get more information about Health Insurance Marketplaces (Exchanges)?

If you would like more information about Health Insurance Marketplaces (Exchanges), log onto Provider Connection at blueshieldca.com/provider. Once you are logged onto our provider portal, follow these steps for more information:

- 1) Click on *Guidelines & resources* at the top of the landing page.
- 2) Click on *Healthcare reform* in the top right.
- 3) On the next page, click on the link *Products and Networks Available through Covered California*.

Here, you will find a wide variety of provider and member resources to enhance your understanding of Health Insurance Marketplaces.

Who do I contact if I have a question about Health Insurance Marketplaces (Exchanges)?

If you have any questions regarding the Health Insurance Marketplaces, please contact Blue Shield's Provider Customer Service Unit at (800) 541-6652.

Section 7

Glossary of BlueCard Program Terms

Administrative Services Only (ASO) ASO accounts are self-funded, where the local plan administers claims on behalf of the account, but does not fully underwrite the claims. ASO accounts may have benefit or claims processing requirements that may differ from non-ASO accounts. There may be specific requirements that affect; medical benefits, submission of medical records, Coordination of Benefits or timely filing limitations.

Blue Shield of California receives and prices all local claims, handles all interactions with providers, with the exception of Utilization Management interactions, and makes payment to the local provider.

Affordable Care Act The comprehensive healthcare reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is used to refer to the final, amended version of the law.

Ancillary Services Ancillary services include independent clinical laboratory services, durable/home medical equipment and supply services, and specialty pharmacy services.

bcbs.com Blue Cross and Blue Shield Association's website, which contains useful information for providers.

BlueCard Access Providers or members can use this toll-free number (800) 810-BLUE (2583) to locate healthcare providers in another Blue plan's area. This number is useful when you need to refer the patient to a physician or healthcare facility in another location.

The BlueCard® Program

BlueCard Doctor and Hospital Finder

A website providers and members can use to locate providers in another Blue Cross and Blue Shield plan's service area. This is useful when you need to refer the patient to a physician or healthcare facility in another location. You can access provider information for all 50 states as well as the BlueCard Worldwide network through blueshieldca.com. Click on *Find a Doctor* and then click on the *Providers outside of CA* link on the bottom of the page.

BlueCard Eligibility®

Providers can use this toll-free eligibility line at (800) 676-BLUE (2583) to verify membership and coverage information and obtain pre-certification on patients from other Blue plans.

Providers can also access eligibility and benefits information for other Blue plan members by accessing blueshieldca.com/provider.

BlueCard PPO

A national program that offers members traveling or living outside of their Blue Cross and/or Blue Shield plan's service area the PPO level of benefits when they obtain services from a physician or hospital designated as a PPO provider.

BlueCard PPO Basic

A national program that offers members traveling or living outside of their Blue Cross and/or Blue Shield plan's service area the PPO basic level of benefits when they obtain services from a physician or hospital designated as a BlueCard PPO Basic provider.

When you see the "PPOB" in a suitcase logo on the front of the member's Blue Plan ID card, it means the member has selected a PPO plan product from a Blue Cross Blue Shield plan. Since Blue Shield of California does not have a BlueCard PPO Basic network, providers will be reimbursed for covered services in accordance with your PPO contract with Blue Shield of California

BlueCard PPO Member

A Blue plan patient who carries an ID card with this identifier on it. Only members with this identifier can access the benefits of the BlueCard PPO.



The BlueCard® Program

BlueCard PPO Network	The network comprising those physicians, hospitals and other healthcare providers PPO members may elect to use to obtain the highest level of PPO benefits.
BlueCard PPO Provider	A doctor, hospital or other healthcare entity enrolled in a network of designated PPO providers.
BlueCard Traditional	A national program that offers members traveling or living outside of their Blue plan's service area the traditional, or indemnity, level of benefits when they obtain services from a physician or hospital outside of their Blue plan's service area. These members will carry an ID card featuring an "empty" suitcase logo.
Blue High-Performance Network (BLUEHPN)	A national network of providers offered in key geographies that provides national accounts enhanced quality and cost savings.
Blue Shield Global Core®	A program that allows Blue plan members traveling or living outside of the United States to receive healthcare services from participating international Blue plan healthcare providers. The program also allows members of international Blue plans to access U.S. Blue plan provider networks. The Global Network of participating providers can be accessed through blueshieldca.com. Click on <i>Find a Doctor</i> and then click on the <i>Providers outside of CA</i> link on the bottom of the page.
Consumer Directed Health Care/Health Plans (CDHC/CDHP)	Consumer Directed Health Care (CDHC) is a broad umbrella term that refers to a movement in the healthcare industry to empower members, reduce employer costs and change consumer healthcare purchasing behavior. CDHC plans provide the member with additional information to make an informed and appropriate decision through the use of member support tools, provider and network information, and financial incentives.
Coinsurance	A provision in a member's coverage that limits the amount of coverage by the plan to a certain percentage. The member pays any additional costs out-of-pocket.

The BlueCard® Program

Coordination of Benefits (COB) Ensures that members receive full benefits and prevents double payment for services when a member has coverage from two or more sources. The member's contract language gives the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.

Copayment A specified charge that a member incurs for a specified service at the time the service is rendered.

Deductible A flat amount the member incurs before the insurer will make any benefit payments.

Electronic Provider Access Electronic Provider Access (EPA) is an online tool giving providers the ability to access out-of-area members' Blue plan provider websites to request medical authorization and pre-service review. To access the EPA tool, log onto Provider Connection at blueshieldca.com/provider and click on *Pre-service review for out-of-area members* in the *Authorizations* section on the opening landing page. Choose the *Electronic Provider Access* option and you will be connected directly to the Blue plan within a secured routing mechanism to begin your request.

Essential Community Providers Healthcare providers that serve predominately low-income, high-risk, special needs and medically-underserved individuals. The Department of Health and Human Services (HHS) proposes to define essential community providers as including only those groups suggested in the ACA, namely those named in section 340B(a)(4) of the Public Health Service Act and in section 197(c)(1)(D)(i)(IV) of the Social Security Act.

Exclusive Provider Organization (EPO) An Exclusive Provider Organization is a health benefits program in which the member receives no benefits for care obtained outside the network except emergency care and does not include a Primary Care Physician selection. EPO benefit coverage may be delivered via BlueCard PPO and is restricted to services provided by BlueCard PPO providers.

FEP The Federal Employee Program.

The BlueCard® Program

Hold Harmless

An agreement with a healthcare provider not to bill the member for any difference between billed charges for covered services (excluding coinsurance) and the amount the healthcare provider has contractually agreed with a Blue plan as full payment for these services.

Marketplace Exchange

For purposes of this document, the term Marketplace/Exchange refers to the public exchange as established pursuant to the Affordable Care Act (ACA): A transparent and competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans. Affordable Insurance Marketplaces will offer a choice of health plans that meet certain benefits and cost standards.

The ACA allows the opportunity for each state to establish a State-based Marketplace. Recognizing that not all states may elect to establish a State-based Marketplace, the ACA directs the Secretary of HHS to establish and operate a federally-facilitated Marketplace in any state that does not do so.

Medicaid

A program designed to assist low-income families in providing healthcare for themselves and their children. It also covers certain individuals who fall below the federal poverty level. Other people who are eligible for Medicaid include low-income children under age 6 and low-income pregnant women, Medicaid is governed by overall federal guidelines in terms of eligibility, procedures, payment level etc., but states have a broad range of options within those guidelines to customize the program to their needs and/or can apply for specific waivers. State Medicaid programs must be approved by CMS; their daily operations are overseen by the State Department of Health (or similar state agency).

Medicare Advantage

Medicare Advantage (MA) is the program alternative to standard Medicare Part A and Part B fee-for-service coverage; generally referred to as "traditional Medicare."

MA offers Medicare beneficiaries several product options (similar to those available in the commercial market), including health maintenance organization (HMO), preferred provider organization (PPO), point-of-service (POS) and private fee-for-service (PFFS) plans.

Medicare Crossover

The Crossover program was established to allow Medicare to transfer Medicare Summary Notice (MSN) information directly to a payor with Medicare's supplemental insurance company.

The BlueCard® Program

Medicare Supplemental (Medigap)

Pays for expenses not covered by Medicare. Medigap is a term for a health insurance policy sold by private insurance companies to fill the “gaps” in original Medicare Plan coverage. Medigap policies help pay some of the healthcare costs that the original Medicare Plan doesn’t cover.

Medigap policies are regulated under federal and state laws and are “standardized.” There may be up to 12 different standardized Medigap policies (Medigap Plans A through L). Each plan, A through L, has a different set of basic and extra benefits. The benefits in any Medigap Plan A through L are the same for any insurance company. Each insurance company decides which Medigap policies it wants to sell.

Most of the Medigap claims are submitted electronically directly from the Medicare intermediary to the member’s Home Plan via Medicare Crossover process.

Medigap does not include Medicare Advantage products, which are a separate program under the Centers for Medicare & Medicaid Services (CMS). Members who have a Medicare Advantage Plan do not typically have a Medigap policy because under Medicare Advantage these policies do not pay any deductibles, copayments or other cost-sharing.

National Account

An employer group with employees and/or retirees located in more than one Blue plan service area.

Other Party Liability (OPL)

A cost containment program that ensure Blue plans meet their responsibilities efficiently without assuming the monetary obligations of others and without allowing members to profit from illness or accident. OPL includes coordination of benefits, Medicare, Workers’ Compensation, subrogation and no-fault auto insurance.

Plan

Refers to any Blue Cross and/or Blue Shield plan member’s health care service coverage, e.g., HMO, PPO, EPO, and POS.

Point of Service (POS)

Point of Service is a health benefit program in which the highest level of benefits is received when the member obtains services from his/her primary care provider/group and/or complies with referral authorization requirements for care. Benefits are still provided when the member obtains care from any eligible provider without referral authorization, according to the terms of the contract.

The BlueCard® Program

PPOB	A health benefit program that provides a significant financial incentive to members when they obtain services from any physician or hospital designated as a PPO provider and that does not require a primary care physician gatekeeper/referral to access PPO providers. Similar to BlueCard PPO/EPO, this network includes providers specializing in numerous types of care, as well as other provider types, such as Essential Community and Indian Health Service providers where they are available.
Preferred Provider Organization (PPO)	Preferred Provider Organization is a health benefit program that provides a significant incentive to members when they obtain services from a designated PPO provider. The benefit program does not require a gatekeeper (primary care physician) or referral to access PPO providers.
Prefix	The three characters preceding the subscriber identification number on the Blue plan ID cards. The prefix identifies the Blue plan or national account to which the member belongs and is required for routing claims.
Provider Connection	Blue Shield's provider website at blueshieldca.com/provider contains useful information for our providers including: basic BlueCard patient administration and claims processing steps, eligibility and benefits information on other Blue plan members, and instructions on where to send BlueCard claims by accessing our Claims Routing Tool.
Qualified Health Plan (QHP)	Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by an Exchange, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.
Small Business Health Options Program (SHOP)	Allows employers to choose the level of coverage and offer choices among health insurance plans. State-run Marketplaces were scheduled to become available by January 2014, with the federal government stepping in to run Marketplaces for states that were not ready. In 2016, all businesses with 100 or fewer employees must be able to purchase insurance through these Exchanges. The Marketplaces have the option of including employees with more than 100 employees beginning in 2017.

The BlueCard® Program

**State
Children’s
Health
Insurance
Program
(SCHIP)**

SCHIP is a public program administered by the United States Department of Health and Human Services that provides matching funds to states for health insurance to families with children. The program was designed with the intent to cover uninsured children in families with incomes that are modest but too high to qualify for Medicaid. States are given flexibility in designing their SCHIP eligibility requirements and policies within broad federal guidelines. Some states have received authority through waivers of statutory provisions to use SCHIP funds to cover the parents of children receiving benefits from both SCHIP and Medicaid, pregnant women, and other adults.

**Traditional
Coverage**

Traditional coverage is a health benefit plan that provides basic and/or supplemental hospital and medical/surgical benefits (e.g., basic, major medical and add-on riders) designed to cover various services. Such products generally include cost sharing features, such as deductibles, coinsurance or copayments.

The BlueCard® Program

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Other Payor Summary List

Other Payor Summary List	
Other Payor	Type of Plan
Blue Cross Blue Shield Plans	Individual and Group Health Plans
Other Arrangements	Arrangements pursuant to which Blue Shield subsidiaries, e.g., Blue Shield of California Life & Health Insurance Company, may utilize the Blue Shield Life Network.
Blue Shield of California Life & Health Insurance Company	Individual Health Plans (Blue Shield Life Network)
Risk Management Accounts (RMCs)	<p><u>Group health plans</u> - Blue Shield of California provides one or more of the following services for a fixed administrative fee: administrative services (such as eligibility and claims processing), benefit determinations, generation of identification (ID) cards, check issuance, and reconciliation.</p> <p>The group is at risk for the cost of health care.</p> <p>Only large groups are eligible.</p> <p>This list is updated periodically. Please contact Blue Shield of California directly if an updated list is needed.</p>
A - PRISM/EI Dorado County	PRISM/San Diego Metro Transit - Z
24 Hour Fitness USA, Inc.	PRISM/San Diego Metro Transit
AAA NCNU	PRISM/Santa Barbara Superior Courts
ACCO Management Company	PRISM/Small Group Program
Activision Publishing, Inc.	PRISM/South Coast Air Quality Management District
Adept Fasteners Inc	PRISM/Stanislaus Superior Courts
AirConditioning and Refrigeration Industry Joint Trust Funds	Private National Mortgage Acceptance Company, LLC dba PennyMac
Alhambra Unified School District	Professional Auto Transport, Inc.
Allen Lund Company, Inc	Prospect Medical Holdings, Inc
Alliance HealthCare Services	Pure Storage, Inc.
Amerit Fleet Solutions	Radnet, Inc.
ARM, INC. (ARM, Physical IP, Inc.)	Raley's
Big Creek Lumber	Reta Trust / Diocese of Great Falls Billings
Blue Shield of CA LODI	Reta Trust/ Diocese of Salina
Blue Shield of CA NON LODI	Reta Trust/ St. John Society
Bosley, Inc	Reta Trust/Abbey of St. Mary & St. Louis
Box, Inc.	Reta Trust/Archdiocese of Portland in Oregon
Brighton Collectibles, LLC.	Reta Trust/Archdiocese of San Francisco
Burrtec Waste Industries Inc	Reta Trust/Bishop Garcia Diego High School
Business Administration Support Services	Reta Trust/Carmelite Sisters
Buttonwillow Warehouse Co Inc.	Reta Trust/Catholic Charities Diocese of San Diego
C&D Technologies	Reta Trust/Catholic Charities Maine (Master)

Other Payor Summary List

A - PRISM/El Dorado County	PRISM/San Diego Metro Transit - Z
California Clinic Management dba Acuity Eye Group	Reta Trust/Catholic Charities of Orange County
California Giant Berry, Inc.	Reta Trust/Catholic Charities of San Francisco
California's Valued Trust	Reta Trust/Catholic Charities of Santa Clara County
Carlsbad Unified School District	Reta Trust/Catholic Charities of the East Bay (Master)
Carlsbad USD - Classified & Management	Reta Trust/Daughters of Charity
Catalina Cylinders, Inc	Reta Trust/Diocesan Fiscal Management Conference
Chico State Enterprises	Reta Trust/Diocese of Belleville
City of Hanford	Reta Trust/Diocese of Bismarck
City of Tulare	Reta Trust/Diocese of Cheyenne
Clovis Unified School District	Reta Trust/Diocese of Davenport
CMG Mortgage, Inc. DBA CMG Financial	Reta Trust/Diocese of Duluth
Cottage Health	Reta Trust/Diocese of El Paso
County of Kings	Reta Trust/Diocese of Jackson, MS
County of Orange	Reta Trust/Diocese of Lafayette Indiana
County of San Mateo	Reta Trust/Diocese of Las Cruces
Credit Karma	Reta Trust/Diocese of Las Vegas
CrossFit, Inc	Reta Trust/Diocese of Manchester
CSEBA/ Hesperia Unified School District - Classified	Reta Trust/Diocese of Monterey
CSEBA/Alta Loma School District	Reta Trust/Diocese of New Ulm
CSEBA/Barstow USD	Reta Trust/Diocese of Norwich
CSEBA/Bassett Unified School District	Reta Trust/Diocese of Oakland
CSEBA/Bear Valley Unified School District	Reta Trust/Diocese of Orange
CSEBA/Beaumont Unified School District	Reta Trust/Diocese of Pueblo
CSEBA/Brea Olinda Unified School District	Reta Trust/Diocese of Rapid City, SD
CSEBA/Central School District	Reta Trust/Diocese of Reno
CSEBA/Centralia School District	Reta Trust/Diocese of Santa Rosa
CSEBA/Chaffey Community College District	Reta Trust/Diocese of Tulsa
CSEBA/Chartersafe - Clear Passage Education Center	Reta Trust/Diocese of Victoria
CSEBA/Chartersafe - New Opportunities Organization	Reta Trust/Discaled Carmelite Friars
CSEBA/Chartersafe - River Springs Charter School	Reta Trust/Home On The Range
CSEBA/Chartersafe - Ross Valley Charter School	Reta Trust/Hospitaller Brothers Healthcare, Inc.
CSEBA/Chartersafe - Sierra	Reta Trust/Immaculate Heart High School
CSEBA/Chino Valley	Reta Trust/JSerra Catholic High School
CSEBA/Colton Jt. Unified School District	Reta Trust/JSerra Catholic High School HPN
CSEBA/Covina Valley Unified School District	Reta Trust/Julie Billiard Network
CSEBA/Cucamonga School District	Reta Trust/Marianist Province of the United States
CSEBA/East San Gabriel Valley ROP	Reta Trust/Mercy High School, Burlingame
CSEBA/Encinitas Union School District	Reta Trust/Mount St. Michael Catholic School
CSEBA/Etiwanda School District	Reta Trust/Oldenburg Academy of the Immaculate Conception
CSEBA/Hemet Unified School District	Reta Trust/Pauline Books and Media
CSEBA/Hesperia Unified School District -Classified	Reta Trust/Providence Cristo Rey High School (Master)
CSEBA/Mountain View School District	Reta Trust/Rancho San Antonio Boy's Home, Inc.

Other Payor Summary List

A - PRISM/EI Dorado County	PRISM/San Diego Metro Transit - Z
CSEBA/North Orange County ROP	Reta Trust/Religious Sisters of Charity
CSEBA/Ontario-Montclair School District	Reta Trust/Roman Catholic Diocese of Helena
CSEBA/Ramona Unified School District	Reta Trust/Roman Catholic Diocese of Sacramento
CSEBA/Rim of the World Unified School District	Reta Trust/Roman Catholic Diocese of Springfield- MA
CSEBA/San Bernardino CSS	Reta Trust/Salesians of St. John Bosco
CSEBA/San Marino Unified School District	Reta Trust/Santa Catalina School
CSEBA/Santee School District	Reta Trust/Sisters of Notre Dame Sponsored Schools
CSEBA/Savanna School District	Reta Trust/Sisters of Notre Dame USA
CSEBA/Summit Leadership Academy High Desert	Reta Trust/Sisters of St. Francis - Mt. Alverno
CSEBA/Victor Valley College	Reta Trust/Sisters of the Company of Mary
CVT PPO/Alisal USD	Reta Trust/Sisters of the Precious Blood
CVT PPO/Barstow Community College	Reta Trust/Sisters of the Society Devoted to the Sacred Heart
CVT PPO/Bella Vista Elementary SD	Reta Trust/Society-Sacred Heart U.S. Prv
CVT PPO/Cascade Union Elementary SD	Reta Trust/St. Michael's Abbey
CVT PPO/Charter Oak USD	Reta Trust/The Roman Catholic Diocese of Gallup
CVT PPO/Children's Community Charter	Reta Trust/Thomas Aquinas College
CVT PPO/College of the Siskiyous	Reta Trust/Verbum Dei Jesuit High School
CVT PPO/Desert Center Unified SD	Riverside Community College District
CVT PPO/Gonzales Unified SD	Rivian
CVT PPO/Greenfield Union SD	Ruiz Food Products Inc
CVT PPO/Junction SD	Sakura Finetek USA Inc
CVT PPO/Live Oak SD	San Francisco Electrical Workers Health & Welfare
CVT PPO/Lone Pine Unified SD	San Francisco Health Service System
CVT PPO/Lucerne Valley Unified SD	San Francisco Symphony
CVT PPO/Mission Union SD	San Francisco Symphony, Inc.
CVT PPO/Modoc COE	Saxco International LLC
CVT PPO/Monterey COE	Seismic Software Inc dba Seismic
CVT PPO/Mountain Elementary SD	Self-Insured Schools of California
CVT PPO/Nevada Joint Union High SD	Sensient Technologies Corporation
CVT PPO/North Cow Creek Elementary SD	Servicon Systems. Inc.
CVT PPO/Owens Valley Unified SD	Sheet Metal Workers Intl Assoc Local Union 104
CVT PPO/Palo Verde Unified SD	Sheppard, Mullin Richter & Hampton LLP
CVT PPO/San Ardo Union Elementary SD	Sierra Forest Products, Inc.
CVT PPO/San Lorenzo Valley Unified SD	Sign Pictorial and Display Industry
CVT PPO/San Lucas Union SD	SISC/Alexander Valley
CVT PPO/Shasta Trinity-ROP	SISC/Alpaugh USD
CVT PPO/Silver Valley Unified SD	SISC/Alvord USD
CVT PPO/Soledad Unified SD	SISC/Antelope Valley CCD
CVT PPO/South Monterey County JUHSD	SISC/Arcadia USD
CVT PPO/Spreckels Union SD	SISC/Arcata School District
CVT PPO/Summerville Union High SD	SISC/ASCIP La Canada USD
CVT PPO/Tuolumne County SOS	SISC/ASCIP Rosemead SD
CVT PPO/Washington Union SD	SISC/Azusa Unified School District
Delano Union School District	SISC/Bennett Valley Union Elementary

Other Payor Summary List

A - PRISM/EI Dorado County	PRISM/San Diego Metro Transit - Z
Downey U.S.D.	SISC/Cabrillo College
EDCO Disposal Corp	SISC/Calistoga Joint Unified School District
Edison International	SISC/Ceiba Public Schools
Educational Media Foundation	SISC/Central Region School
Electronics for Imaging, Inc	SISC/Ceres Unified School District
Enloe Medical Center	SISC/Chawanakee USD
Enlyte (Formerly Mitchell International Inc)	SISC/Chowchilla Elementary
Enphase Energy Inc	SISC/Cinnabar Elementary
Ensign Services, Inc.	SISC/Cloverdale Unified
EXELIXIS, INC.	SISC/College of the Desert
F and A Federal Credit Union	SISC/Delhi USD
Farwest Corrosion Control	SISC/Dunham School District
Fire Districts Association of California	SISC/EI Centro Elementary School District
Foster Farms	SISC/Empire Union Elementary
Fresno City Employees Health & Welfare Trust	SISC/Evergreen School District
Fresno Truck Center	SISC/Firebaugh-Las Deltas Joint Unified School District
Gar Bennett LLC (Formerly Gar Tootelian)	SISC/Fort Ross Elementary
GitHub, Inc	SISC/Fullerton Elementary School District
Glidewell Laboratories	SISC/Geyserville Unified
Golden Valley Health Centers	SISC/Gratton Elementary
Grimmway Enterprise	SISC/Gravenstein Union Elem
Haight, Brown and Bonesteel, LLP	SISC/Guerneville SD
Hanford Joint Union High School District	SISC/Harmony Union Elementary
Hankey Investment Co.	SISC/Hart Ransom Union Elementary
Hutchison & Bloodgood	SISC/Hickman Community Charter School District
Illumina, Inc	SISC/Holtville Unified
ILWU-PMA Welfare Plan	SISC/Kashia Elementary
Indian Health Council, Inc.	SISC/Kentfield School District
Interface Rehab, Inc.	SISC/Kenwood Elementary
Intuitive Surgical Incorporated	SISC/Keyes Union School District
Iron Mechanical, Inc.	SISC/Larkspur Corte Madera SD
Irvine Unified School District	SISC/Liberty Elementary
Jazz Pharmaceuticals, Inc	SISC/Live Oak Charter School
JBR Inc. DBA San Francisco Bay Gourmet Coffee	SISC/Los Banos USD
JFC International/Kikkoman Sales USA	SISC/Madera County Office of Education
Juniper Networks, Inc	SISC/Marin Community College District
Los Angeles Dodgers	SISC/Mark West Union
Lyons Magnus, LLC	SISC/McKinleyville Union School District
Madsen, Kneppers and Associates	SISC/Mendocino USD
Manco Abbott, Inc.	SISC/Monte Rio Union Elem
Marin Healthcare District	SISC/Montgomery Elem
Mattel, Inc	SISC/Mt San Antonio College
MCSIG / Big Sur Charter School	SISC/Oak Grove Union Elem
MCSIG / Big Sur Unified School District	SISC/Old Adobe Union Elem
MCSIG / Bradley Union School District	SISC/Pajaro Valley Unified School District

Other Payor Summary List

A - PRISM/El Dorado County	PRISM/San Diego Metro Transit - Z
MCSIG / Carmel Unified School District	SISC/Palm Springs Unified School District
MCSIG / Castro Valley Unified School District	SISC/Palmdale Aerospace Academy
MCSIG / City of Seaside	SISC/Palmdale School District
MCSIG / El Dorado County Office of Education	SISC/Pasadena Unified School District
MCSIG / Gonzales Unified School District	SISC/Petaluma School District
MCSIG / Graves School District	SISC/Piner-Olivet Union Elem
MCSIG / Hartnell College	SISC/Plumas Unified School District
MCSIG / International School of Monterey	SISC/Redondo Beach USD
MCSIG / King City Union School District	SISC/Redwood Empire School Ins Grp
MCSIG/Lagunitas School District	SISC/RESIG COBRA RETIREE
MCSIG/Learning 4 Life Charter School District	SISC/Retiree Pool
MCSIG/MCSIG Cobra	SISC/Rincon Valley Union Elem
MCSIG/Mission Union School District	SISC/Rio School District
MCSIG/Monterey Bay Charter School District	SISC/Roseland Elem
MCSIG/Monterey COE/Headstart	SISC/Salida Union Elementary
MCSIG/Monterey County Office of Education	SISC/San Gabriel USD
MCSIG/Monterey Educational Risk Mgmt Authority	SISC/Santa Cruz City Schools
MCSIG/Monterey Peninsula Unified School District	SISC/Santa Rosa Junior College
MCSIG/Municipalities Colleges Schools Insurance Group	SISC/Sebastopol Ind Charter
MCSIG/Oak Grove School District	SISC/Shiloh Elementary
MCSIG/Ohlone College	SISC/Shoreline Unified
MCSIG/Pacific Grove Unified School District	SISC/Sierra Joint Community College District
MCSIG/Salinas City Elementary School District	SISC/Sierra Unified
MCSIG/Salinas Union High School District	SISC/Sonoma County Office of Ed
MCSIG/San Antonio Union School District	SISC/South Orange County CCD
MCSIG/San Lucas Union School District	SISC/Stanislaus Union Elementary
MCSIG/San Luis Obispo Community College District	SISC/Tamalpais Union HSD
MCSIG/Santa Rita Union School District	SISC/Tree of Life Charter
MCSIG/Soledad Comm Health Care District Foundation	SISC/Twin Hills Union SD
MCSIG/South Monterey County Join Union HSD	SISC/Two Rock Union Elementary
MCSIG/The International School of Monterey	SISC/Victor Elementary School District
Medimpact Healthcare Systems, Inc.	SISC/Waugh Elem
Modesto Industrial Electrical	SISC/West Hills CCD
Monterey Peninsula Surgery Center LLC	SISC/West Side Union School District
Municipalities Colleges Schools Insurance Group	SISC/West Sonoma County HSD
Myers Automotive Group, Inc dba Toyota of Escondido	SISC/Westminster School District
National University	SISC/Westside Union Elem
Nikon Precision, Inc.	SISC/Wilmar Union Elem
North American Video Corporation	SISC/Yosemite Community College District
North Coast Schools Medical Insurance Group	SISC/Yosemite USD
Northern CA Sheet Metal Workers Local 162	SoCal Pipe Trades

Other Payor Summary List

A - PRISM/EI Dorado County	PRISM/San Diego Metro Transit - Z
Northern California Tile Industry Health Trust	Southern California Edison Company (Edison International)
Northgate Gonzalez	Southwest Traders
organicgirl LLC	SpaceX (Space Exploration Technologies)
Ossur North America, Inc.	Stanford University
Pacific Coast Building Products	Sukut Construction Inc
Pacific Medical, Inc	Sutter Homes (Trincherro Family Estates)
Pacific Southwest Container, LLC	The Heffernan Group
Palantir Technologies	The Hignell Companies
Palo Alto Network	The Lagunitas Brewing Company
Paskenta Band of Nomiaki Indians	The Sun Valley Group
PathPoint	The Wonderful Company
Pauma Band of Mission Indians	Tom's Truck Center
Pechanga Band Of Luiseno Mission Indians	Topcon Positioning Systems Inc. dba Topcon America Corp
Petco Animal Supplies Inc	Tri Cal
Pinterest Inc	Tutor Perini Corporation
Pioneers Memorial Healthcare District	UA 447 Local Pipe Trades & Welfare Trust Fund
Pomona Valley Hospital Medical Center	Uber Technologies Inc.
Powerschool Group LLC	UFCW & Employers Benefit Trust
Premium Packing, Inc	UFCW Comprehensive Benefit Trust
Prime HealthCare Services	Ultragenyx Pharmaceutical Inc
Printing Specialties & Paper Products Joint Benefits H&W Trust	United Agricultural Benefit Trust
PRISM (Formerly CSAC Excess Insurance Authority)	UnitedAg Benefit Trust Restricted
PRISM/Amador County	Valley Children's Hospital
PRISM/City of Huntington Beach	Valley Pacific Petroleum Services
PRISM/City of Irvine	Victor Community Support Services Inc
PRISM/City of Oceanside	Washington Hospital
PRISM/City of Redding	Wellfleet Insurance Company (UC Berkeley Student Health Insurance Plan)
PRISM/City of Walnut Creek	Western Dental Services Inc
PRISM/City of Yuba City	Whittier Union High School District
PRISM/Community Development Commission of Los Angeles	Wilbur Ellis Holdings
PRISM/County of Imperial	Yelp
PRISM/County of Santa Barbara	Yocha Dehe Wintun Nation (Cache Creek Casino)
PRISM/EI Dorado County	ZenDesk Inc.