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2.1 Blue Shield HMO Benefit Plans

Blue Shield offers the Access+ HMO® Plan and Local Access+ HMO Plan to Small Business and Core Account groups. Point-of-service (POS) and SaveNet HMO plans are included in the Core HMO family of products. Blue Shield offers Trio HMO plans to Small Business, Core, and IFP (on-exchange and mirrored only).

Most groups, such as the Federal Employees' Health Benefits Plan (FEHBP) for example, select the Access+ HMO Plan, which offers a unique self-referral feature called Access+ *Specialist*℠. Blue Shield may also tailor or customize plans for groups with 126+ eligible employees. For example, the California Public Employees Retirement System (CalPERS) HMO consists of two types of plans: a basic CalPERS benefits plan and a Medicare Supplement plan.

The Blue Shield HMO benefit summaries listing the plan-specific benefits and copayments can be found on Provider Connection at blueshieldca.com/provider under *Eligibility & benefits,* then *Benefit summaries*. You can also view and download the Individual Medicare Advantage – Prescription Drug HMO Summary of Benefits under the same link.

The Individual Medicare Advantage – Prescription Drug HMO Summary of Benefits also appears online at www.medicare.gov under the Medicare Plan Finder.

For questions on HMO benefit information, eligibility, claims, and/or billing, call Blue Shield Provider Customer Service at (800) 541-6652.

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Access+ HMO Features

The majority of Blue Shield of California HMO members are covered under the Access+ HMO® program, which allows HMO members direct access to specialists.

The major features of the Access+ HMO program are:

- Access+ *Specialist*℠
- Access+ *Satisfaction*®
- Preventive care at no charge
- Virtually no claim forms for members to complete

Access+ *Specialist*℠

Access+ *Specialist* is a feature that allows HMO members to go directly to a specialist in the same participating IPA/medical group as their primary care physician (PCP), without a referral, for a higher copayment.

IPA/medical groups participate in the Access+ *Specialist/Satisfaction* Program and are considered Access+ Provider Groups for members having an Access+ HMO plan. An Access+ HMO member ID card features the symbol "A+" next to the IPA/medical group name indicating that the member is eligible for Access+ *Specialist* services and that the IPA/medical group is an Access+ Provider Group.

A female member may self-refer to an obstetrician/gynecologist (OB/GYN) or family practice physician in the same IPA/medical group as her PCP for OB/GYN services. This is not considered an Access+ *Specialist* visit. The standard office visit copayment applies.

Access+ *Satisfaction*®

The Access+ *Satisfaction* feature allows HMO members to provide feedback on the service they receive from Access+ HMO primary care physicians during a covered office visit. If they are unhappy with the service, members can request a refund of their standard office visit copayment. Blue Shield monitors the member feedback obtained through this program and uses the information to evaluate the services provided by HMO network physicians.

Access+ HMO Features *(cont'd.)*

Self-Referral for OB/GYN Services

Female members may arrange for obstetrical and/or gynecological (OB/GYN) services by an obstetrician/gynecologist or family practice physician (who is not their designated PCP) without referral from her PCP. However, the obstetrician/gynecologist or family practice physician must be in the same medical group as the primary care physician. Obstetrical and gynecological services are defined as:

- Physician services related to prenatal, perinatal, and postnatal care
- Physician services provided to diagnose and treat disorders of the female reproductive system and genitalia
- Physician services for treatment of disorders of the breast
- Routine annual gynecological examinations/annual well-woman examinations.

The OB/GYN or family practice physician will notify the primary care physician of the results of the examination. If the examination results identify the need for specialty services (e.g., mammography, surgery, ultrasound, etc.), the member's PCP must provide or arrange for the additional services.

Provider and Member Participation

Provider Participation

Physicians contracted with IPA/medical groups that participate in the Access+ *Specialist/Satisfaction* Program automatically become participating physicians in the Program. Participating Access+ Provider Groups are listed as such in the *Blue Shield HMO Physician and Hospital Directory*.

Member Participation

The Access+ *Specialist* office visits are available only to members who belong to Access+ HMO plans. An Access+ HMO member ID card has the symbol "A+" next to the IPA/medical group name indicating that the member is eligible for Access+ *Specialist* services and the IPA/medical group is an Access+ Provider Group.

The Blue Shield Medicare Advantage plan (Blue Shield's Medicare Advantage – Prescription Drug HMO plan) and Blue Shield Added Advantage POS℠ (point-of-service) plan do not offer the Access+ *Specialist/Satisfaction* feature.

Role of Primary Care Physicians/Specialists in Access+ HMO

Primary Care Physicians (PCPs)

Under the Blue Shield Access+ HMO Plan, primary care physicians maintain their role in coordinating the Access+ HMO member's healthcare needs. However, members access mental health and substance use disorder services through participating providers of Blue Shield's mental health service administrator (MHSA).

Specialists

Access+ HMO members may go to any specialist for a consultation, as long as that specialist is affiliated with the same IPA/medical group as that of his/her PCP.

Specialists agree to see Access+ HMO members who self-refer for Access+ *Specialist* services and to continue to coordinate the healthcare needs of Access+ HMO members with their PCP through the IPA/medical group's authorization process.

Seeing a Member on a Regular Basis

A specialist who has determined that it is medically necessary for the member to see him or her on a continuing basis should contact the member's PCP to discuss the proposed treatment plan or other relevant information and to arrange for a standing referral. Consultation notes and treatment plans should be shared with the member's PCP.

The member's primary care physician may request authorization from his or her IPA/medical group, which may deny or approve the request for a standing referral.

If additional services are authorized, the member may go back to the specialist for the authorized services and pay the usual office visit copayment. If the member elects to self-refer again for additional services, the member is responsible for paying the higher Access+ *Specialist* office visit copayment.

Additional self-referred services are limited to the approved services listed. (For service coverage information, see the Access+ *Specialist* Services subsection on the following pages.)

Referring Members Back to Their Primary Care Physicians

An Access+ HMO member can see a specialist either with a referral from his or her primary care physician or through the Access+ *Specialist* feature with a self-referral to a specialist in the same IPA/medical group as his or her PCP. If an Access+ HMO member self-refers to a specialist who is affiliated with an IPA/medical group that is *not* an Access+ Provider Group, the specialist should refer the member back to his or her PCP or to Blue Shield's Member Services Department for assistance. If the specialist who is not an Access+ Provider renders services without a referral, the member will be liable for all charges.

Using Access+ *Satisfaction*

Access+ HMO members may call Blue Shield's Member Services Department to provide feedback on the service they receive from Access+ HMO physicians and their primary care physician's office staff during covered office visits.

If a Member is dissatisfied with the service provided during an office visit with a Plan Physician, the Member may contact Member Services at the number provided on the back page of the *Evidence of Coverage*.

Procedure for Accessing Care through Access+ *Specialist*

The Access+ *Specialist* feature is utilized only if a member chooses to go to a specialist without a referral from his/her primary care physician. The member can choose to receive services within the HMO benefit plan at lower copayment levels by first seeing his/her Primary care physician and receiving authorization/referral to a specialist.

Described below is the process that explains how an Access+ HMO member accesses care through the Access+ *Specialist* option for other than mental health and substance use disorder services.

Access+ HMO Member Self-Refers Using Access+ *Specialist*

An Access+ HMO member chooses to consult a specialist for Access+ *Specialist* services and self-refers directly to a specialist within the same IPA/medical group as that of his or her primary care physician instead of going to his or her PCP for a referral. The member's Access+ *Specialist* office visit copayment is payable at the time of the visit.

A female member may self-refer to an Obstetrician/Gynecologist (OB/GYN) or Family Practice Physician in the same IPA/medical group as her PCP for OB/GYN services. This is not considered an Access+ *Specialist* visit. The standard office visit copayment applies.

Procedure for Accessing Care through Access+ *Specialist* *(cont'd.)*

Specialist Provides Access+ *Specialist* Services

The Access+ HMO member makes an appointment with a specialist and presents the Access+ HMO member ID card.

Before providing Access+ *Specialist* services, the specialist verifies the member's eligibility by checking the member's Access+ HMO member ID card or by calling Blue Shield's Member Services Department.

> *Note:* An Access+ HMO member ID card that has the symbol "A+" next to the IPA/medical group name indicates that the member is eligible for Access+ *Specialist* services and the IPA/medical group is an Access+ Provider Group.

The Access+ HMO member consults with the specialist. The specialist's office staff collects the member's Access+ *Specialist* office visit copayment. The specialist provides the member's PCP with the consultation note(s).

If additional services or procedures are recommended, the specialist coordinates care with the member's PCP and follows the IPA/medical group's current authorization procedures.

If additional services or procedures are authorized, the member may go back to the specialist for the authorized services and pay the usual office visit copayment. If the member elects to self-refer again for additional services, the member is responsible for paying the Access+ *Specialist* office visit copayment. Additional self-referred services are limited to the approved services listed. (For service coverage information, see the Access+ *Specialist* Services subsection on the following pages.)

Access+ *Specialist* Services

The Access+ *Specialist* visit includes:

- An examination or other consultation provided to the Access+ HMO member by an IPA/medical group plan specialist without referral from the member's primary care physician
- Conventional X-rays, such as chest X-rays, abdominal flat plates, and X-rays of bones to rule out the possibility of fracture (but does not include any diagnostic imaging such as CT, MRI, or bone density measurements)
- Laboratory services
- Diagnostic or treatment procedures that a plan specialist would regularly provide under the referral from the member's primary care physician

An Access+ *Specialist* visit does not include:

- Any services which are not covered, or which are not medically necessary
- Services provided by a non-Access+ provider (such as podiatry and physical therapy), except for the X-ray and laboratory services described above
- Allergy testing
- Endoscopic procedures
- Any diagnostic imaging, including CT, MRI, or bone density measurements
- Injectables, chemotherapy or other infusion drugs, other than vaccines and antibiotics
- Infertility services
- Emergency services
- Urgent services
- Inpatient services, or any services which result in a facility charge, except for routine X-ray and laboratory services
- Services for which the IPA/medical group routinely allows the member to self-refer without authorization from the primary care physician
- OB/GYN services by an obstetrician/gynecologist or family practice physician within the same IPA/medical group as the member's primary care physician

Access+ *Specialist* Claims Processing

Specialist Submits Access+ *Specialist* Claims to IPA/Medical Group

Access+ *Specialist* services are included in the IPA/medical group's capitation. Claims should be processed as follows:

- The specialist submits a photocopy of the Access+ HMO member ID card and Access+ *Specialist* claim to his or her IPA/medical group.
- The IPA/medical group processes the Access+ *Specialist* claim and pays the specialist according to its agreement with the specialist. Access+ Specialist services are submitted to Blue Shield as encounters.

For more specific information on *Access+ Specialist* claims processing, refer to your IPA/medical group contract with Blue Shield.

Access+ *Specialist* Encounters - Electronic Encounters

Access+ *Specialist* claims may be submitted electronically. Access+ provider groups must be able to identify an Access+ *Specialist* visit on their electronic encounter submission by one of the following methods:

1. Enter the word(s) "bypass" or "access plus" in the Referring Physician Last Name field of the Western Region HMO/IS format (Record - EA0: Field 22), or

   837P - 2300 CN1 Loop, CN101- 9. CN104-ACCESSPLUS (or BYPASS)

2. Enter the word(s) "bypass", "access" or "access plus" in the Claim Header Record Local Filler field of the Referring Physician Last Name field of the Western Region HMO/IS format (Record - CA0: Field 22), or

   837P – 2300 CN1 Loop, CN101- 9. CN104- ACCESSPLUS (or BYPASS)

3. Enter the word(s) "bypass," "access," or "access plus" in the Referring Physician field of the X12 005010X222A1:837 – Health Care Claim Professional ANSI Format (loop 2010BB REF, or loop 2310A NM103)

   837P – 2300 CN1 Loop, CN101 - 9. CN104 – ACCESSPLUS (or BYPASS)

   BHT06= RP

   2300 Loop CN101=9

   2300 Loop CN104= ACCESSPLUS or BYPASS

Access+ *Specialist* Claims Processing *(cont'd.)*

Access+ *Specialist* Encounters - Electronic Encounters *(cont'd.)*

These are Blue Shield's currently defined indicators for Access+ *Specialist* claims. Once the record is identified as an Access+ *Specialist* visit, the following data elements are required (in addition to the standard required HMO/IS or ANSI data fields):

1. Allowed amount (for example Record FB0: Field 06) or (2430/CAS03) based on 837P implementation guide page 561.
2. Paid amount (for example Record FA0: Field 35) or (2430/CAS03) based on 837I implementation guide page 561.

For additional information, please call Blue Shield's Electronic Data Interchange (EDI) Help Desk at (800) 480-1221 or visit Provider Connection at blueshieldca.com/provider and click on *Claims*, then *Manage electronic transactions.*

2.3 Blue Shield Accountable Care Organizations (ACOs)

Blue Shield's Accountable Care Organizations (ACOs) are alliances formed with physician groups and hospitals who, together with Blue Shield, share responsibility and accountability for the quality, cost, and overall care of a defined group of members. Blue Shield is committed to partnering with selected providers to leverage their expertise and innovative care models to fundamentally change healthcare delivery. Members benefit from collaboration, innovation, stronger coordination between providers, and the sharing of critical information which help to drive better healthcare outcomes.

Underlying each ACO collaboration is a contract that establishes a set of financial incentives that serve to align the parties to work together toward improved healthcare outcomes, cost efficiency and quality improvement. Financial incentives are built on a foundation of shared risk where all parties in an ACO collaboration are motivated to work together toward these goals. Members benefit from lower costs which are passed down to them in the form of lower premiums. Blue Shield provides our ACO groups and hospitals with resources from the Provider Partnerships, Clinical Pharmacy, Quality Improvement, and Actuary teams to support the success of our ACOs.

Trio HMO

The Trio Health Maintenance Organization (HMO) is a product supported by a network of Accountable Care Organization (ACO) providers. In 2017, Trio was newly offered to Covered California with goals of improved patient access, higher quality outcomes and increased cost efficiency. Trio uses an integrated network delivery model across specialties and hospitals that provides coordinated care and leverages relationships with select providers in specific regions.

The name "Trio" represents our ACO program collaboration that creates a community of care to support improved health outcomes for Trio members and helps reduce healthcare costs. As with a traditional HMO plan, members' care is coordinated by a primary care physician. Further, Trio plans are designed to help:

- Link members to the right services
- Create a cross-organizational focus on members with complex needs
- Improve discharge processes and programs to reduce hospital readmissions

Provider Participation

Provider participation in the Trio HMO Network is based on the entire IPA/Medical Group, not on the individual physician's contract with Blue Shield. If your IPA/medical group is participating in the Trio HMO Network, then you are participating as well. To check a physician's participation in the Trio HMO Network, contact your IPA or Medical Group, or go to www.blueshieldca.com and click on *Find a Doctor.*

Trio HMO *(cont'd.)*

Added Benefits

Trio HMO is a family of HMO plans that are focused on delivering choice, coordinated care and affordability. When Blue Shield developed Trio HMO, it was built with members' key concerns in mind. In addition to affordable care, the following unique features are offered:

- Low or no deductibles
- Select local physicians, specialists, and hospitals
- Lifestyle programs to support prevention, treatment, and reversal
- A dedicated customer care line for Trio members: Shield Concierge
- 24/7 virtual consults with Teladoc for $0 copays
- Option to self-refer to specialists within the same medical group

Wellvolution

Included in Trio HMO is Wellvolution, a platform of personalized lifestyle-based tools and support to help improve health, lose weight, and feel better.

Wellvolution focuses on things that make our members happier and healthier. The platform offers digital whole health programs designed to give our members a way to go beyond just doctors and prescriptions and live their best life. There are over 10 programs to choose from, ranging from general well-being, to supporting stress, sleep, and other mental health concerns, to helping members prevent or treat and reverse the course of serious chronic conditions. With the right tools, coaching, nutrition counseling and health professional support, members can start their journey to make a big difference for a healthier tomorrow.

Once the member receives their Blue Shield member ID card, they can go to Wellvolution.com to set up their profile, preferences and pick programs. Wellvolution customizes the path to better health, matching the member with programs and popular apps that are personalized and have proven results, at no extra cost.

The following programs are offered through Wellvolution:

Well-Being Programs – A hand-selected set of proven general well-being programs, designed to help generally healthy members achieve their health goals of sleeping better, lowering stress, exercising more, eating better, or quitting smoking.

Trio HMO *(cont'd.)*

Wellvolution *(cont'd.)*

Mental Health Programs – To support our members in achieving optimal whole person health, our mental health programs are perfect for members that are seeking opportunities to incorporate everyday mindfulness into their daily lives to reduce stress, increase resilience, and get a better night's rest as well as for members seeking support for low- to moderate- anxiety or depression. Programs include guided meditations, sleepcasts, mindfulness exercises, 24/7 Behavioral Health coaching, personalized care plan, and more.

Weight Loss Programs – Programs specifically designed to help members make changes that fit their lifestyle and promote a healthy weight. Members can lose weight and keep it off with coaching support and a personalized step by step plan on how to decrease cravings, hunger, and weight without dieting. Most members see an average loss of 3-4 pounds per week and improvement in their quality of life across the board.

Diabetes Prevention Programs – Targeting reduction of risk for type 2 diabetes and heart disease, prevention programs provide members with a health coach and an individualized plan that meet the unique needs and address several areas of a member's life, including physical activity, nutrition, sleep, and stress management.

Chronic Condition Reversal Programs – Turn back the clock and reverse the course of chronic conditions like hyperlipidemia, hypertension, type 2 diabetes and more with the support from physician, health coaches and a supportive patient community. Our high touch reversal programs, often incorporating in-person or digital coaching options, are focused on normalization of A1C levels, weight, and blood pressure, as well as elimination of medication dependence in a matter of weeks.

All Wellvolution programs are 100% covered by Blue Shield of California.

Shield Concierge

Trio offers a high level of customer service and engagement to members and more flexibility for the member with a choice of local doctors, specialist, hospitals, and pharmacy locations. Trio members have access to Shield Concierge, a team of professionals consisting of customer care representatives, registered nurses, social workers, health coaches, pharmacy technicians, and pharmacists available to provide information to a member regarding benefits, doctors and specialists, coordination of care, case management, and questions on formulary and prescription medication authorizations.

Members who have questions about their benefits should call Shield Concierge at the number listed on the back of the member ID card.

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2.4 Blue Shield Added Advantage POS℠ (Point-of-Service) Plan

Blue Shield's Added Advantage POS Plans combine the benefits of the Access+ HMO with access to the Blue Shield Preferred Plan (PPO) provider network. The Added Advantage POS℠ Plan is called a point-of-service plan because the member can decide at the time that healthcare services are needed whether to access benefits under the HMO option or under the "In-PPO Network" or "Out-of-PPO Network" options. These options offer varying degrees of financial responsibility.

Under the HMO option of the Added Advantage POS Plan, members obtain services through their HMO primary care physician and pay a fixed copayment for most covered services, with virtually no claim forms. Or, if they prefer, members may use the "In-PPO Network" option and seek care from a Blue Shield Preferred Provider or from a non-network physician, without consulting their primary care physician. Services received under the "In-PPO Network" and "Out-of-PPO Network" options are subject to a deductible and applicable copayments and coinsurance. Care received from non-network physicians is covered at the lowest benefit level. When members receive services from non-network physicians, members must also file claim forms and pay any difference between the amount Blue Shield allows for those services and the amount billed by a non-network physician. Preventive Services are only covered under the HMO option of the POS Plan.

> *Note:* Mental health and substance use disorder services are accessed through Blue Shield's mental health service administrator (MHSA) utilizing MHSA participating providers and MHSA non-participating providers.

Plan Benefits

Blue Shield's Added Advantage POS Plans are only offered to Core Account employer groups. These plans combine standard Access+ HMO plan benefits with Blue Shield's PPO network of providers at an increased financial responsibility for the member.

Blue Shield's Added Advantage POS Plans benefit coverage is based on benefits available under Blue Shield's HMO plan. When the member elects to use "In-PPO Network" and "Out-of-PPO Network" providers, only the member's level of financial responsibility is changed; benefits available are not changed. However, there may be some benefit exceptions for custom groups (e.g., the Stanford Triple Option Plan). The IPA/medical group will be notified of these exceptions.

The Added Advantage POS Plan does not include the Access+ *Specialist* or the Access+ *Satisfaction* features.

Plan Benefits *(cont'd.)*

Non-Emergency Admissions

Added Advantage POS Plan members who want to access services at their Level I HMO Option must obtain an authorization from the HMO primary care physician for non-emergency hospital admissions. Prior authorization is also required for a non-emergency hospital admission when an Added Advantage POS Plan member accesses services using the Level II or Level III PPO network option. The treating physician should contact Blue Shield's Provider Customer Service at (800) 541-6652 and select the authorizations option, at least five business days prior to the admission.

Emergency Admissions

In the case of an admission for emergency services, Blue Shield should receive Emergency Admission Notification within 24 hours or as soon as reasonably possible following medical stabilization, whichever is later. Blue Shield's Medical Care Solutions will discuss the benefits available, review the medical information provided and may recommend that to obtain the full benefits of this health plan the services must be performed on an outpatient basis.

Information about which Added Advantage POS plan the member belongs to is found on the Blue Shield POS Eligibility Report in the coverage level column.

Claims Submission

Hard Copy or Batched Claims Submission

Claims for in-network services referred or rendered by the physician and outlined as IPA/medical group responsibility in the applicable Division of Financial Responsibility (DOFR), should be submitted electronically to the IPA/medical group for payment determination.

For payment determination, the IPA/medical group must submit directly to Blue Shield the following types of claims:

- In-network institutional services
- Out-of-network institutional services
- Out-of-network professional services
- Point of Service Plan Tier II and Tier III Self-referred Services
- Other Services deemed by the Division of Financial Responsibility (DOFR) to be Plan responsibility.

If the IPA/medical group requires its physicians to submit all claims to the IPA (including those that are for self-referred services), the IPA/medical group should indicate which services were self-referred when submitting the electronic claim using the instructions below before sending them to Blue Shield for payment.

Claims Submission *(cont'd.)*

Submit Self-Referred Claims Electronically

When Point of Service (POS) plan members self-refer to a specialist use the instructions below to bill electronically. For questions, contact your clearinghouse or billing system vendor or contact the EDI Help Desk at (800) 480-1221.

Submitting Self-Referral for Professional Claims:

Loop 2310A NM103 = SELFREFERRAL

Loop 2310A NM104 = BLANK

First Name = SELFREFERRAL

Last Name = Blank

NM1*DN*1*SELFREFERRAL*****1002233777~

Submitting Self-Referral for Institutional Claims:

Loop 2310F NM103 = SELFREFERRAL

Loop 2310F NM104 = BLANK

First Name = SELFREFERRAL

Last Name = BLANK

Sample: NM1*DN*1*SELFREFERRAL*****XX*1002233777~

Submitting Self-Referral for POS Professional & Institutional claims:

- Self-Referral for Professional is identified in Loop 2310A
- Self-Referral for Institutional is identified in Loop 2310F
- Insert SELFREFERRAL for NM103 but leave blank NM104
- Use generic NPI for NM109

Sample: SELFREFERRAL

NM1*DN*1*SELFREFERRAL*****xx*1002233777

Note: This electronic billing process for Added Advantage POS Plan claims does not apply to services billed by the member's physician or services rendered to regular Blue Shield HMO members. Independent laboratory providers should continue to enter the ordering physician's name and identification number in the appropriate fields for correct processing.

Claims Submission *(cont'd.)*

Corrected Claims

Once the initial claim has finalized in our system, resubmit the corrected claim with the appropriate adjustment bill type. Corrected claims should be submitted within 365 days from the claim finalized date unless otherwise specified in the contract.

Claims Payment Determination

When a provider of service submits a claim directly to Blue Shield, the criteria on the following page is used to determine financial responsibility.

Professional Services Claims

If there is a record that the member has self-referred or "opted out," Blue Shield will pay the claim at the PPO benefit level.

If there is no record that the member has self-referred, the billing provider will receive an *Explanation of Benefits* (EOB) with the following message:

> "This patient's Blue Shield plan has self-referral benefits. Claims for services not authorized by the patient's HMO primary care physician (PCP) should be billed to Blue Shield and have 'self-referral' written on the claim. Services provided or authorized by the patient's HMO PCP should be billed to the physician's IPA/medical group. Because these services were provided or authorized by the patient's HMO PCP, this claim has been forwarded to:
>
> IPA "Name"
> IPA "Address"
> IPA "City, State, Zip"
>
> Please note this address and submit future claims for this member to this address."

If the IPA/medical group approves the service, it will pay the professional claim and return it to Blue Shield as an encounter.

If the service is not approved, the billing physician should resubmit the claim to Blue Shield HMO indicating that the member is "self-referring" to access his or her PPO benefits.

Claims Payment Determination *(cont'd.)*

Institutional Services Claims

If there is a record of an IPA/medical group or Blue Shield authorization, Blue Shield will pay the claim at the HMO benefit level.

If there is a record of an Added Advantage POS Plan member self-referral or "opt-out,' Blue Shield will pay the claim at the PPO benefit level.

If there is no record of a self-referral or an IPA/medical group or Blue Shield authorization, processing of the claim will be suspended while Blue Shield requests the IPA/medical group authorization form from the billing provider. If the provider sends Blue Shield a copy of the authorization form, the claim will be processed at the member's HMO Level I option. If the provider indicates that the member has self-referred, Blue Shield will process the claim at the member's Level II PPO or Level III non-network option.

Emergency (ER) Services

Standard HMO procedures are used to adjudicate emergency room claims and other claims that may be for emergency services. If the services were rendered to treat a medical or psychiatric emergency (under the reasonable person standard), then the services are covered under the HMO Level I option. If the services are not covered under the HMO option (i.e., non-emergency), they may be covered at Level II or Level III according to Blue Shield policy and are subject to any applicable deductible, copayment, or coinsurance.

Emergency Room Physician Services Note: After services have been provided, Blue Shield may conduct a retrospective review. If this review determines that services were provided for a medical condition that a person would not have reasonably believed was an emergency medical condition, benefits will be paid at Level II or Level III as specified under Outpatient Physician Services Benefit in the Professional (Physician) Benefits in the *Summary of Benefits and Coverage* and will be subject to any calendar year medical deductible.

2.4 Blue Shield Added Advantage POS℠ (Point-of-Service) Plan

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Benefit Descriptions

The following benefits are listed in the members' *Evidence of Coverage* (EOC) and will include the number of allowed visits and member copay responsibility. Providers are required to look up members benefits and eligibility on Provider Connection at blueshieldca.com/provider under *Eligibility and benefits.* Review the benefits for acupuncture and chiropractic to determine if the members plan includes these benefits as they may or may not be included and vary by plan.

Acupuncture Services

For Blue Shield fully insured plans, benefits are provided for medically necessary acupuncture services for a maximum number of visits per calendar year, when received from an American Specialty Health Group, Inc. (ASH Group) participating provider. Covered services must be determined as Medically Necessary by American Specialty Health Plans, Inc. (ASH Plans). This benefit includes an initial examination, subsequent office visits, acupuncture services, and adjunctive therapy specifically for the treatment of neuromusculoskeletal disorders, nausea, and pain up to the benefit maximum.

Questions concerning these benefits may be directed to:

ASH Plan Member Services (800) 678-9133

ASH Plan Provider Services (800) 972-4226

For Self-Funded, ASO, Shared Advantage, FEP PPO, and BlueCard members, all medically necessary acupuncture services that are included in these plans are provided by Blue Shield's direct network of acupuncturists.

Chiropractic Services

For Blue Shield fully insured plans, benefits are provided for medically necessary chiropractic services, including spinal manipulation or adjustment, when received from an American Specialty Health Group, Inc. (ASH Group) participating provider. Covered services must be determined as Medically Necessary by American Specialty Health Plans, Inc. (ASH Plans). This benefit includes an initial examination and subsequent office visits, adjustments, and adjunctive therapy up to the benefit maximum. Benefits are also provided for x-rays.

Members are referred to the primary care physician for evaluation of conditions not related to a neuromusculo-skeletal disorder and for evaluation for non-covered services, such as CT scans or MRIs.

Chiropractic appliances are covered up to a maximum of $50 in a calendar year as authorized by ASH Plans.

Benefit Descriptions *(cont'd.)*

Chiropractic Services *(cont'd.)*

Questions concerning these benefits may be directed to:

ASH Plan Member Services (800) 678-9133

ASH Plan Provider Services (800) 972-4226

For Self-Funded, ASO, Shared Advantage, FEP PPO, and BlueCard members, all medically necessary chiropractic services that are included in these plans are provided by Blue Shield's direct network of chiropractors.

Additional Hearing Aid Benefits

For Core Accounts, this optional coverage includes hearing aid services subject to the conditions and limitations listed below. This rider provides an allowance towards the purchase of hearing aids and ancillary equipment.

For benefit coverage, review the member's Hearing Aid Rider language to obtain allowance, frequency, and limitations of the hearing aid benefit.

The hearing aid allowance includes:

- A hearing aid instrument, monaural, or binaural, including ear mold(s)
- Visit for fitting, counseling, device checks and adjustments
- Electroacoustic evaluations for hearing aids
- The initial battery and cords

The following services and supplies are not covered:

- Purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase
- Spare hearing aids
- Assisted listening devices or amplification devices
- Charges for a hearing aid which exceed specifications prescribed for correction of a hearing loss
- Replacement parts for hearing aids, repair of hearing aid after the covered warranty period and replacement of a hearing aid more than the benefit allowance period
- Surgically implanted hearing devices

Benefit Descriptions *(cont'd.)*

Additional Infertility Benefits

Covered services for Infertility Benefit include all professional, hospital, ambulatory surgery center, ancillary services, injectable drugs when authorized by the primary care physician, to a member for the inducement of fertilization.

Please refer to the member's Infertility Benefit Rider for coverage limitations, exclusions, lifetime maximums and copayments, coinsurance, and deductibles. Benefits are only provided for services received from a Participating Provider.

Infertility is defined as:

The member must be actively trying to conceive and has either:

1) A demonstrated condition recognized by a licensed physician and surgeon as a cause for infertility; or
2) The inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year of regular sexual relations without contraception.

   Note: Services to diagnosis and treat the cause of infertility are covered by all group HMO plans under basic medical benefits.

The IPA/medical group provider network is to be used for all infertility services. All covered services under the infertility rider are the financial responsibility of and are authorized and reimbursed by Blue Shield.

Dental

Section 1367.71 of the Health & Safety Code requires that health plans cover general anesthesia and associated facility charges for dental procedures performed in a hospital or surgery center when required due to clinical status or underlying medical condition, and:

- The patient is less than seven years of age, or
- The patient is developmentally disabled, regardless of age, or
- The patient's health is compromised and for whom general anesthesia is medically necessary, regardless of age.

Prior authorization is required by Blue Shield HMO and coverage for anesthesia and associated facility charges are subject to all other terms and conditions of the plan. Blue Shield HMO is not responsible for the cost of dental procedures. Dental procedures for diagnostic services, endodontics, periodontics, preventive care, prosthetics, and restorative dentistry are covered in plans administered by Dental Benefit Providers of California (DBP) and are available for purchase separately from medical plans.

Benefit Descriptions *(cont'd.)*

Vision

This benefit is administered through EyeMed. It covers services for refractions, lenses, and frames. Any questions concerning these benefits may be directed to:

EyeMed (877) 601-9083

2.6 Exclusions and Limitations

Blue Shield's commercial HMO and POS benefit plans have a standard set of exclusions and limitations. Services subject to the standard exclusions under some plans, such as those for vision, infertility, chiropractic, and dental services, may be covered under optional benefits.

Note: For Blue Shield's Medicare Advantage Plan Prescription Drug exclusions and limitations, see Section 6.2.

General Exclusions and Limitations

Unless exceptions to the following exclusions are made elsewhere in the group contract, no benefits are provided for services that are:

1. Routine physical examinations, except as specifically listed under Preventive Health Benefits, or for immunizations and vaccinations by any mode of administration (oral, injection or otherwise) solely for the purpose of travel, or for examinations required for licensure, employment, insurance or on court order or required for parole or probation;
2. For hospitalization primarily for X-ray, laboratory, or any other outpatient diagnostic studies or for medical observation;
3. Routine foot care items and services that are not medically necessary, including callus, corn paring or excision and toenail trimming except as may be provided through a Participating Hospice Agency; over-the-counter shoe inserts or arch supports, or any type of massage procedure on the foot;
4. Inpatient treatment in a pain management center to treat or cure chronic pain, except as may be provided through a Participating Hospice Agency or through a palliative care program offered by Blue Shield;
5. Home services, hospitalization, or confinement in a health facility primarily for rest, Custodial, Maintenance, or Domiciliary Care, except as provided under Hospice Program Benefits;
6. Services in connection with private duty nursing, except as provided under Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, and except as provided through a Participating Hospice Agency;
7. Prescription and non-prescription food and nutritional supplements, except as provided under Home Infusion/Home Injectable Therapy Benefits, PKU Related Formulas and Special Food Products Benefits, or as provided through a Participating Hospice Agency;
8. Hearing aids;
9. Eye exams and refractions, lenses and frames for eyeglasses, and contact lenses except as specifically listed under Prosthetic Appliances Benefits, and video-assisted visual aids or video magnification equipment for any purpose;

General Exclusions and Limitations *(cont'd.)*

10. Surgery to correct refractive error (such as but not limited to radial keratotomy, refractive keratoplasty);
11. Any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine, or any other language assistive devices, except as specifically listed under Prosthetic Appliances Benefits;
12. For dental care or services incident to the treatment, prevention, or relief of pain or dysfunction of the Temporomandibular Joint and/or muscles of mastication, except as specifically provided under the Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones Benefits and Hospital Benefits (Facility Services);
13. For or incident to services and supplies for treatment of the teeth and gums (except for tumors, preparation of the member's jaw for radiation therapy to treat cancer in the head or neck, and dental and orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures) and associated periodontal structures, including but not limited to diagnostic, preventive, orthodontic and other services such as dental cleaning, tooth whitening, X-rays, imaging, laboratory services, topical fluoride treatment except when used with radiation therapy to the oral cavity, fillings, and root canal treatment; treatment of periodontal disease or periodontal surgery for inflammatory conditions; tooth extraction; dental implants, braces, crowns, dental orthoses and prostheses; except as specifically provided under Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones Benefits and Hospital Benefits (Facility Services);
14. For cosmetic surgery except for the medically necessary treatment of resulting complications (e.g., infections or hemorrhages. Without limiting the foregoing, no benefits will be provided for the following surgeries or procedures:
    a. Surgery to excise, enlarge, reduce, or change normal structures of any part of the body to improve appearance.
    b. Surgery to reform or reshape skin or bone to improve appearance.
    c. Lower eyelid blepharoplasty.
    d. Upper eyelid blepharoplasty without documentation of significant visual impairment or symptomology.
    e. To correct spider veins.
    f. Services and procedures to smooth the skin (e.g., chemical face peels, laser resurfacing, and abrasive procedures).
    g. Items and services for the promotion, prevention, or other treatment of hair loss, hair growth or hair removal, including hair transplantation.
    h. Reimplantation of breast implants originally provided for cosmetic augmentation.

General Exclusions and Limitations *(cont'd.)*

i. Surgery to excise or reduce skin or connective tissue that is loose, wrinkled, sagging, or excessive on any part of the body.

j. Voice modification surgery.

15. For reconstructive surgery where there is another more appropriate covered surgical procedure or when the proposed reconstructive surgery offers only a minimal improvement in the appearance of the member.

    This exclusion shall not apply to breast reconstruction when performed subsequent to a mastectomy, including surgery on either breast to achieve or restore symmetry.

16. For sexual dysfunctions and sexual inadequacies, except as provided for treatment of organically based conditions;

17. Any services related to assisted reproductive technology, including but not limited to the harvesting or stimulation of the human ovum, in vitro fertilization, Gamete Intrafallopian Transfer (GIFT) procedure, artificial insemination (including related medications, laboratory, and radiology services), services or medications to treat low sperm count, services incident to reversal of surgical sterilization, or services incident to or resulting from procedures for a surrogate mother who is otherwise not eligible for covered pregnancy and maternity care under a Blue Shield health plan;

18. Home testing devices and monitoring equipment except as specifically provided in the Durable Medical Equipment Benefits;

19. Genetic testing except as described in the sections on Outpatient X-ray, Pathology and Laboratory Benefits;

20. Mammography's, Pap Tests, or other FDA (Food and Drug Administration) approved cervical cancer screening tests, family planning and consultation services, colorectal cancer screenings, Annual Health Appraisal Exams by Non-Plan Providers;

21. Services performed in a hospital by house officers, residents, interns, and others in training;

22. Services performed by a close relative or by a person who ordinarily resides in the member's home;

23. Services provided by an individual or entity that is not appropriately licensed or certified by the state to provide health care services, or is not operating within the scope of such license or certification, except for services received under the Behavioral Health Treatment benefit under Mental Health and Substance Use Disorder Benefits;

24. Massage therapy that is not physical therapy or a component of a multimodality rehabilitative treatment plan;

General Exclusions and Limitations *(cont'd.)*

25. For or incident to vocational, educational, recreational, art, dance, music or reading therapy; weight control programs; or exercise programs; nutritional counseling except as specifically provided for under Diabetes Care Benefits. This exclusion shall not apply to medically necessary services which Blue Shield is required by law to cover for the treatment of mental health and substance use disorders.

26. Learning disabilities or behavioral problems or social skills training/therapy, or for testing for intelligence or learning disabilities This exclusion shall not apply to medically necessary services which Blue Shield is required by law to cover for the treatment of mental health and substance use disorders.

27. Services which are Experimental or Investigational in nature, except for services for Members who have been accepted into an approved clinical trial as provided under Clinical Trial for Treatment of Cancer or Life-Threatening Condition Benefits;

28. Drugs, medicines, supplements, tests, vaccines, devices, radioactive materials and any other services which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (the FDA) except as otherwise stated; however, drugs and medicines which have received FDA approval for marketing for one or more uses will not be denied on the basis that they are being prescribed for an off-label use if the conditions set forth in California Health & Safety Code, Section 1367.21 have been met;

29. For non-prescription (over-the-counter) medical equipment or supplies such as oxygen saturation monitors, prophylactic knee braces and bath chairs that can be purchased without a licensed provider's prescription order, even if a licensed provider writes a prescription order for a non-prescription item, except as specifically provided under Preventive Health Benefits, Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, Hospice Program Benefits, Diabetes Care Benefits, Durable Medical Equipment Benefits, and Prosthetic Appliances Benefits;

30. Patient convenience items such as telephone, television, guest trays, and personal hygiene items;

31. For disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, diapers, under pads, and other incontinence supplies, except as specifically provided under the Durable Medical Equipment Benefits, Home HealthCare, Hospice Program Benefits, or the Outpatient Prescription Drug Benefits.

32. Services for which the member is not legally obligated to pay, or for services for which no charge is made;

General Exclusions and Limitations *(cont'd.)*

33. Services incident to any injury or disease arising out of, or in the course of, any employment for salary, wage, or profit if such injury or disease is covered by any worker's compensation law, occupational disease law or similar legislation. However, if Blue Shield provides payment for such services, it will be entitled to establish a lien upon such other benefits up to the amount paid by Blue Shield for the treatment of such injury or disease;

34. For spinal manipulation or adjustment and adjunctive therapy by a chiropractor, except as specifically provided under Professional (Physician) Benefits (other than for Mental Health and Substance Use Disorder Benefits) in the Plan Benefits section;

35. For transportation services other than provided under Ambulance Benefits in the Plan Benefits section;

36. Drugs dispensed by a Physician or Physician's office for outpatient use;

37. For services, including hospice services rendered by a Participating Hospice Agency, not provided, prescribed, referred, or authorized as described herein except for Access+ *Specialist* visits, OB/GYN services provided by an obstetrician/gynecologist or family practice physician within the same medical group/IPA as the primary care physician, Emergency Services or Urgent Services as provided under Emergency Room Benefits and Urgent Services Benefits in the Plan Benefits section.

38. For inpatient and Other Outpatient Mental Health and Substance Use Disorder Services unless authorized by the MHSA except for medical services for the treatment of gender dysphoria, eating disorder and substance use disorder treatment which are the responsibility of the IPA/medical group and Blue Shield.

39. Services not specifically listed as a Benefit.

Medical Necessity Exclusion

All services must be medically necessary. The fact that a physician or other provider may prescribe, order, recommend, or approve a service or supply does not, in itself, make it medically necessary, even though it is not specifically listed as an exclusion or limitation. Blue Shield may limit or exclude benefits for services that are not medically necessary.

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Third Party Liability (TPL)

If a member is injured or becomes ill due to the act or omission of another person (a "third party"), Blue Shield, the member's designated medical group, or Independent Practice Association (IPA) will provide the necessary treatment according to plan benefits. If the member receives a related monetary award or settlement from a third-party, third-party insurer, or from uninsured or underinsured motorist coverage, Blue Shield, the medical group, or the IPA have the right to recover the cost of benefits paid for treatment of the injury or illness. The total amount of recovery will be calculated according to California Civil Code Section 3040.

The member is required to:

1. Notify Blue Shield, the member's designated medical group or the IPA in writing of any claims or legal action brought against the third party as a result of their role in the injury or illness within 30 days of submitting the claim or filing the legal action against the third party;

2. Agree to fully cooperate and complete any forms or documents needed to pursue recovery from the third party;

3. Agree, in writing, to reimburse Blue Shield for benefits paid from any recovery received from the third party;

4. Provide a lien calculated according to California Civil Code Section 3040. The lien may be filed with the third party, the third party's agent or attorney, or the court, unless otherwise prohibited by law; and,

5. Respond to information requests regarding the claim against the third party and notify Blue Shield and the IPA/medical group, in writing, within ten (10) days of any recovery obtained.

If this plan is part of an employee welfare benefit plan subject to the Employee Retirement Income Security Act (ERISA), the member is also required to do the following:

1. Ensure that any monetary recovery is kept separate from the member's other assets and agree in writing that the amount necessary to satisfy the lien is held in trust for Blue Shield; and,
2. Instruct legal counsel retained by the member to hold the portion of the recovery to which Blue Shield is entitled in trust for Blue Shield.

Coordination of Benefits (COB)

Coordination of Benefits (COB) is utilized when a member is covered by more than one group health plan. Payments for "allowable expenses" will be coordinated between the plans up to the maximum benefit value or amount payable by each plan separately.

COB ensures that benefits paid by multiple group health plans do not exceed 100% of eligible expenses and the plans follow a consistent order of payment.

Determining the Order of Payment

When a plan does not have a COB provision, that plan will provide its benefits first. Otherwise, the plan covering the person as an employee will provide its benefits before the plan covering the person as a dependent.

The following applies to coverage for dependent children:

- When the parents are not divorced or separated, the group health plan of the parent, whose date of birth (month and day) occurs earlier in the year, is primary. If either parent's plan does not have a COB provision regarding dependents, this rule does not apply. The rule established by the plan without a COB provision determines the order of benefits.
- When the parents are divorced or separated and the specific terms of the court decree state that one of the parents is responsible for the health care expenses of the child, that parent's group health plan is primary. The group health plan of the other parent is secondary.
- When the parents are not married, or are divorced or separated and there is no court order which would otherwise establish coverage for the child, primary responsibility is determined in the following order:
    - The group health plan of the custodial parent.
    - The group health plan of the spouse of the custodial parent.
    - The group health plan of the non-custodial parent.
- When the parents are divorced or separated and there is a court decree that the parents share joint custody, without specifying which parent is responsible for the health care expenses of the child, the group health plan of the parent whose date of birth (month and day) occurs earlier in the year is primary.

If the above rules do not apply, the plan that has covered the person for the longer period of time is the primary plan, provided that:

- The group health plan covering the person, or the dependent of such person, as an active employee, provides benefits before the group health plan that covers the person, or the dependent of such person, as a laid-off or retired employee. If either plan does not have a COB provision regarding laid-off or retired employees, this rule does not apply.

Coordination of Benefits (COB) *(cont'd.)*

When Blue Shield is the Primary Plan

The IPA/medical group will provide Blue Shield Plan benefits without considering the existence of any other group health plan.

Upon request, the IPA/medical group will provide the member or the secondary group health plan with a statement documenting copayments paid by the member or services denied so the member may collect the reasonable cash value of those services from the secondary group health plan. It is not necessary to provide the member with an itemized billing.

When Blue Shield is the Secondary Plan

If, as the secondary plan, the IPA/medical group covers a service that would otherwise be the primary group health plan's liability, the IPA/medical group may collect the reasonable cash value of that service from the primary group health plan.

When a disagreement exists as to which group health plan is secondary, or the primary group health plan has not paid within a reasonable period of time, Blue Shield will provide benefits as if it were the primary group health plan, provided the member:

- Assigns to Blue Shield the right to receive benefits from the other group health plan;
- Agrees to cooperate with Blue Shield in obtaining payment from the other group health plan; and
- Allows Blue Shield to verify benefits have not been provided by the other group health plan.

References

Additional information regarding COB is available through the following references:

- California Code of Regulations, Title 28, Section 1300.67.13
- The member's *Evidence of Coverage* (EOC

Limitations for Duplicate Coverage (Commercial)

Veterans Administration (VA)

The member's primary plan is required to pay the Veterans Administration (VA) for medically necessary plan benefits provided to the member who is a qualified veteran, who is not on active duty, and who is at a VA facility for a condition unrelated to military service (based on the reasonable value or Blue Shield's allowable amount). VA claims cannot be denied solely because the member failed to obtain a referral or authorization.

If an issue arises as to whether an illness or injury is related to military service, the VA determination prevails. While the VA determination is not subject to review, the VA will, upon request, provide documentation to substantiate their decision.

If the member is treated by the VA, the VA notifies Blue Shield by sending a copy of an assignment of benefits and will cooperate with requests for medical records. The VA will accept payment equal to what would ordinarily be paid to other providers in its geographic area. Regular administrative procedures should be followed, as if the VA were part of the member's IPA/medical group.

Department of Defense (DOD), TRICARE/CHAMPVA

Access+ HMO is always primary (unless another group plan is primary) for covered services, even if provided for conditions related to military service, provided at a Department of Defense (DOD) facility when the member is a qualified veteran who is not on active duty. Payment is based on the reasonable value or Blue Shield's allowable amount. TRICARE - CHAMPVA will not provide payment if the services are a benefit through Blue Shield but were not paid because the member did not comply with service delivery rules (e.g., non-authorized, out-of-network, non-emergency/urgent services). TRICARE - CHAMPVA may cover other services excluded by Blue Shield.

Medi-Cal

Medi-Cal is considered a payor of last resort.

Limitations for Duplicate Coverage (Commercial) *(cont'd.)*

Medicare Eligible Members

1. Blue Shield will provide benefits **before** Medicare in the following situations:
    a. When the member is eligible for Medicare due to age, if the subscriber is actively working for a group that employs 20 or more employees (as defined by Medicare Secondary Payor laws).
    b. When the member is eligible for Medicare due to disability, if the subscriber is covered by a group that employs 100 or more employees (as defined by Medicare Secondary Payor laws).
    c. When the member is eligible for Medicare solely due to end stage renal disease during the first 30 months that the Member is eligible to receive benefits for end-stage renal disease from Medicare.
2. Blue Shield will provide benefits **after** Medicare in the following situations:
    a. When the member is eligible for Medicare due to age, if the subscriber is actively working for a group that employs less than 20 employees (as defined by Medicare Secondary Payor laws).
    b. When the member is eligible for Medicare due to disability, if the subscriber is covered by a group that employs less than 100 employees (as defined by Medicare Secondary Payor laws).
    c. When the member is eligible for Medicare solely due to end stage renal disease after the first 30 months that the Member is eligible to receive benefits for end-stage renal disease from Medicare.
    d. When the member is retired and age 65 years or older.

When Blue Shield provides benefits after Medicare, the combined benefits from Medicare and the Blue Shield group plan may be lower but will not exceed the Medicare Allowed charges. The Blue Shield group plan Deductible and Copayments or Coinsurance will be waived.

Services for Members in Custody of the Penal System

Section 1374.11 of the Health & Safety code prohibits health care plans from denying hospital, medical or surgical services for the sole reason that the individual served is confined in a city or county jail, or is a juvenile detained in any facility if the individual is otherwise entitled to receive services. Blue Shield health plan is also required to provide covered services when the member is injured during the act of committing a crime.

HMO plans are responsible for providing non-emergency covered services only to the extent that the justice system allows the IPA to assume responsibility for the member's care (e.g., when the member's emergency condition has been stabilized). No benefits are available if the IPA is denied the right to assume responsibility for the member's non-emergency care. In this case, the IPA should carefully document such refusal.

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Care Management

Blue Shield's comprehensive, integrated care management programs, including Shield Support, Shield Advocate, Shield Concierge, and Connect, include member-focused clinical interventions to optimize health and quality of life. These programs offer a personalized, coordinated approach to care, encouraging members to be active participants in the management and improvement of their own health. Through shared decision making and a whole-person approach, the goal is for each member to receive care that is customized to their specific needs.

Blue Shield's experienced care management teams include registered nurses, behavioral health clinicians, social workers, dietitians, physicians, and pharmacists who provide long and short-term support, including:

- **Case management** for acute, long-term, and high-risk conditions, designed to help members live better with illness, recover from acute conditions, and develop self-management skills
- **Care coordination** services to help members navigate the healthcare system and access care, and to facilitate information sharing among the healthcare team involved in the member's care

Through skilled interviewing, the care team empowers members to take action and choose their own health goals. A personalized care plan is developed to help ensure that member needs and preferences are known and communicated. The care team maintains frequent contact with members, their caregivers, and providers in order to help assure the provision of safe, appropriate, and effective care and provides support by coordinating the wide range of specialized care from numerous providers to help prevent duplicate or unnecessary treatments and tests. The care team also provides coaching on medical conditions as well as behavioral health support and lifestyle modifications for an optimal quality of life.

Blue Shield's care team works to prevent readmissions by completing safety risk assessments, discussing follow-up care plans, reconciling medication, and facilitating adherence to prescribed treatment plans. The care team prepares members in advance for hospital stays, including guided imagery recordings to assist members in preparing for surgery or dealing with other health issues. These programs are supported by medical directors who provide clinical direction and oversight to the care team.

Blue Shield's care management programs are designed to allow the member to better manage their medical treatment, their health condition, and the many related issues that may impact their quality of life.

Member identification for Blue Shield's care management programs is based on our customized predictive risk score. This predictive risk score was developed to optimize outreach to those members who are likely to become high risk and are most likely to benefit from care management support. Additionally, condition specific triggers and utilization patterns are used to identify members.

Care Management *(cont'd.)*

Members may also be identified from an acute event or hospital admission or discharge. Care management encompasses a broad spectrum of interventions for short-term care coordination as well as ongoing complex case management support for the following conditions or utilization (including but not limited to):

- Behavioral health
- Cancer
- Cardiovascular, e.g., Coronary Artery Disease, Heart Failure
- Catastrophic injury
- Chronic Pain
- Diabetes
- ER utilization, post-discharge from hospital, opioid use, high-cost and direct referrals
- End-stage renal disease
- Musculoskeletal
- Pre-term infants in the Neonatal Intensive Care Unit (NICU) and post NICU
- Respiratory, e.g., Asthma, COPD
- Stroke
- Transgender
- Transplant (solid organ and bone marrow)

The following services are offered through the care management programs:

- Telephonic coaching from nurses, behavioral health clinicians, social workers, and pharmacists
- Biometric home monitoring (for some members with diabetes, coronary artery disease, COPD, and heart failure)
- Cognitive behavioral therapy modules
- Online tools and educational materials

Physician referrals are an important component of Blue Shield's Care Management Programs and may allow for identification of a member more quickly. Blue Shield providers may refer Blue Shield members to our Care Management Programs by submitting the referral. To download an electronic copy of the referral form, please visit www.blueshieldca.com/provider/guidelines-resources/patient-care/programs.sp. Each referral will be evaluated for eligibility and appropriateness.

Care Management *(cont'd.)*

In addition to the care management programs described above, the following Maternity support is available:

Maternity Management

Blue Shield has teamed up with Maven to offer Maven Maternity to our members. Maven Maternity is a 24/7 digital and virtual program designed to support Blue Shield members during and after pregnancy. Maven is also available to eligible Blue Shield medical plan members and their partners who have experienced a pregnancy loss. Blue Shield members can use Maven to book coaching and educational video appointments with providers across more than 30 specialties, including OB-GYNs, mental health specialists, doulas, lactation consultants, and more. Providers can encourage members to enroll in the Maven Maternity Program by visiting blueshieldca.com/maternity.

Screening, treatment, and referral to services for maternal mental health-related conditions is strongly encouraged. If a member screens positive for a mental health condition, such as anxiety or depression, Blue Shield physicians can refer directly to a behavioral health provider. Physician referrals are an important component of Blue Shield's Care Management Programs and may allow for identification of a member in need more quickly. Blue Shield providers may connect a member to appropriate maternal mental health resources through accessing multiple pathways based on the member's needs. These include connecting directly to Maven, through Blue Shield Care Management, or behavioral health providers through the Mental Health Service Administrator, Magellan network.

Providers can refer to Blue Shield Care Management Programs via secure email to bscliaison@optum.com or fax to (877) 280-0179. To download an electronic copy of the referral form, please visit blueshieldca.com/provider/guidelines-resources/patient-care/programs.sp. Providers can refer members to Magellan by calling Customer Service at (877)263-9952 or request a clinical referral form at BSCClinicalLiaison@MagellanHealth.com. Each referral will be evaluated for eligibility and appropriateness.

Care Management *(cont'd.)*

Dual Eligible Special Needs Plan Model of Care

For members enrolled in Blue Shield's Medicare Advantage Dual Eligible Special Needs Plan (D-SNP), Blue Shield has developed a D-SNP Model of Care (MOC), in compliance with CMS, which outlines Blue Shield's actions, in coordination with the member's IPA/medical group, to meet the individual needs of D-SNP members.

An individualized care plan (ICP) is developed based on the member's responses to the Health Risk Assessment (HRA) and includes a detailed list of identified problems, interventions, and goals. The ICP is then shared with the member/member's caregiver, the IPA/medical group, and the member's PCP. This care management plan identifies interdisciplinary care team (ICT) members that are needed and appropriate for the individual members to manage the medical, cognitive, psychosocial, and functional needs of the member. Blue Shield's ICT includes social workers; pharmacists; complex case managers; health educators; disease managers; behavioral health providers; and a medical director. The IPA/medical group must have a network of medical, nursing, and allied health professionals who will collaborate with the ICT and provide clinical expertise.

The care management plan is reviewed and revised at least annually, sooner if the member's health status changes, with participation from the IPA/medical group. The IPA/medical group must provide the following ICT members as needed: PCP; specialists; IPA/medical group case manager; and/or IPA/medical group medical director.

The IPA/medical group is responsible for coordinating basic care management services that meet the needs of the member and for implementing the care management plan, with oversight by Blue Shield, by coordinating care and arranging professional and ancillary services proportional to the member's needs. The IPA/medical group must maintain a documented process of how medical professionals and service providers were utilized to coordinate adequate care and achieve individual members' goals.

Additional Care Management Program Descriptions

The following programs are available to certain Blue Shield members depending on their plan design:

- **Shield Advocate.** The Shield Advocate program provides a designated team of registered nurses to a client's membership to provide a proactive, member-focused approach to navigate the healthcare system, resolve problems, answer health and treatment related questions, provide health counseling, and support coordination of care.

Care Management *(cont'd.)*

Additional Care Management Program Descriptions *(cont'd.)*

- **Shield Concierge.** Shield Concierge is an integrated service designed to provide a customer-specific, personalized service experience for members covered by Blue Shield. This program strives to improve and expand the member experience by resolving more inquiries during the first contact with the member and proactively identifying services specifically beneficial to the member. A team of professionals consisting of Shield Concierge representatives, registered nurses, social workers, health coaches, pharmacy technicians, and pharmacists provide information to a member regarding benefits, doctors and specialists, coordination of care, case management, and questions on formulary and drug authorizations.

- **Connect.** Connect offers an integrated, holistic, and personalized healthcare experience based on each member's needs, including a broad spectrum of robust, member-focused interventions driven by a smart-data platform with predictive analytics that leverage our best-in-class member care teams. The Connect care team is composed of specialists across claims and benefits, clinicians and care managers, pharmacists and technicians, and social workers to address any questions that could be asked during the first call. In those rare instances in which additional information is needed and a call cannot be resolved, the Connect care team takes complete ownership of any remaining tasks and offers to call the member back once resolved. The Connect care team proactively engages members, either digitally or over the phone, when early interventions or extra communications might lead to better health outcomes. Members are guided to available programs and resources to address their health issues, prevent emergency-room visits, and avoid higher costs associated with inpatient admissions in the future.

- **Home-Based Complex Care.** Chronically ill members meeting certain criteria are offered 24/7 access to medical professionals and in-home urgent care. Community-based, physician-led medical teams specializing in house calls and home-based care deliver medically needed services to these chronically ill patients. This does not replace members' primary care providers (PCPs), but rather supports the work of these members' existing providers. The program clinicians communicate and collaborate with the patients' PCP and specialists to reinforce the PCP's in-office care plan. Blue Shield identifies eligible members for this program based on their health status and needs.

Care Management *(cont'd.)*

Transplant Management Program

Transplants of major organs and bone marrow (excludes cornea, kidney only and skin) are coordinated between the IPA/medical group and Blue Shield. These services are provided through an established network of facilities with expertise in a particular organ or bone marrow transplant. All transplant facilities are evaluated through stringent criteria to determine the safety and appropriateness of their transplant services. After this review, only selected facilities are accepted for the Blue Shield of California Transplant Network. Blue Shield requires Commercial HMO members to have all major organ and bone marrow transplants performed at a facility approved for the specified type of transplant within Blue Shield of California's Major Organ/Bone Marrow Transplant Network. All HMO members should be offered a referral to a Blue Shield of California Major Organ/Bone Marrow Transplant Network facility approved for the specified organ, under their HMO benefit.

All transplant evaluation referrals should be authorized by the IPA/medical group or as otherwise specified and performed by a Blue Shield facility approved for the specified type of transplant. No self-referrals for transplant evaluations will be approved under the POS. All Blue Shield members are entitled to transplant evaluations at any Blue Shield transplant network facility approved for the specified type of transplant, whether or not that facility has a contractual relationship with the IPA/medical group. Members who are in a transplant treatment continuum must be cleared by the Blue Shield of California Transplant Medical Care Solutions Team prior to changing IPA. All requests should be sent via fax to the Transplant Medical Care Solutions Team at (916) 350-8865.

Prior written authorization must be obtained from Blue Shield's Transplant Medical Care Solutions Team for all transplants except cornea, kidney only and skin, as these are handled as routine inpatient services. Transplant Medical Care Solutions is a centralized program that is responsible for prior authorization of major organ and bone marrow transplant requests, related admissions, and case management for transplant patients during the transplant process. For members living in California, referrals to an out-of-state transplant facility must be at the referral of a Blue Shield of California's Major Organ/Bone Marrow Transplant Network facility approved for the specified type of transplant based upon medical necessity. For coverage, all referrals for medical necessity to an out-of-state provider must be pre-authorized by a Blue Shield of California Medical Director.

Generally, hospitals within the Blue Shield Major Organ/Bone Marrow Transplant Network assume financial responsibility for all inpatient and outpatient facility, professional, and other services and supplies provided in connection with a major organ or bone marrow transplant during a "global case rate period," when these services are provided at or by the transplant center. If these services cannot be provided at or by the transplant center (i.e., Acute Rehabilitation, Home Health Care, etc.) financial responsibility for professional and facility services are typically allocated between Blue Shield and the IPA/medical group as all other non-transplant related services.

Care Management *(cont'd.)*

Transplant Management Program *(cont'd.)*

The exact duration of the global case rate period and the specific services and supplies for which the hospital assumes financial responsibility vary based on such things as the specific type of transplant and the terms of the hospital's contract with Blue Shield. Financial responsibility for professional and facility services provided before and after the global case rate period is typically allocated between Blue Shield and the IPA/medical group in the same manner as all other non-transplant-related services.

Please reference the Division of Financial Responsibility (DOFR) that is part of your contract, for more information regarding allocation of financial responsibility.

For more information regarding the specific services for which a hospital has assumed financial responsibility during the global case rate period, please contact the Transplant Medical Care Solutions Team at (800) 637-2066, extension 841-1130. You may also contact the Transplant Medical Care Solutions Team for information on Transplant network hospitals and their applicable transplant categories.

Wellness and Prevention Programs

Blue Shield offers member-directed health improvement programs. Blue Shield's mission is to support a member's access to high quality care and facilitate participation in managing his or her own health. Blue Shield actively encourages providers to become familiar with these programs so they can assist members in learning about and taking advantage of these services. Blue Shield offers the following preventive health and wellness initiatives:

Diabetes Prevention Program

The Diabetes Prevention Program helps members who are at risk of type 2 diabetes lose weight and adopt healthy habits. The program includes 16 weekly sessions over the span of six months, followed by monthly maintenance sessions during which members will learn new ways to eat healthier, increase activity, and manage challenges with help from a personal health coach and a small support group. The program is embedded in the Wellvolution platform and can be accessed by enrolling in Wellvolution at wellvolution.com.

Wellness and Prevention Programs *(cont'd.)*

LifeReferrals 24/7SM

(800) 985-2405

A phone call connects members with a team of advisers who can help them with personal, family, and work issues. They will be guided to the appropriate professional, depending on their needs. Some of the services offered are:

- **Legal and financial –** Members can contact a financial coach on money matters or an attorney on a variety of legal services. Members may be eligible to receive a 60-minute legal consult and two 30-minute financial consults at no cost to them.
- **Personal challenges including relationship problems or coping with grief –** Members can talk to a referrals specialist and set up three face-to-face or telephonic sessions with a licensed therapist in any six-month period at no cost to them.
- **Work/life resources –** Members can consult with a specialist who can provide useful information and referrals to a wide range of resources, such as educational programs, adult and elder care, childcare, meal programs, relocation services, transportation, and more.

The LifeReferrals 24/7 team is available to discuss your patients' concerns and guide them to possible solutions anytime, day or night, at (800) 985-2405. All of the services and referrals to resources are treated confidentially.

NurseHelp 24/7SM

(877) 304-0504

Members can access a registered nurse anytime, day or night, seven days a week, 365 days a year at no cost by phone at (877) 304-0504 or online, www.blueshieldca.com. Experienced nurses are ready to answer questions, listen, and provide members with information that can help them choose the most appropriate level of care for their situation. The nurses are trained to offer callers:

- **Health information** – Better understanding of health concerns and chronic conditions, education about possible treatment options to help patients make informed decisions and suggestions for preparing for doctor appointments.
- **Healthcare assistance** – Guidance in understanding and choosing the most appropriate types of health care such as hospital, urgent care center, doctor visit, or home treatment. Assistance with questions about medical tests, medications and living with chronic conditions.
- **Preventive and self-care measures** – Helpful tips for taking care of minor injuries at home, such as a twisted ankle or a common illness like a cold or the flu.

Wellness and Prevention Programs *(cont'd.)*

NurseHelp 24/7℠ *(cont'd.)*

- **Online nurse help** – One-on-one personal Internet dialogue with a registered nurse 24 hours a day, seven days a week. Members get immediate answers to their general health questions and research assistance. The online nurses can also refer members to health information, resources, and member programs on blueshieldca.com.

NurseHelp 24/7 is designed to complement, not replace, the care you provide to your patients.

Preventive Health Guidelines

Blue Shield's Preventive Health Guidelines are based on nationally recommended guidelines for screening examinations, immunizations, and counseling topics for healthy individuals, as well as for individuals at risk for disease. These guidelines are updated and distributed annually to members via blueshieldca.com. Clinical reference sources include the US Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services, American Academy of Pediatrics, the Advisory Committee on Immunization Practice, and the Health Resources and Services Administration Women's Preventive Services Guidelines.

Guidelines available in both English and Spanish are located on Provider Connection at blueshieldca.com/bsca/bsc/wcm/connect/provider/provider_content_en/guidelines_resources/patient_care_resources/preventive_health.

Preventive Health Services Policy

Blue Shield has developed a Preventive Health Services Policy as a result of the Affordable Care Act (ACA) of the health reform legislation, adopting United States (US) Preventive Services Task Force (USPSTF) recommendations; the US Department of Health and Human Services, Health Resources and Services Administration (HRSA) recommendations for infants, children, adolescents, and women; immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC); American Academy of Pediatrics/Bright Futures/Recommendations for Pediatric Preventive Healthcare; and additional requirements mandated by the state of California. This policy applies to new and renewing members.

Preventive care services are those provided for the early detection of disease when no symptoms are present. These services, when criteria are met and the primary reason for the visit is preventive care, will be provided under the preventive care services benefits with no cost-sharing to the member when applicable procedure and diagnosis codes are billed together. When a preventive service is provided during a non-preventive visit, the entire visit will be provided under the medical benefit of the member's plan, and cost-sharing may apply per member benefits.

Wellness and Prevention Programs *(cont'd.)*

Wellness Discount Programs

To make it easier for members to take care of themselves, Blue Shield offers a wide range of member discounts on popular programs that can help them save money while they get healthier, including:

- **Fitness Your Way by Tivity** – With four different gym packages to choose from, including a digital only package, members have access to thousands of well-known fitness locations near home, work, or when traveling nationwide all for a low one-time initiation fee and a low monthly cost. Simply visit fitnessyourway.tivityhealth.com/bsc to enroll.
- **Alternative Care Discounts** – 25% savings on acupuncture, chiropractic services, and therapeutic massage services from practitioners participating in the ChooseHealthy® program.
- **LASIK surgery** – Discounts on LASIK surgery through QualSight LASIK, and LASIK and PRK surgery through NVISION, Inc.
- **Discount Vision Program** – Discounts on vision exams, frames and lenses, contacts lenses, and more.

Wellvolution

Wellvolution focuses on things that make our members happier and healthier. The platform offers digital and in-person whole health programs designed to give our members a way to go beyond just doctors and prescriptions and live their best life. There are over 10 programs to choose from, ranging from general well-being, to supporting stress, sleep, and other mental health concerns, to helping members prevent or treat and reverse the course of serious chronic conditions. With the right tools, coaching, nutrition counseling and health professional support, members can succeed with small changes today to make a big difference for a healthier tomorrow.

Once the member receives their Blue Shield member ID card, they can go to Wellvolution.com to set up their profile, preferences and pick programs. Wellvolution customizes the path to better health, matching the member with programs and popular apps that are personalized and have proven results, at no extra cost.

The following programs are offered through Wellvolution:

- **Well-Being Programs** – A hand-selected set of proven general well-being programs, designed to help generally healthy members achieve their health goals of sleeping better, lowering stress, exercising more, eating better, or quitting smoking.

Wellness and Prevention Programs *(cont'd.)*

Wellvolution *(cont'd.)*

- **Mental Health Programs** – To support our members in achieving optimal whole person health, our mental health programs are perfect for members that are seeking opportunities to incorporate everyday mindfulness into their daily lives to reduce stress, increase resilience, and get a better night's rest as well as for members seeking support for low- to moderate- anxiety or depression. Programs include guided meditations, sleepcasts, mindfulness exercises, 24/7 Behavioral Health coaching, personalized care plan, and more.
- **Weight Loss Programs** – Programs specifically designed to help you make changes that fit your lifestyle and promote a healthy weight. You can lose weight and keep it off with coaching support and a personalized step by step plan on how to decrease cravings, hunger, and weight without dieting. Most members see an average loss of 3-4 lbs. per week and an improvement in their quality of life across the board.
- **Disease Prevention Programs** – Targeting reduction of risk for type 2 diabetes and heart disease, prevention programs provide you with a health coach and an individualized plan that meet your unique needs and address several areas of your life, including physical activity, nutrition, sleep, and stress management. Most members see a reduction in medications they take, as well as normalization of blood sugar and blood pressure.
- **Chronic Condition Reversal Programs** – Turn back the clock and reverse the course of chronic conditions like hyperlipidemia, hypertension, type 2 diabetes and more with the support from physician, health coaches and a supportive patient community. Our high touch reversal programs, often incorporating in-person or digital coaching options, are focused on normalization of A1C levels, weight, and blood pressure, as well as elimination of medication dependence in a matter of weeks.

All Wellvolution programs are 100% covered by Blue Shield of California.

Pharmaceutical Benefits

Drug Formulary

The Blue Shield of California Drug Formulary (formulary), approved by the Blue Shield of California Pharmacy and Therapeutics (P&T) Committee, is designed to assist physicians in prescribing medically appropriate, cost-effective drug therapy.

The formulary contains medications approved by the Food & Drug Administration (FDA) which have been reviewed for safety, efficacy, bio-equivalency, and cost. The P&T Committee is the governing committee responsible for oversight and approval of policies and procedures pertaining to formulary management, drug utilization, pharmacy-related quality improvement, educational programs and utilization management programs, and other drug issues related to patient care. The Committee determines clinical drug preference for formulary inclusion, medication coverage policies and clinical coverage requirements based on the medical evidence for comparative safety, efficacy, and cost when safety and efficacy are similar. The voting members of the P&T Committee are practicing physicians and pharmacists in the Blue Shield network who are not employees of Blue Shield. The P&T Committee meets on a quarterly basis.

The formulary applies to members with outpatient prescription drug benefits through Blue Shield. Some drugs require prior authorization to determine medical necessity or to ensure safe use of a drug. Providers are encouraged to use the formulary to optimize drug benefits for our members, and to help them minimize their out-of-pocket expenses. Prescribers must submit prior authorization to Blue Shield for prescription medications before medications are dispensed. Prior authorizations submitted by an unauthorized source, including but not limited to pharmacies, will be dismissed and a request sent directly to the prescriber's office for prior authorization.

Blue Shield offers coverage for different types of outpatient prescription drugs. Drugs are placed into formulary drug tiers, and member cost-share (copayment or coinsurance) for covered medications varies by tier.

For drugs that require prior authorization or an exception to benefit or coverage rules, coverage decisions are based on the medication coverage policies approved by Blue Shield’s P&T Committee and the following will be considered during the review for coverage and will be approved if satisfied:

1. The requested drug, dose, and/or quantity are safe and medically necessary for the specified use.
2. Prior use of formulary alternative(s) or required prescription drugs have not achieved therapeutic goals (drug was discontinued due to lack of efficacy or effectiveness, diminished effect, sub-optimal results, or an adverse reaction) or are inappropriate for the specific member’s situation.
3. Treatment is stable on the prescribed drug.

Pharmaceutical Benefits *(cont'd.)*

Drug Formulary *(cont'd.)*

4. Relevant clinical information provided with the authorization request supports the use of the requested medication over formulary drug alternatives. This includes:
    a. Formulary drugs alternatives are expected to be ineffective or are likely or expected to cause an adverse reaction or physical or mental harm based on the characteristics of the member's known clinical characteristics and history of the member's prescription drug regimen.
    b. Formulary drug alternatives are not clinically appropriate because they are expected to do any of the following:
        i. Worsen a comorbid condition.
        ii. Decrease the capacity to perform daily activities.
        iii. Pose a significant barrier to adherence or compliance.

Commercial Plans

Pharmacy Benefit Medications: Providers can submit a prior authorization request electronically by utilizing one of our contracted electronic prior authorization (ePA) vendors, Surescripts or Cover My Meds. Providers also have the option to complete and fax the California Prescription Drug Prior Authorization or Step Therapy Exception Request Form 61-211 (Revised 12/2016) to (888) 697-8122. This form is available on blueshieldca.com/provider under *Authorizations, Prior authorization forms and list,* then *Prior authorization forms.* Providers may also submit prior authorization requests online by going to blueshieldca.com/provider under *Authorizations* then *Request pharmacy authorization* or *Request pharmacy prior authorization electronically* to submit a prior authorization request through an ePA vendor.

Providers have the alternate option to use AuthAccel to complete, submit, attach documentation, track status, and receive determinations for pharmacy prior authorizations. Registered users may access the tool, in the Authorizations section, after logging into Provider Connection at blueshieldca.com/provider. When providers submit requests via AuthAccel, it is not necessary for them to complete a separate California Prescription Drug Prior Authorization or Step Therapy Exception Request Form (61-211), as the required information is built into the tool.

Pharmaceutical Benefits *(cont'd.)*

Drug Formulary *(cont'd.)*

Medicare Plans

The Centers for Medicare & Medicaid Services (CMS) compiles a "Preclusion List" of prescribers, individuals, and entities that fall within either of the following categories: (a) are currently revoked from Medicare, are under an active reenrollment bar, and CMS determines that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or (b) have engaged in behavior for which CMS could have revoked the prescriber, individual, or entity to the extent applicable if they had been enrolled in Medicare, and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program. CMS makes the Preclusion List available to Part D prescription drug plans and Medicare Advantage plans. Plans are required to deny payment for claims submitted by or associated with prescriptions written by prescribers and providers on the list. Full enforcement of the Part C and D prescriber exclusion list requirement began on January 1, 2019.

Providers can submit a prior authorization request electronically by utilizing one of our contracted electronic prior authorization (ePA) vendors, Surescripts or Cover My Meds. Providers also have the option to request a prior authorization or exception request by faxing a Medicare Coverage Determination Request Form (available at blueshieldca.com/provider) to (888) 697-8122 or via phone to (800) 535-9481 Monday through Friday, 8:00 a.m. until 6:00 p.m. PST, excluding holidays.

Providers have the alternate option to use AuthAccel to complete, submit, attach documentation, track status, and receive determinations for pharmacy prior authorizations. Registered users may access the tool, in the *Authorizations* section, after logging into Provider Connection at blueshieldca.com/provider. When providers submit requests via AuthAccel, it is not necessary for them to complete a separate Medicare Coverage Determination Request Form, as the required information is built into the tool.

Once all required supporting information is received, a coverage decision, based upon medical necessity, is provided within the following timelines:

- Commercial plans within 24 hours for urgent requests and 72 hours for standard requests.
- Medicare Part D plans within 24 hours for an expedited review and 72 hours for standard requests.

Specialty Drugs are covered at a copayment or coinsurance and most require prior authorization for coverage. Specialty Drugs are available through a Blue Shield Network Specialty Pharmacy.

Pharmaceutical Benefits *(cont'd.)*

Drug Formulary *(cont'd.)*

The most current version of Blue Shield formularies and other information about Blue Shield prescription drug benefits and pharmacies can be accessed on blueshieldca.com in the *Provider Connection* or *Pharmacy* sections or by calling (800) 535-9481.

Note: Different drug formularies apply depending on the member's plan.

Mandatory Generic Drug Policy

In general, generic drugs should be prescribed whenever possible to help keep the member's out-of-pocket costs low. We recommend that physicians indicate or write *Generic Substitution Permitted/OK* on the prescription to inform the pharmacist to fill with a generic equivalent if available. Even when there is no generic equivalent for a brand-name drug, consider prescribing an alternative drug in the same class that is available as a generic. Most FDA-approved generic drugs are covered on the formulary. Transmitting a prescription using e-Prescribing technology provides the best method for determining and prescribing available generic equivalents and alternatives covered on the drug formulary.

If a brand name drug is dispensed when a generic is available upon request of the member or prescriber, the member may be responsible for paying the difference between the cost of the brand name drug and its generic equivalent, in addition to the associated drug copayment. Exceptions may be granted to cover the brand name drug at a plan copayment if medically necessary and use of the generic equivalent is not clinically appropriate for the individual patient.

Information about covered generic drugs on the formulary can be accessed on blueshieldca.com in the *Provider Connection* or *Pharmacy* sections.

Mail Service Prescriptions

Members may have their prescriptions for medications taken on a regular basis, for a chronic or long-term medical condition filled by Blue Shield's mail service pharmacy and delivered to the location of their choice for convenience and to optimize their copayment. Prescriptions for mail service must be prescribed for a quantity to cover up to a 90-day supply. Prescriptions can be sent electronically, by phone, or by fax.

Information about contacting Blue Shield's mail service provider can be accessed on blueshieldca.com/provider under *Guidelines & resources* and then *Drugs and pharmacy*.

Pharmaceutical Benefits *(cont'd.)*

Drug Formulary *(cont'd.)*

Specialty Drugs

Specialty Drugs are drugs that may require special handling or manufacturing processes, coordination of care, close monitoring, or extensive patient training for safe self-administration that generally cannot be met by a retail pharmacy and are available at a Network Specialty Pharmacy. Specialty Drugs may also be drugs restricted by the FDA or drug manufacturer to prescribing by certain physicians or dispensing at certain pharmacies. A Network Specialty Pharmacy provides up to a 30-day supply of Specialty Drugs by mail or, upon a member's request, at an associated retail pharmacy for pickup.

- The list of Specialty Drugs and information about Network Specialty Pharmacies may be accessed at blueshieldca.com.
- New prescriptions for Specialty Drugs should be sent to a Network Specialty Pharmacy.
- Specialty Drugs may be dispensed by any willing pharmacy for Medicare Part D plans.

Pharmaceuticals in the Medical Benefit

Drugs approved by the Food and Drug Administration (FDA) and covered under a Blue Shield member's medical benefit are generally those that are incident to a medical service, administered by a healthcare professional in a provider office, outpatient facility, infusion center, or by home health/home infusion (not self-administered by the patient). Some medical benefit drugs may require prior authorization and step therapy for coverage based on medical necessity. Additional authorization for select medical drugs may also be required for the administration of the drug at an outpatient hospital facility site in addition to authorization of coverage for the drug.

For drugs that require prior authorization or an exception to step therapy requirements, coverage decisions are based on the medication coverage policies approved by Blue Shield's P&T Committee and the following will be considered during the review for coverage:

1. The requested drug, dose, and/or quantity are safe and medically necessary for the specified use.
2. Prior use of step therapy alternative(s) has not achieved therapeutic goals or are inappropriate for the specific member's situation.
3. Treatment is stable and a change to an alternative treatment may cause clinical decompensation or immediate harm.

Pharmaceutical Benefits *(cont'd.)*

Pharmaceuticals in the Medical Benefit *(cont'd.)*

4. Relevant clinical information provided with the authorization request supports the use of the requested medication over step therapy drug alternative(s). This includes:
    a. Step therapy drug alternatives are expected to be ineffective or are likely or expected to cause an adverse reaction or physical or mental harm based on the characteristics of the member's known clinical characteristics and history of the member's prescription drug regimen.
    b. Step therapy drug alternatives are not clinically appropriate because they are expected to do any of the following:
        i. Worsen a comorbid condition.
        ii. Decrease the capacity to perform daily activities.
        iii. Pose a significant barrier to adherence or compliance.

Blue Shield requires that all delegated IPA/medical groups adhere to Blue Shield Medication Policies which may include step therapy and site of administration criteria. Ultra-high-cost medications including CAR-T and Gene Therapy or drugs costing over $100,000 per single dose are subject to Blue Shield review for coverage according to Blue Shield Medication Policy regardless of if utilization management is delegated to the IPA/medical group. Refer to Section 5.1: Prior Authorization.

The Blue Shield Pharmacy and Therapeutics Committee (P&T) reviews medication coverage policies for medical benefit drugs on a quarterly basis for drugs requiring prior authorization. Medication coverage policies for medical benefit drugs can be found on Provider Connection at blueshieldca.com/provider. Once you have logged on, select *Authorizations*, *Clinical policies and guidelines*, then *Medical policies & procedures.* For Blue Shield Medicare Advantage HMO plan Members, Blue Shield follows Medicare guidelines for risk allocation, Medicare national and local coverage guidelines, and Blue Shield Medication Policy.

Pharmaceutical Benefits *(cont'd.)*

Pharmaceuticals in the Medical Benefit *(cont'd.)*

Childhood Immunizations

All childhood immunizations first recommended for use by the Advisory Council on Immunization Practices (ACIP) or the American Academy of Pediatrics (AAP) on or after January 1, 2001 will become the full financial responsibility of Blue Shield unless an IPA/medical group agrees to accept financial responsibility. Childhood immunizations that were part of the ACIP recommendation schedule prior to January 1, 2001, and the cost of vaccine administration are both the financial responsibility of the IPA/medical group. Please note that new combination vaccines of previously recommended immunizations or changes to dosing frequency or age restrictions will not be included in this classification unless they represent a material change in cost under a current contract. Claims must be submitted by the IPA/medical group, not the individual participating providers, for reimbursement regardless of financial responsibility. Please refer to Section 4.4 for encounter and claims processing procedures.

Office/Facility-Administered Medications

For some IPA/medical group commercial contracts, Blue Shield identifies and maintains a separate financial risk classification as dictated by the Richman Injectable List for certain (a) office-administered, (b) high-cost, (c) chemotherapy, and (d) chemotherapy and supportive/adjunctive injectable drugs. Medications are updated to these various risk allocation classifications on a quarterly basis when CMS assigns the drug its unique HCPCS code. Please refer to your Division of Financial Responsibility (DOFR) for the classification (s) of drugs that are currently contractually carved out to Blue Shield. This policy does not apply to the Medicare Advantage product, as all IPA/medical groups are capitated on a percent of premium methodology, which is presumably self-adjusting and for which we follow Medicare guidelines in risk allocation.

Regardless of financial risk classification, the IPA/medical group is responsible for reimbursing providers for these medications directly. The IPA/medical group shall submit encounters to Blue Shield. When Blue Shield has risk for drugs on the Richman Injectable List, as defined in the IPA/medical group's contract, the IPA/medical group shall submit encounters to Blue Shield for reimbursement at rates set forth in the IPA/medical group's contract with Blue Shield. Encounters for these medications shall be submitted by the IPA/medical group, not the individual participating providers, with the appropriate National Drug Code (NDC) and HCPCS code. Please refer to Section 4.4 Claims for Medical Benefit Drugs for encounter and claims processing procedures.

For reimbursement of medications administered at an outpatient facility, select drugs may require site of service medical necessity authorization for coverage in addition to the authorization of the drug.

Pharmaceutical Benefits *(cont'd.)*

Pharmaceuticals in the Medical Benefit *(cont'd.)*

The criteria for classification of High-Cost injectables includes those FDA-approved in 1998 or later with an estimated treatment cost per patient at or above $10,000 average wholesale price (AWP) per year. For newly released drugs, the high-cost drug classification is based on average weight or body surface area of adult males and females based on the FDA approved dosage. A validation and reconciliation of the high-cost category will be conducted annually based on the previous years' Blue Shield utilization data using updated AWP pricing information and historical claims data to determine average dosing including duration of therapy. The validation process will determine if specific drugs are removed or added to the high-cost drug category based on actual claims experience which reflects aggregate drug utilization for Blue Shield members. The high-cost drug category does not take into consideration differences in weight, dosage, or specific duration of therapy at a member level since many drugs are weight based. A complete list of High-Cost Injectables and corresponding HCPCS Codes that meet the classification criteria is posted quarterly on Provider Connection at blueshieldca.com/provider under *Claims*, then *Policies & guidelines,* then *Medications.* You may also contact your Provider Relations Coordinator for a listing.

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