Chapter 3

Products, Networks and Payment

Unit 1: Product Information

In This Unit

3.1 Participating and Preferred Provider Networks

Overview

This section provides a description of Highmark Blue Shield's professional provider networks.

Mutual Roles And Obligations For Physicians And Highmark

As a participant in any of Highmark Blue Shield's networks, professional providers agree to a set of regulations that outline their obligations to Highmark Blue Shield members. Highmark Blue Shield has obligations to its network participants as well.

The mutual obligations are contained in the agreements and regulations that professional providers execute when joining the network.

Key contractual provisions include:

- Network providers will accept the network allowance as payment-in-full for covered services, less any applicable copayments, deductibles and/or coinsurance.
- Highmark Blue Shield will make payment directly to network providers and will notify the member of any responsibility they may have (such as, non-covered services, coinsurance or deductibles).
- Network providers will handle basic claims filing paperwork for the member.
- Highmark Blue Shield will encourage members to obtain health care services from network providers, which could increase the provider's patient base.
- Network providers will recommend their patients see other network providers when necessary.

Types of Contracted Health Care Professionals

Highmark Blue Shield pays claims for services performed by licensed, eligible health service providers, as defined by state law. These providers include:

- Doctor of Medicine;
- Doctor of Osteopathy;
- Doctor of Dental Surgery;
- Doctor of Podiatry;
- Doctor of Optometry;
- Doctor of Chiropractic;
- Nurse midwives;
- Licensed physical therapist;
- Independent clinical laboratories;
- Licensed psychologist;
- Certain certified registered nurses;
- Licensed audiologist;
- Licensed speech-language pathologist; and
- Licensed teachers of persons who are hearing impaired

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3.1 Participating and Preferred Provider Networks, Continued

The Participating Provider Network

Highmark Blue Shield has agreements with more than 46,000 Participating Providers – 8 out of 10 health care providers in the state – representing every major specialty.

Any eligible professional provider licensed to practice in Pennsylvania may apply for participating status by completing Highmark Blue Shield's Participating Provider Agreement. This is not a credentialed network – a professional provider's admission to the network is based solely on medical licensure and the execution of the network agreement.

- Highmark Blue Shield Participating Providers agree to perform services for members according to the Regulations for Participating Providers, Pennsylvania state laws, the corporate bylaws governing Highmark Blue Shield and subscription agreements and master contracts.
- Participating Providers accept Highmark Blue Shield's allowances as payment-in-full for covered services, minus any applicable copayments, deductibles or coinsurance. Participating Providers also handle all basic claims filing paperwork for Highmark Blue Shield's members.
- Participating Providers are eligible to become actively involved with Highmark Blue Shield as corporate professional members and as members of the company's various professional committees and advisory councils.
- This network services our traditional Highmark Blue Shield programs, including traditional BlueCard, as well as BlueCard POS and HMO programs.

3.1 PremierBlue Shield Network Information

The PremierBlue Shield Network

The PremierBlue Shield Network is Highmark Blue Shield's statewide selectively contracted preferred provider network. There are more than *41*,000 providers in the PremierBlue Shield network. Any eligible professional provider licensed to practice medicine in Pennsylvania may apply for the PremierBlue Shield network. You must meet the network's credentialing criteria to be accepted into the network. Because PremierBlue Shield supports managed care products. Highmark Blue Shield must ensure the network complies with the regulations of the Pennsylvania Department of Health governing Managed Care Organizations (28 PA Code, Chapter 9). These regulations require that we ensure network providers' offices meet certain standards. As a result, Highmark Blue Shield staff conducts site visits and medical record reviews of primary care physicians, ob-gyns and high volume behavioral health provider offices.

The application for this credentialed network requests information about a provider's qualifications to practice quality medicine, practice location(s), the doctor's medical education, work history, etc.

Network providers are classified as primary care physicians (PCPs) or specialists. PCPs include family practitioners, general practitioners, internists and pediatricians.

PCPs and specialists sign separate network agreements. Members are free to choose any network provider to receive maximum benefits.

What Region Am I?

This network supports a variety of coverage programs. PremierBlue Shield also supports the BlueCard PPO programs, and is used by other carriers who have made an arrangement with Highmark Blue Shield. The Federal Employee Program is the largest customer that utilizes this network in the Central, Eastern and Northeastern Regions. The Western Region network supports the Federal employee Program in the western part of the state. More information on these networks are found throughout this unit.

PremierBlue Shield providers agree to perform services for members according to the Regulations for PremierBlue Shield Providers, Pennsylvania state laws, the corporate bylaws governing Highmark Blue Shield and individual subscription agreements and master contracts. They also agree to accept the PremierBlue Shield allowance as payment in full for covered services, less any applicable copayments, deductibles or coinsurance.

3.1 Facility, Ancillary, and Mid-Level Provider Networks

Facility Network

What Region Am I?

Highmark Blue Shield holds contracts with all 38 acute care facilities in the 21-county Central Pennsylvania and Lehigh Valley areas.
In addition, we contract with substance abuse treatment centers, psychiatric facilities, rehabilitation facilities, skilled nursing facilities, and state-owned psychiatric hospitals.

Mid-Level Provider Network

Mid-level providers who are not eligible to participate in the Participating Provider or PremierBlue Shield networks may be eligible to contract with Highmark Blue Shield to provide services for certain government programs only, i.e., Federal Employees Program (FEP) and Medicare Advantage as follows:

FEP
- Acupuncturist
- Licensed Clinical Social Worker

Medicare Advantage
- Occupational Therapist
- Physician Assistant

Both FEP and Medicare Advantage
- Dietician/nutritionist

Ancillary Provider Network

To supplement the professional provider and facility networks, Highmark Blue Shield has contracted with a network of ancillary providers. These include freestanding and facility-based providers in the specialties including but not limited to:

Ambulatory Surgical Centers	Ambulance
Renal Dialysis	Durable Medical Equipment
Home Health	Home Infusion
Hospice	Orthotics/Prosthetics
Comprehensive Outpatient Rehabilitations Facilities (CORF)	
Independent Laboratories	

Recommending Other Network Providers

In order for our members to receive the highest level of benefit that their plan offers, please be sure to use other network providers when you must recommend members for care.

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3.1 Facility, Ancillary, and Mid-Level Provider Networks, Continued

Recommending Other Network Providers (continued)

You and the member can access our health care directory through NaviNet and Highmark's Informational Member Web sites.

Please visit NaviNet or one of Highmark's Informational Web Sites via www.highmark.com.

Medicare Advantage

The cornerstone of the program is the network:

- When members receive covered services from network providers, those services are paid at the higher level defined in the benefit contract. (Some services require a copayment or coinsurance even when rendered by a network provider.)

- Members can still receive most covered services from non-network providers, but if they choose to do so, they are responsible for a greater share of the financial responsibility for the services. Coverage is generally at the lower level of coverage as defined in the benefit contract after the member has met his or her annual non-network deductible.

To be included in a Medicare Advantage provider network, a provider must participate in the Medicare program itself.

For more information on the Medicare Advantage network, please visit Chapter 3, Unit 6 of this manual.

3.1 Dual Networks

Overview

Some customers choose to have more than one professional provider network support their managed care coverage program. These programs have both a primary provider network and a secondary network comprised solely of Highmark Blue Shield's Participating Provider network. The Pennsylvania Insurance and Health Departments have approved these dual-network programs.

Dual-network managed care programs use a separate, supplemental member contract. This contract applies when a member chooses to receive services from a participating provider not in the primary network. Payment under the supplemental contract is based on UCR. Service benefits apply when a Highmark Blue Shield participating provider renders the services.

The Explanation of Benefits form that accompanies the UCR payment states that a Participating Provider must accept the UCR allowance as payment in full for covered services, in accordance with the terms of the Participating Provider agreement. The participating provider may collect any applicable coinsurance or deductibles from the member.

3.1 Coverage Programs

Overview

Highmark Blue Shield offers a wide range of programs. These programs are supported by the networks previously outlined.

When treating a Highmark Blue Shield member, find out which coverage program they are enrolled in and which network the program uses.

Highmark Blue Shield's programs cover:

- National accounts – large employer groups who have employees living in Pennsylvania and in other states;
- Pennsylvania accounts – large and small groups located in Pennsylvania;
- Individual account members – individuals who do not belong to a group account and who pay for their own coverage.

Customer Contracts Specify Covered Services

All the services covered under our programs are subject to specific contract benefit exclusions. Each program is governed by the specific terms of the applicable contract and medical policy in effect at the time a service is performed, and is subject to change without prior notice.

A reminder: In response to rising health costs, more customers are choosing health plans that require their employees to share in the cost of their health care. These plans include higher deductibles, copayments or coinsurance. Highmark Blue Shield has responded by making these plan designs more widely available to the market place. Be sure to verify a member's benefits and cost-sharing obligations at the time they receive services from you. Member information can be found on NaviNet.

What We Mean By Program And Product

When used in this manual, program and product have approximately the same meaning, but somewhat different usage. They both refer to the patient's type of insurance coverage. They help to differentiate the types of insurance coverage, especially under a single insurance company. Program refers to the type of coverage (i.e., HMO or POS) whereas product refers to the brand name of the program (i.e., PPOBlue or FreedomBlue).

Highmark Blue Shield has many different types of managed care coverage as well as many types of indemnity coverage. Knowing the product helps you to understand which specific managed care rules and guidelines to follow.

3.1 Traditional Fee-For-Service Programs

Indemnity Programs

Under indemnity programs, Highmark Blue Shield members can seek care directly from any Participating Provider, without coordination from a primary care physician (PCP). As long as the service is covered under the member's benefit plan and the services provided are medically necessary, Highmark reimburses the provider. Indemnity programs offer the greatest degree of member choice among all Highmark Blue Shield products.

Indemnity Programs Across The State

What Region Am I?

Please visit www.highmark.com and select the region specific to you. A list of indemnity programs (e.g. ClassicBlue) is provided for you under the 'member' heading. Then, access the "Have a Greater Hand in your Health" section.

Network For Indemnity Products

The foundation of the Highmark Blue Shield indemnity programs is the Participating Provider network of professional and ancillary providers, along with Highmark Blue Shield's network of contracted facility providers.

- Facility providers include hospitals, skilled nursing facilities, home health agencies, hospices, dialysis centers and other kinds of medical facilities.
- Professional providers include PCPs - pediatricians, internists, family practitioners and general practitioners -- who play key roles in managing the care members receive. Specialty providers render services of a more specialized nature for particular conditions a member may have, such as heart disease, a digestive disorder or a pregnancy.
- Ancillary providers include, but are not limited to, suppliers of home infusion therapy, durable medical equipment, orthotics and prosthetics and ambulance transportation.

Indemnity Product Payment Levels

Payments made for indemnity products are based on the UCR payment mechanism or Fixed Fee Schedule allowances. You can find additional information about this in Chapter 3, Unit 3, "Payment Methodology."

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3.1 Traditional Fee-For-Service Programs, Continued

ClassicBlue: Traditional and Comprehensive Indemnity Programs

While the particulars of coverage may vary from one employer group to another, these generalizations can be made about the kinds of services covered under each of the three components of ClassicBlue:

- Institutional/hospital - This portion of ClassicBlue indemnity benefit plans typically covers inpatient and outpatient care provided by a Highmark Blue Shield participating facility such as a hospital or a skilled nursing facility.

- Medical-surgical - This portion of ClassicBlue benefit plans typically covers the services of network professional providers such as physicians.

- Major medical - This portion of ClassicBlue benefit plans typically considers eligible services such as durable medical equipment and professional office visits not covered by either of the other two components.

An individual member's benefit plan may provide any or all of these types of coverage. Although ClassicBlue products do not require a member to select a PCP, limited medical management processes do apply.

Two Possible Configurations Of ClassicBlue

Employer groups, as well as individual, direct-pay customers, can purchase ClassicBlue indemnity coverage in either of two configurations:

- **ClassicBlue Traditional**

  Under ClassicBlue Traditional programs, if a member receives institutional services, those charges are processed under the basic institutional portion of the benefit program, with covered services typically paid at 100%.

  If the ClassicBlue Traditional member receives medical-surgical services, these charges are processed under the basic medical-surgical portion of the benefit program, with covered services typically paid at 100% of UCR.

  The major medical component supplements these two coverages and typically provides coverage at 80%, usually after an annual deductible. Concurrent major medical processing is a feature that incorporates the major medical benefit into the traditional benefits. See Chapter 5, Unit 2, "Claims Submission and Billing Information" for additional information.

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3.1 Traditional Fee-For-Service Programs, Continued

Two Possible Configurations Of ClassicBlue, continued

- **ClassicBlue Comprehensive**

  Under ClassicBlue Comprehensive, the three components (basic institutional, basic medical-surgical and major medical) are combined into one product design. ClassicBlue Comprehensive typically provides coverage for the same types of services as ClassicBlue Traditional. However, an annual deductible and 20% member coinsurance typically apply to most services under this design.

UCR Programs

Most fee-for-service programs are supported by the Participating Provider network and reimbursed based on the UCR allowance. (See Chapter 3, Unit 3, "Payment Methodology" for a discussion of the UCR payment mechanism.)

When a member enrolled under this program receives services, Highmark Blue Shield pays the service on the basis of the usual, customary or reasonable criteria.

When medical-surgical services are rendered by a Participating Provider, the amount paid constitutes payment-in-full, except when payments are reduced for amounts exceeding the maximum or deductible and coinsurance amounts.

Participating Providers agree not to bill the member for the difference between the provider's charge and the UCR allowance, except for copayments, deductibles, coinsurance or amounts exceeding a maximum, and non-covered services regardless of the member's income.

- **Highmark Blue Shield 100 (also called UCR 100 or UCR full payment)**
  The Highmark Blue Shield UCR 100 program is currently Highmark Blue Shield's most popular fee-for-service program. Most covered services are reimbursed at 100 percent of the UCR allowance.

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3.1 Traditional Fee-For-Service Programs, Continued

UCR Programs, continued

- **Comprehensive and wraparound major medical programs**
  - Comprehensive programs combine institutional/hospital, medical surgical and major medical coverages into a single package of benefits.
  - Wraparound programs combine Highmark Blue Shield and major medical coverage into a single benefits package. The program "wraps" around the separately provided hospital program.

Most comprehensive and wraparound major medical programs combine all of these different types of coverage into one program and apply a single deductible or copayment to all covered services. Comprehensive and wraparound major medical contracts include services that normally are covered under Highmark Blue Shield's major medical benefit. Examples of such services are home and office visits, drugs, injections and outpatient psychiatric and psychological services.

Medical-surgical benefits within a comprehensive or wraparound major medical program are usually based on the UCR provider reimbursement mechanism.

Benefit packages include various deductibles and program maximums. Various coinsurance alternatives are available; however, payment is typically made at 80 percent of the UCR allowance for covered services, up to a specific "out-of-pocket" maximum. Expenses incurred after the member's out-of-pocket payments have reached the out-of-pocket maximum typically are reimbursed at 100 percent of the UCR allowance. Lifetime maximums and re-instatement options also are available.

These services should be billed to Highmark Blue Shield, instead of asking the patient to pay the full charge at the time the service is performed. Highmark Blue Shield will then make payment directly to the Participating Provider, who must accept the UCR allowance as payment-in-full. Participating providers may bill the patient for any deductible or coinsurance amounts that may apply.

3.1 Fee Schedule Programs

Overview

Highmark Blue Shield's fee schedule programs are 1800S, Plan C and Plan 5000S. They are "fixed-fee" programs. This means that Highmark Blue Shield pays a predetermined amount for specific health care services, or the provider's actual fee -- whichever is less.

These programs differ primarily in the provider reimbursement and income levels. The differences in payment levels are reflected in the rates for these programs. Thus, the lowest-performing fee schedule program is affordable to persons of very low income.

Participating Providers agree to accept the reimbursement made under these fee schedule programs as payment-in-full, when they perform covered services for members whose incomes fall within the designated limits. Members are eligible to receive service benefits under the program with rates proportionate to their incomes.

Providers have the option of charging members who do not fall within the income limits for the difference between the fee schedule allowance and their actual charge. (See Chapter 3, Unit 3, "Payment Methodology" for additional information.)

Fee Schedule Program Income Limits

Highmark Blue Shield defines annual income as total income from all sources of the applicant and his or her eligible dependents. The member's income is based on the full calendar year prior to the date of service. Participating Providers determine initially whether or not a member is of low income. If there is a dispute about the income status of a member, Highmark Blue Shield will make the final determination. Please reference the grid below for Fee Schedule Program Limits.

Plan	Single Income	Family Income
Plan 1800S	$6,000	$12,000
Plan C	$12,000	$24,000
Plan 5000S	$18,000	$36,000

3.1 Major Medical

Major Medical

Major medical benefits supplement the hospital and medical/surgical portions of basic coverages. The member shares in the cost of medical expenses through an annual deductible and coinsurance.

Deductible

Major medical requires an annual deductible for the member and each dependent. The amount of the deductible varies according to the member's contract. A new deductible amount is required each calendar year.

Coinsurance

Generally, when the deductible is satisfied for the member or dependent(s), major medical pays 80 percent of the allowances for covered medical expenses, and the member is liable for the other 20 percent.

Note: Under most major medical contracts, outpatient psychiatric care is reimbursed at 50 percent of the allowance for covered medical expenses.

Maximum Amounts

Many contracts have annual and/or lifetime maximum amounts that are paid for benefits. The maximums vary according to the contracts.

Major Medical Benefits

Major medical extends the coverage available under basic contracts and provides coverage for additional services, such as:

- Ambulance service
- Blood products
- Doctors' office visits
- Durable medical equipment
- Outpatient therapy and rehabilitation services
- Prescription drugs

Major Medical Claims

If the member is enrolled in a standalone major medical program and, during a calendar year, the member's or dependent's expenses exceed the deductible, the member should complete a major medical claim form. The member should submit the claim along with itemized bills, to the Blue Plan through which the member is enrolled.

In addition to being offered as a standalone benefit option, major medical can be incorporated into the traditional benefits package. Claims processing is accomplished through a feature called concurrent major medical processing. See Chapter 5, Unit 2, "Claims Submission and Billing Information" for additional information.

3.1 Understanding Managed Care

Defining Managed Care

Managed care programs integrate the delivery and financing of medical care. The programs offer health care coverage through a network of contracting physicians who provide care to people who subscribe to the plan, called members.

Managed care programs provide preventive coverage to members and use its network of physicians to assist in determining the appropriateness and the efficiency of the members' care in order to promote and maintain good health while conserving resources.

3.1 Managed Care Terms

Authorization	The official acknowledgement from Highmark that services/items requested meet the definition of "medically necessary and appropriate."
Covered Services	Those medically necessary and appropriate services and supplies that are provided as part of a benefit program. There are several ways to determine what services are covered as part of a members benefit program. • Benefit information is available online in NaviNet, • Procedures/DME that require authorization can be found on the Provider Resource Center under Administrative Reference Materials, • Requests for authorization are reviewed by Healthcare Management Services, • Medical Policy can be viewed under the Medical & Claim Payment Guidelines heading on the Provider Resource Center.
Exclusions	Items or services that are not covered as part of a program.
Primary Care Physician (PCP)	PCP is the acronym for primary care physician, a physician selected by a member in accordance with the member's managed care program requirements. The physician provides, coordinates, or authorizes the health care services covered by the managed care program. The PCP may be a general practitioner, family practitioner, internist, or pediatrician.

3.1 Managed Care Products - PPOs

PPO Programs

Preferred provider organization (PPO) programs offer members the ability to obtain care from a network-participating provider.
Members may also receive care from providers not participating in a network, for which the member will receive a lower level of reimbursement and will be responsible for the difference between the provider's charges and the actual payment provided by Highmark. All services are subject to specific contract coverage and limitations.

What Region Am I?

PPOBlue

PPOBlue *and ShortTermBlue Individual PPO are* offered in the western and central regions.

General Characteristics

- Members are not required to select PCPs to coordinate their care.
- All practitioners are paid fee-for-service for care rendered to PPO members.
- Members can seek care without coordination or authorization, except for inpatient admission and outpatient therapy services for Medicare Advantage PPO.
- Blues On Call services including preventive care benefits are integral components.
- See specific benefit details for additional Medicare Advantage PPO requirements.

Components Of PPO Programs

There are two components of the PPO programs: institutional and medical-surgical.

- The institutional portion typically covers inpatient and outpatient care provided by a Highmark Blue Shield participating facility, such as a hospital or skilled nursing facility.
- The medical-surgical portion typically covers the services of network professional providers, such as physicians, and ancillary providers, such as durable medical equipment suppliers.

Medical-surgical benefits cover a range of preventive care services, including periodic physical exams and diagnostic tests. Women's care benefits include routine gynecological exams, PAP tests and mammograms. Covered pediatric care includes routine immunizations and check-ups. Members are also covered for emergency and out-of-area care. Although PPO programs do not require members to select a primary care physician, limited medical management processes do apply.

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3.1 Managed Care Products - PPOs, Continued

Network Providers For PPO Program Members With Highmark Blue Shield

The foundation of PPO programs is the PremierBlue Shield network of preferred professional providers located in the 21 counties of Central Pennsylvania and the Lehigh Valley plus institutional and ancillary providers that contract with Highmark Blue Shield in this region. Members also have access to PremierBlue Shield professional providers in the 13 counties of Northeastern Pennsylvania and the five-county Greater Philadelphia area.

In the 29 counties of Western Pennsylvania, members have access to an additional network of professional, institutional and ancillary providers. These providers will be reimbursed at the higher benefit level for covered services.

Please note: The statewide PremierBlue Shield network of preferred professional providers provides high-level access for out-of-area PPO members through BlueCard.

- Facility providers include hospitals, skilled nursing facilities, home health agencies, hospices, dialysis centers and other types of medical facilities.
- Professional providers include primary care physicians and specialty providers. Primary care physicians are pediatricians, internists, family practitioners and general practitioners who play key roles in managing the care members receive. Specialty providers render services of a more specialized nature for particular conditions a member may have, such as heart disease, a digestive disorder or a pregnancy.
- Ancillary providers include, but are not limited to, suppliers of durable medical equipment, orthotics and prosthetics, home infusion therapy, ambulance transportation.

Network And Out-Of-Network Reimbursement

Payments made under PPO programs are based on the lesser of the PremierBlue Shield fee schedule allowance or the provider's charge.

PPO programs provide higher-level reimbursement for services received from network providers and lower-level reimbursement for services received outside the network. The specific percentages for network and out-of-network services are determined by the particular employer group contract. In the case of lower-level payment (for out-of-network services), members can be billed for any deductibles or coinsurances that apply to the services received, in addition to the difference between the approved amount and the provider's charge.

3.1 Managed Care Programs – PPOs, Continued

Individual PPO Programs

Effective August 1, 2008, Highmark offers ShortTermBlue. ShortTermBlue is designed for those who need health care coverage for a short period of time like seasonal workers, people who are between jobs, new hires whose employer-sponsored coverage does not become effective immediately and others in similar situations.

ShortTermBlue is a medically underwritten product. To apply for it, interested individuals must complete an online or paper application which includes several health screening questions. If the potential member can answer NO to all such questions, he or she can proceed to submit the application.

ShortTermBlue members can select the number of days for which they need coverage, from 31 to 180 days. ShortTermBlue is not automatically renewable.

ShortTermBlue

ShortTermBlue Individual PPO is offered in the western and central regions.

General Characteristics

- *Pre-Existing Condition clause for the entire coverage period (with the 60-month look-back) applies to both medical services and outpatient prescription drugs.*
- *When obtaining prescription drugs, members pay the full Highmark-negotiated discounted price at the pharmacy and then complete and submit a Prescription Drug Claim form for reimbursement.* ***If it is determined that the drug is related to a pre-existing condition, ShortTermBlue will not cover the cost of the drug.*** *A copy of the Prescription Drug Claim form is included with this bulletin. The claim form is also available in the Provider Resource Center via NaviNet or Highmark's public member sites. Hover on Provider Forms and select the Miscellaneous Forms link from the fly-out menu. Then, select ShortTermBlue Member Prescription Drug Claim Form.*
- *No coverage for maternity services.*
- *No coverage for mental health or substance abuse treatment services. (As always, you can verify member benefits for these services under the Behavioral Health/Substance Abuse benefit category in NaviNet.)*
- *For most in-network services, Highmark will reimburse at 80 percent of the allowable amount, after the deductible has been met. Member coinsurance for in-network services is 20 percent. When out-of-network services are covered, Highmark will reimburse at 60 percent of the allowable amount, after the deductible is met, and the member is responsible for a 40 percent coinsurance.*
- *Each inpatient hospital admission (including admissions to inpatient rehabilitation) is limited to 31 days.*
- *Five-visit limit per coverage period for physical medicine. Combined limit of five visits per coverage period for occupational and speech therapy. There is no out-of-network coverage for these services.*

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3.1 Managed Care Programs – PPOs, Continued, Continued

Identifying ShortTermBlue Members

There are three ways to identify a ShortTermBlue member: Confirmation of Enrollment Letter, ID Card, or NaviNet Eligibility and Benefits file. ShortTermBlue coverage becomes effective the day after the application and premium are submitted (or the day after the signature date on a paper application, or a future date within 30 days of the application date, as selected by the member). Once the materials have been received, the member will be sent a letter confirming his or her enrollment. This letter can serve as proof of coverage until the ID card is received.

Identifying Termination Date For ShortTermBlue Members

Providers should pay close attention to effective and termination dates and the applicability of pre-existing condition limitations. ShortTermBlue members could present for services as early as Aug. 2, 2008. To identify the end of the coverage period for a ShortTermBlue member, providers should refer to the Term Date field (located immediately below the Effective Date field) on the NaviNet Eligibility and Benefits screen. (See the sample Eligibility and Benefits screen included with this bulletin.) Providers may be familiar with the Term Date field if they previously reviewed Eligibility and Benefits for members with coverage through the Federal Employee Health Benefits Program (FEP).

Please note that the ShortTermBlue ID card does not display a termination date.

Inquiries About Eligibility, Benefits, Claim Status or Authorizations

For inquiries about eligibility, benefits, claim status or authorizations, Highmark encourages providers to use the electronic resources available to them – NaviNet and the applicable HIPAA transactions – prior to placing a telephone call to the Provider Service Center.

3.1 Managed Care Products - EPOs

EPO Programs

Exclusive Provider Organizations (EPOs) provide members with coverage for a wide range of services when they are received from in-network providers and facilities. EPOs function like a PPO, but offer no out-of-network benefits except for emergency services. Members are not required to select a PCP to coordinate covered care, but it is recommended. By utilizing the local Blue Plan PPO network, EPOs allow access to the largest provider network in the Highmark service area, as well as a large provider network across the country.

EPOBlue

EPOBlue is offered in the western and central regions.

What Region Am I?

General Characteristics

- Members utilize the existing managed care networks in the western and central region and the local "Blue" Plan PPO providers outside of the 49-county region.
- There is no coverage when a member receives services from an out-of-network provider, except emergency services, which are covered at the in-network level.
- Members are not required to select PCPs to coordinate their care, but it is recommended.
- Providers are required to contact Healthcare Management Services (HMS) to obtain authorization for in-network inpatient admissions within the western and central regions.
- Members are required to contact HMS to obtain authorization prior to in-network inpatient admission outside of the western or central regions.
- Members may be responsible for copayments on such services as, but not limited to, physician office visits, emergency room services, mental health outpatient visits, substance abuse outpatient visits, spinal manipulation, physical therapy, occupational and speech therapy.

3.1 Managed Care Products – Open Access

Open Access Programs

Open access programs do not require members to select a network primary care physician (PCP), though it is recommended. Like POS programs, open access programs allow members to receive care outside of the network. For out-of-network care, benefits are paid at the program's lower level of reimbursement, and the members are responsible for filing claims and pre-certifying care.

DirectBlue

DirectBlue is offered as an open access group product in the western and central regions.

General Characteristics

- It is not mandatory for members to choose a PCP, but they are strongly encouraged to do so.
- Open access product members may receive care at the higher level of benefits for covered services in:
  - The 29 counties of western PA when they access physicians, hospitals or other health care providers within the Western Region network
  - The 21 counties of central PA when they access physicians, hospitals or other health care providers within the PremierBlue℠ Shield professional network and the Highmark Blue Shield facility network.
- Members may change PCPs upon request.
- Both PCPs and specialists are paid fee-for-service for care rendered to open access product members.
- For services requiring an authorization, the ordering physician should obtain the authorization.
- Blues On Call services including disease management and preventive care benefits are integral components.

DirectBlue Payment Levels Corresponding To Member Options

DirectBlue is reimbursed according to the PremierBlue Shield fee schedule. The program provides two levels of payment, corresponding to the options the member chooses when accessing care.

- If DirectBlue members choose to receive care from providers associated with the PremierBlue Shield network located in the 21counties of Central Pennsylvania and the Lehigh Valley or the Highmark Managed Care network in the 29-counties of Western Pennsylvania, covered services will be reimbursed at the higher, in-network level provided by the group contract.
- If DirectBlue members choose to seek services from a provider outside the 21-county PremierBlue Shield network or the 29-county Highmark Managed Care network, covered services will be reimbursed at the lower, out-of-network level provided by the group contract.

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3.1 Managed Care Products – Open Access, Continued

DirectBlue Payment Levels Corresponding To Member Options, (continued)	Each employer group offering DirectBlue determines what the higher and lower payment percentages will be for its own members. A DirectBlue member who chooses out-of-network care is responsible for any resulting deductible, coinsurance and/or copayment amounts, as well as the difference between the provider's charge and the plan allowance.
When Care Cannot Be Provided By A Network Provider	Healthcare Management Services, Highmark Blue Shield's medical management division, may authorize a DirectBlue member to receive services from a non-network provider if the care he or she requires cannot be provided within the network. In such situations, reimbursement will be made at the higher, in-network level.

3.1 Managed Care Products – HMOs – *Western Region Only*

What Region Am I?

Overview

A health maintenance organization (HMO) is a healthcare plan that provides comprehensive medical, surgical, hospital, and ancillary medical services including preventive care services.

Members receive this comprehensive benefits package in exchange for exclusive use of the HMO's established provider network and compliance with its requirements. Care and case management services and typically authorization requirements are inherent components of HMO programs and help ensure that care is medically necessary and provided in an appropriate setting.

HMO Products

In the western region only, Highmark, through its western region network offers two HMO products. HMO coverage requires you to select a primary care physician (PCP) who will become familiar with all aspects of your health and health care and, as your personal physician, will be responsible for treating you for your basic health care needs. While you are required to get your preventive care (such as adult and pediatric routine physicals and pediatric immunizations) from your PCP, you can go directly to a network specialist for other covered services - without a referral.

For more information on western region Medicare Advantage HMO products, please visit Highmark's member sites.

General Characteristics

- HMO products require members to select a network-participating primary care physician who provides preventive care services, directs patients to seek specialty care if required, and communicates with specialists to ensure continuity and coordination of care.
- For all HMO products except the Western Region Medicare Advantage HMO, routine adult and pediatric physicals and pediatric immunizations must be performed by the member's PCP to receive coverage.
- Members may change PCPs upon request.
- For services requiring an authorization, the ordering physician should obtain the authorization.
- Blues On Call[SM] services including disease management and preventive care benefits are integral components.

3.1 Commercial Group/Direct Pay HMO Members Who Require Services Outside The Local Area -- Western Region Only

Introduction

Highmark's commercial group/direct pay HMO members rely on a network of medical practitioners, in the western region network service, to supply medical care area. However, members still have coverage when they are outside the network service area. The type of coverage that a member has depends on two elements:

- the care required and
- whether they are traveling or living outside the service area.

What Region Am I?

Western Region Network Service Area

The commercial western region HMO network extends across the 29 counties of western Pennsylvania as shown below.

Allegheny	Armstrong	Beaver	Bedford	Blair	Butler
Cambria	Cameron	Centre (partial)	Clairon	Clearfield	Crawford
Elk	Erie	Fayette	Forest	Greene	Huntington
Indiana	Jefferson	Lawrence	McKean	Mercer	Potter
Somerset	Venango	Warren	Washington	Westmoreland	

Continued on next page

3.1 Commercial Group/Direct Pay HMO Members Who Require Services Outside The Local Area -- Western Region Only, Continued

Required Care Definitions For

The required care definitions for commercial group/direct pay HMO are noted below.

Note: These definitions are not applicable to Medicare Advantage HMO products.

Care required	Definition
Emergency Care	The initial treatment: • For bodily injuries resulting from an accident; or • Following the onset of a medical condition; or • Following, in the case of a chronic condition, a sudden and unexpected medical event; that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent lay person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in one or more of the following: a) Placing the health of the member or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy; or b) Serious impairment to bodily functions; or c) Serious dysfunction of any bodily organ or part. Transportation and related emergency services provided by an ambulance service shall constitute an emergency care service if the injury or the condition satisfies the criteria above.

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3.1 Commercial Group/Direct Pay HMO Members Who Require Services Outside The Local Area -- Western Region Only , Continued

Required Care Definitions For HMO Members (continued)

Care required	Definition
Symptomatic Care	Medical needs that are symptomatic, but can be treated at the discretion of the physician and patient. Reasonable delays will most likely not affect the outcome of service. For HMO members this type of care may be considered "urgent care" when traveling outside of the 29-county western Pennsylvania service area. Urgent care is defined as an unexpected illness or injury that cannot wait to be treated until the member returns home.
Routine Asymptomatic And Preventive Care	Medically asymptomatic conditions that can be addressed at the discretion of the physician and patient. Reasonable delays will not affect the outcome of services. For HMO members, this type of care may be considered "follow-up" care when traveling outside the 29-county western Pennsylvania service area. Follow-up care is defined as ongoing services that a member requires, even, when they are traveling, for care that was initiated while they were home (e.g. allergy shots, suture removal, cast check). **Note:** Routine preventive care services such as routine physicals, immunizations or screening diagnostic tests would not be covered out-of-area as "follow-up" care.

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3.1 Quick Reference Chart for Out-of-Area Care

What Region Am I?

Out-Of-Area Care

Care for members who receive care out of the service area works differently for each product. The following table presents a quick overview of members' options for out-of-area care categorized by product and care required.

Product	Emergency care	Symptomatic care	Routine asymptomatic and preventive care
Western Region Commercial HMO Group/Direct Pay Members	May seek emergency care immediately from any provider without contacting PCP. Member should notify his or her PCP within 48 hours or as soon as it is reasonably possible to coordinate any needed follow-up care.	May arrange initial visit for "urgent care" (non-emergency care) with participating physicians in other plan areas through the BlueCard program. Physicians may be located by calling 1-800-810-2583 or online at www.bcbsa.com. May arrange initial appointment with participating physician without contacting PCP; must coordinate any additional care with PCP before receiving services. May choose to coordinate even initial care through PCP.	Must coordinate "follow-up" care with PCP prior to traveling out-of-area. May arrange "follow-up" care with participating physicians in other Plan areas through BlueCard program. Physicians may be located by calling 1-800-810-2583 or online at www.bcbsa.com. Once approved by PCP, member may arrange appointment with participating physician. Other routine asymptomatic or preventive care is not covered out of area.

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3.1 Quick Reference Chart for Out-of-Area Care, Continued

Out-Of-Area Care (continued)

Product	Emergency care	Symptomatic care	Routine asymptomatic and preventive care
PPOBlue **Western Region PPO** **HDHP PPO** **(**high deductible health plan PPOs)	May seek care immediately and receive high-level coverage.	May utilize BlueCard Program by calling 1-800-810-BLUE or online at www.bcbsa.com to find the names of preferred providers in other Plan areas in order to receive the higher level of benefits while traveling out-of-area. Some services may only be covered at the in-network level.	
DirectBlue	May seek care immediately and receive high-level coverage.	May wait until return home to receive in-network care.	
EPOBlue	May seek care immediately and receive high-level coverage.	May seek care out-of-area care, but must be from an in-network provider. Services received from providers within the PPOBlue Network or from any local "Blue" Plan PPO provider are paid at the in-network level. There is no coverage when a member receives services from an out-of-network provider, except in emergency situations.	

3.1 Away From Home Care™ Guest Membership Program (HMO)

AFHC

Away From Home Care (AFHC) is a registered trademark of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

What Is Guest Membership?

The Blue Cross and Blue Shield Association sponsors the AFHC Guest Membership program through participating Blue HMOs at numerous locations throughout the United States. The western region commercial HMO product participates in this program both as a "home" HMO plan, offering this to our members and also as a "host" HMO plan, where members from other Blue HMO plans may have a HMO guest membership in the western PA service area.

NOTE: This program is not available to Medicare Advantage HMO members.

How The Guest Membership Program Works

- Guest membership enables HMO members who are residing outside the 29-county western Pennsylvania service area for at least 90 consecutive days to have an HMO benefit program in another Blue HMO plan location.
- Members should contact Member Services at least 30 days in advance to determine program availability in the location in which they will be temporarily, or in the case of dependents, permanently residing.

Note: The AFHC Guest Membership program is not available in all areas of the country.

- Once a member is established as a guest member, he or she receives the services covered under the "host" HMO benefit program, which includes the selection of a PCP and coordination of care based on the rules of the local HMO program.
- During the time HMO members have a guest membership in another Blue HMO, these member's names will not appear on the PCPs These members names will not appear on the PCP's membership roster.

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3.1 Away From Home Care™ Guest Membership Program (HMO), Continued

How To Set Up A Guest Membership

The process appears here to assist PCP practices in directing our members who need this service.

Step	Action
1	The member must call the Member Service number on his or her ID card at least 30 days prior to needing a guest membership.
2	The Member Service representative forwards the information to the AFHC coordinator at Highmark.
3	The AFHC coordinator mails a Guest Application to the member.
4	The member must complete, sign and date the application and return it to the AFHC coordinator.
5	The AFHC coordinator at Highmark sends the application to the AFHC coordinator at the participating Blue HMO Plan.
6	The AFHC coordinator in the participating Blue HMO Plan will assist in the pre-selection of a PCP at the local HMO. The member will then receive a guest "Welcome Kit" with an ID card for the local HMO. **Note**: Highmark will issue ID cards to HMO members who have a guest membership at another Blue HMO. This card should be used when receiving medical care while traveling outside the guest membership area. If prescription drug coverage is part of the member's benefits, this ID card will allow them to access their "home" prescription drug benefits, since prescription drug benefits are not included as part of the "host" HMO plan benefit program.

Continued on next page

3.1 Away From Home Care™ Guest Membership Program (HMO), Continued

What Region Am I?

Members Visiting The Western Region Managed Care Service Area	Our HMO members with a guest membership in another plan area who need non-emergency care when home in the western region service area, may receive care only from a physician in the western region managed care network. If the member had an established relationship with a western region HMO network PCP prior to their guest membership, this is the provider they should contact. If the member did not have an established PCP relationship prior to their guest membership they should contact the Away From Home Care Coordinator at 1-800-249-9579. A physician must authorize any covered services received while at home. In an emergency, no prior approval is required. The member should go to the nearest medical provider. If follow-up care is needed while the member is at home, it can be arranged in the same manner as described above.
Members Returning To The Western Region Managed Care Service Area	When a member who has had a Guest Membership permanently returns to the western region service area, he or she must select a PCP from the western region HMO network and will then receive the covered services included in their "home" HMO benefit program.
Member Questions	If members have questions about how this program works, they should call Member Services at the telephone number listed on the back of their ID card.

3.1 Visiting HMO Members

Introduction

The Away From Home Care (AFHC) Guest Membership program offered through the Blue Cross and Blue Shield Association is for members enrolled in other Blue HMOs across the country. The program allows HMO members temporarily or permanently residing in the 29 county western region.

Hosting Guest Members

A western region network PCP may be contacted by an AFHC coordinator from Highmark to host a member from another plan who will be temporarily or permanently residing in our region.

If a network PCP is chosen to host a member from another plan, they will be contacted by the AFHC coordinator by letter. This letter will notify them of their selection as well as providing member information such as name, address, birthday and member ID.

During the duration of the guest membership, all Highmark authorization policies and procedures apply to the treatment of guest members. The AFHC coordinator assigned to the case will assist you with any administrative concerns.

Payment For Treatment Of Guest Members

Providers should submit claims in the exactly the same manner as you would a claim for a local member.

3.1 Medicare Advantage Products

Overview

Medicare Advantage products are available only to individuals who are entitled to Medicare Part A and enrolled in Medicare Part B: those over the age of 65 and/or disabled.

Medicare Advantage Products

Highmark offers three Medicare Advantage products.
For more information on Medicare Advantage Products, please visit Members section of www.highmark.com.

1. Western Region FreedomBlue PPO
   Central and Northeastern FreedomBlue PPO

2. Western Region FreedomBlue Private Fee-for-Service (PFFS)
   Central and Northeastern FreedomBlue Private Fee-for-Service (PFFS)

3. Western Region Medicare Advantage HMO Product Description

Medicare Advantage Eligibility Requirements

To enroll in Highmark's Medicare Advantage HMO, a member must have both Medicare Part A and B and must reside in the 17-county Western Region service area. To enroll in Highmark's FreedomBlue PPO, a member must have both Medicare Part A and B and must reside in the 40-county service area. Effective January 1, 2008 however, Highmark FreedomBlue PPO expanded to 62 counties including all Pennsylvania counties excluding Bucks, Chester, Delaware, Montgomery, and Philadelphia. Additionally, the member cannot have end stage renal disease at the time of enrollment, unless he or she is a current member of a Highmark commercial product.

FreedomBlue PPO

FreedomBlue PPO offers its members additional benefits and services beyond those covered by the Medicare program. These include preventive services, routine dental and vision care and prescription drugs.

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3.1 Medicare Advantage Products, Continued

FreedomBlue Private Fee-For-Service
New!

Effective January 1, 2008 Highmark Blue Shield began offering another Medicare Advantage plan option – Private Fee-for-Service.

FreedomBlue PFFS provides Medicare Parts A and B benefits, as well as routine vision/hearing and SilverSneakers®. As a non-network plan, FreedomBlue PFFS does not require a contract making it different than Highmark's FreedomBlue PPO product.

Members can:

- see any licensed professional provider that has or is eligible for a Medicare billing number, has not opted out of the original Medicare program, and accepts FreedomBlue's PFFS terms and conditions of participation.

- be treated at any Medicare-certified facility that accepts FreedomBlue PFFS terms and conditions of participation

Providers are not required to see FreedomBlue PFFS and elect to do so on a per service basis. If you do provide services, you do so under the terms and conditions of that member's plan.

Providers with questions about claims payment should call the Provider Service Center at 1-866-675-8635 between the hours of 8 a.m. and 4:30 p.m. Monday through Friday, Eastern Standard Time (EST).

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3.1 Medicare Advantage Products, Continued

Becoming A Deemed Provider Under FreedomBlue FFS
New!

Providers, both Medicare participating and nonparticipating, are considered deemed when they meet the following conditions:

1. Are aware in advance that the patient is a FreedomBlue PFFS member. All FreedomBlue PFFS members receive an identification card that includes the FreedomBlue PFFS logo to help identify them as PFFS members.

2. Have a copy of or reasonable access to FreedomBlue PFFS's terms and conditions of participation.

3. Provide services covered by FreedomBlue to a FreedomBlue PFFS member.

Terms and conditions are under Administrative Reference Materials on the Provider Resource Center. Select Medicare Advantage PFFS from the list. Once on the PFFS page, select the appropriate regional terms and conditions of this product. Terms and conditions are also available in the Appendix of the Highmark Blue Shield Office Manual.

For more information on the Medicare PFFS product please visit, www.highmark.com and select the appropriate regional member website.

Appeals and Grievances for FreedomBlue PFFS

The members of FreedomBlue PFFS, their physicians, or authorized representatives on their behalf may request an appeal of an adverse coverage determination made by FreedomBlue PFFS including when services are limited, no provided, not paid for or not allowed. This would also include an appeal regarding a delay in providing or approving drug coverage or services, or any cost sharing the member is required to pay for a drug or a service.

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3.1 Medicare Advantage Products, Continued

Appeals and Grievances for FreedomBlue PFFS

Medical appeals should be sent to:

Provider initiated appeals:
FreedomBlue PFFS
P.O. Box 890392
Camp Hill, PA 17089-0392

Member initiated appeals:
FreedomBlue PFFS
P.O. Box 535047
Pittsburgh, PA 15253-5047

Medicare prescription drug coverage appeals:
FreedomBlue PFFS
P.O. Box 535047
Pittsburgh, PA 15253-5047

Western Region Medicare Advantage PPO *(Western Region Only)*

Western Region Only:

Western Region Medicare Advantage HMO coverage replaces Medicare coverage; however, Western Region Medicare Advantage HMO members may retain their Medicare card while they are covered under the Western Region Medicare Advantage HMO.

A Western Region Medicare Advantage HMO member must show his or her identification card to receive services. Services cannot be paid by traditional Medicare while the person is a member of a Western Region Medicare Advantage HMO, except for services incurred during a hospice election period and routine costs associated with clinical trials paid by Medicare.

Expedited Appeals for Western Region Medicare Advantage HMO

Western Region Medicare Advantage HMO members have a special expedited appeals process. Members of Medicare Advantage programs, or their representatives, may request a 72-hour expedited review of a service if they believe the member's health, life, or ability to regain maximum function may be jeopardized by waiting for the standard review process.

In accordance with Centers for Medicare and Medicaid Services (CMS) guidelines, members may request the initial expedited review without speaking to the PCP first.

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3.1 Medicare Advantage Products, Continued

Out-Of-Service-Area Benefit	An out-of-network benefit applies to the Medicare Advantage FreedomBlue PPO product. Members have access to covered services out-of-network, both in area and out-of-area. Members are responsible for paying any applicable cost sharing for covered services. Renal dialysis services are covered at 100%, on a temporary basis, while outside the 40-county service area. Effective January 1, 2008 this service area expanded to a 62-county service area, including all Pennsylvania counties excluding Bucks, Chester, Delaware, Montgomery, and Philadelphia.
Prescription Drug Coverage	Some drugs are covered at participating pharmacies or through mail order. Coverage varies by product: generic or brand copayments, formulary limitations and annual maximums apply. Employer-sponsored plans may vary copayments and annual maximums. For more information about pharmaceuticals online, refer to the Provider Resource Center under Pharmacy/Formulary Information.
Geriatric Care Guidelines	Highmark's Geriatric Quality Improvement Committee has developed guidelines to use when caring for Western Region Medicare Advantage HMO members. These guidelines have been compiled in a manual titled the Geriatric Resource Binder. The manual is available online, at Highmark's Provider Resource Center under Clinical Reference Materials.

3.1 BlueAccount

Overview

BlueAccount Programs are an option for those members who choose to combine a Highmark plan with a

- Health Savings Account (HSA)
- Health Reimbursement Account (HRA) or
- Flexible Spending Account.

Generally members who choose a BlueAccount HSA are those that chose a qualified high-deductible plan. All of the BlueAccount products allow members to save money to cover the cost of their higher out-of-pocket liabilities.

Using NaviNet To Determine Whether The Member Has A BlueAccount

To determine whether a Highmark member has chosen to have their liability paid directly to your office via a BlueAccount, use NaviNet's Eligibility and Benefits function.

Beginning mid-January 2007, if the member has chosen this option, the Product Field will state, "Direct Payment to Provider – Yes." For members who have not chosen this option, the Product field will contain only the name of the product under which the member has coverage. Members have the capability of selecting or deselecting this option at any time.

Another helpful function on NaviNet is the Benefit Accumulator. This function reflects the status of a member's deductible, based on all claims finalized and processed to date.

Direct Payment To Providers

Members may also choose to have their member deductible or copayments paid directly to the provider via one of these accounts. If a member has chosen this option and money is available in the account, you will receive a separate payment (check or Electronic Funds Transfer (EFT)) and notice (known as an Explanation Of Payment (EOP)) for claims paid under a member's account. If the member's HSA, HRA or FSA does not have the full amount due, you will receive whatever amount is in the account. You can then bill the member directly for the remainder as the member will receive any remaining payments.

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3.1 BlueAccount, Continued

Explanation of Payment (EOP)

Whenever a full or a partial payment is made to you, both the member and the provider's office will receive an Explanation of Payment (EOP), to document the transaction. NaviNet-enabled providers will receive their EOPs via the NaviNet ERA and Remittance Inquiry function. The few facilities without this functionality will receive EOPs in hard-copy format via U.S. mail, courier pickup, or whatever arrangement they currently use for receiving the paper remittance advice.

This new direct payment to provider option from a member's health care account does not eliminate your ability to collect patient liability, such as copayments or other outstanding balances, due at the time of service. Please note, however, that if you collected payment upfront for member liability, and subsequently receive payment via an EOP, be sure to issue the refund directly to the member.

3.1 Healthcare Gift Card – Still Accepted – No Longer Sold

Overview

The Healthcare Gift Card is a tool consumers can use to cover the costs associated with health-related purchases and procedures or to give as a gift to others. Companies also can give the card to employees as a reward or perk to help them cover health and wellness expenses. The card is accepted anywhere that Visa debit cards are accepted and is intended to be used for a variety of health and wellness related purchases.

How Do Patients Use It?

When presented with the card as a form of payment, please accept it as you would a patient or customer's Visa credit card.

The card should be processed the same way you would a normal Visa credit card transaction.

The Healthcare Gift Card is valid for a wide variety of health and wellness expenses, including copays for doctor visits and prescriptions or for vision care, dental care, health products and medical supplies, health club memberships and elective procedures. If a card holder attempts to make purchases outside the list of approved merchant categories, the card will not be accepted at the point of purchase.

Healthcare Gift Card Not Insurance Product

Although it is a Highmark product, the Healthcare Gift Card is not a health insurance product, nor is Highmark coverage required for use or purchase of the card. Purchasers and recipients of the card do not have to have an affiliation to Highmark, although some, of course, will. There is no connection to the Blue Cross Blue Shield Association.

Where Do I Get A Healthcare Gift Card?

You may still see the healthcare gift card as a form of payment in your office, however the gift card is no longer being sold.

Further Questions?

If you have further questions regarding the Healthcare Gift Card, please contact card member services via:

Phone: 1-866-466-8019
Email: eps.cardholder.support@fnis.com
Mail: Card member Services, P.O. Box 550160, Ft. Lauderdale, FL 33355

3.1 Lifestyle Returns℠

Overview

Lifestyle Returns is a consumer-driven program that rewards members for taking responsibility for their health. This program is available in the Western and Central Regions only. It is designed to motivate members to quit smoking, eat sensibly, exercise, take the right prescriptions, as appropriate, get the recommended screenings and use the health care system wisely.

What Region Am I?

What Providers Need to Know About Lifestyle Returns

Members who have the Lifestyle Returns program will be encouraged and motivated to seek appropriate preventive services such as mammography, annual gynecological exams and annual physicals.

Members may also be more motivated to discuss health lifestyle and behavior modification issues. Remember that you can always direct Highmark members to Blues on Call℠ (1-888-BLUE-428) and/or their personalized member Web sites to find lots of helpful information, resources and guidance, including many free services offered by our Preventive Health Division. Members can log in to their personalized Web sites through the links below.

What Region Am I?

Western Region Highmark Member Web Site

Central Region Highmark Member Web Site

The Wellness Scorecard

To encourage members to obtain appropriate preventive care, members have been given a My Wellness Scorecard. The purpose of the scorecard is to help members record when they've received certain services along with the results, then enter the information online.

Payment for Preventive Care

Benefits for preventive care are limited to those services that are covered on the preventive schedule that the employer group provides. Most groups follow Highmark's Preventive Schedule, but others create their own. Therefore, it's important to verify benefits before performing or ordering preventive services.

Most services on Highmark's Preventive Schedule are covered based on age, gender and risk factors. It's important to follow the schedule carefully and use the appropriate codes. If a member requires a test for a medical reason but falls outside of the age/gender/frequency limits on the schedule and a preventive or screening procedure code is used, the claim will be denied. In these situations, since the member has a medical diagnosis, a medical procedure code should be used so the claim will be processed as medical and not routine.

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3.1 Lifestyle Returns℠, Continued

Copay Information for Members with Lifestyle Returns

Members who participate in Lifestyle Returns may have a new copay for routine physical/routine gynecological exams indicated on their ID cards, if their employer elected to offer a different copayment. You may see "RT PHY/RT GYN" on their ID card. The copay amount will vary, depending on the employer's benefit elections.

The Comprehensive Preventive Exam procedure codes included in this copay category include:

What Region Am I?

- Gyn Exams: G0101, S0610, S0612 and in the western region only S0613
- Routine Physical Exams (Pediatric): 99381 through 99384; 99391 through 99394, and 99432
- Routine Physical Exams (Adult): 99385 through 99387; 99395 through 99397

With Your Help We Can Create Rewards that Last a Lifetime

Lifestyle Returns takes the proven data on health behavior change and creates a new opportunity for members, their employers and Highmark to make a mutual commitment. And, with your support, Lifestyle Returns will proactively encourage healthier Lifestyles to help prevent and control chronic illness.

3.1 Baby BluePrints®: Maternity Education and Support Program

Tip Sheet

Overview

Effective January, 2008 Highmark launched Baby BluePrints, a maternity education and support program available to expectant Highmark members. This free program is designed to help expectant families better understand and enjoy every stage of pregnancy and make more informed care and lifestyle decisions.

Program Details

Baby BluePrints is a free program that offers expectant Highmark members educational information on all aspects of pregnancy through multiple printed and online resources during each trimester of pregnancy. Topics include prenatal care, proper use of medications, avoiding alcohol and tobacco, working, travel considerations, nutrition and weight gain, exercise, body changes and many others. Baby BluePrints will also provide program participants access to individualized support throughout their pregnancy from a nurse Health Coach.

Providers are encouraged to promote patient enrollment to reinforce medical care and maternity information so that pregnant women may "have a greater hand in their health".

Who Is Eligible For Baby BluePrints?

Baby BluePrints is available to expectant Highmark members enrolled in a commercial group product, direct pay product or social mission product. Baby BluePrints is not available for members enrolled in a Medicare/Medicare Advantage product, an FEP member, Mountain State Blue Cross Blue Shield members or any ASO/ASC opt-out account.

How Members Can Enroll

Enrollment in Baby BluePrints is simple and convenient. Expectant mothers can enroll at no cost over the phone starting January 14, 2008 by calling toll free 1-800-918-5267.

What Members Can Expect

Upon enrollment members will receive a welcome package that contains:

- Comprehensive maternity brochure covering all phases of pregnancy and provides important health information and guidelines
- Directions for using various educational resources and online support programs found on the Highmark member site
- Fliers detailing available discount programs
- Childbirth education class reimbursement form
- Child immunization and preventive care pamphlet
- Vouchers for three gifts included in the program
- And more…

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3.1 Baby BluePrints®: Maternity Education and Support Program, Continued

What Members Can Expect (continued)

Throughout pregnancy members will receive free gifts including:

- A choice of pregnancy/childcare book upon enrollment
- Baby picture album during second trimester
- Book on child emergency/first aid and child dish set after delivery.

Members will also receive access to pregnancy-related information on the member web site and proactive outreach from a nurse health coach. After delivery members may also be referred to enroll in post-partum depression program, when appropriate.

If the member's program includes Blues On Call she can call the toll-free number at any time to talk to a health coach about any questions/concerns she may have following pregnancy. For more information on Blues On Call please see the next page of this unit.

For More Information

If you have further questions about Baby BluePrints, please contact the Provider Service Center.

If members have further questions about Baby BluePrints, please encourage them to call member service at the number on their ID card.

Articles and bulletins are also available as a reference on the Provider Resource Center under the Publications and Mailings heading.

3.1 Blues On Call

What is Blues On Call℠

Highmark Blue Shield has an integrated program, Blues On Call, to attempt to address the total health care needs of the patient rather than focusing on one specific condition. Highmark members may contact Blues On Call 24 hours a day, every day of the year. The Blues On Call team includes health coaches who provide support over the telephone to discuss health information, assist with health decisions, and offer educational material including audio and videotapes.

What Blues On Call Is Not

Blues On Call does not:

- Address benefit issues
- Address claims issues
- Provide diagnosis or medical advice

Who Is Eligible

Most Highmark members are automatically eligible to make use of Blues On Call services. No registration is required, and the service is free.

When To Refer A Patient

Refer a patient to Blues On Call any time he or she needs more information or assistance about a health care topic or if support by a Blues On Call health coach would benefit the patient.

How To Refer To Blues On Call

- Encourage your patient to call the Blues on Call phone line: **1-888-258-3428 (1-888-BLUE-428).** This number is also located on the back of the member ID card.

- Fax the completed Blues On Call Physician Referral Form to the Blues on Call Program. This form is located on the Provider Resource Center under Blues On Call.

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3.1 Blues On Call, Continued

Links To Other Highmark Resources	Blues On Call Health Coaches can provide information on a variety of health and wellness topics. They also work closely with other Highmark resources for members.
How To Access The Web Site	You may access the Healthwise Knowledgebase® through the Provider Resource Center, under Blues On Call.
Blues On Call Program Questions	Providers may call the Blues On Call Physician Support Line at 1-866-348-3504 for answers to questions about the Blues On Call program.

3.1 Blues On Call Program Components

Chronic Condition Support

Blues On Call focuses on helping members manage their chronic illnesses, placing special emphasis on the importance of dealing with the co-morbidities that face most seriously ill individuals. Since most chronically ill members have more than one chronic condition, the Blues On Call "whole patient" approach is a significant improvement over "silo-structured" disease management programs. The program content is objective and evidence-based. Information and material is from national sources such as the American Diabetes Association, and all content is reviewed by the Foundation for Informed Medical Decision Making. The scope of chronic condition support through Blues On Call includes:

- Condition-specific standards of care related to Asthma, CHF, COPD, CAD, and diabetes.
- Medication compliance
- Specific activities related to medical condition monitoring (weight monitoring, blood sugar monitoring)
- Regular physician visits
- Flu and pneumonia vaccines

Medical Decision Support

Using the Shared Decision-Making® information and materials developed by the Foundation for Informed Medical Decision Making, Blues On Call Health Coaches educate and support those facing significant medical decisions related to conditions, such as:

- Back pain (spinal stenosis, herniated disc and chronic low back pain)
- Breast cancer (adjuvant therapy, choosing your surgery, choosing your treatment)
- Benign uterine problems
- End-of-life care
- Prostate issues (benign prostatic hyperplasia, PSA decision)
- Knee osteoarthritis
- Coronary artery disease

Health Coaches provide objective, evidence-based information to help individuals understand their situation, including the potential benefits and potential harms of treatment choices. Health Coaches help patients gain insights into their choices and provide a framework to think through the decision. Most importantly, patients can incorporate their personal values and preferences into the decision and communicate more effectively with their provider.

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3.1 Blues On Call Program Components, Continued

Symptom Management Support

Using the Healthwise Knowledgebase® symptom algorithms, Blues On Call Health Coaches provide support over the telephone to help members interpret and act on symptoms. Coaches are available 24 hours a day, every day of the year. Health Coaches use the Shared Decision-Making® approach to symptom management support. This approach uses algorithms to educate and support patients to help them make informed decisions about their current situation. This approach provides patients with the opportunity to learn skills that can be used when similar situations arise in the future.

3.1 Social Mission Programs

Overview

Highmark makes health care programs available to children and adults in lower income households. These subsidized social mission programs include Special Care, Children's Health Insurance Program of Pennsylvania (CHIP) and adultBasic. The newly expanded CHIP coverage offers programs for all uninsured children regardless of household income.

Health Care Providers Make The Programs Possible

It is only through a partnership with our providers that these programs are successful and Highmark Blue Shield can continue its social mission to provide health care coverage to as many Pennsylvanians as possible. Highmark Blue Shield extends its sincere appreciation to its providers for their continued commitment to provide services to children and families who qualify for these programs. Your help has contributed to Pennsylvania's ranking as one of the states with the lowest rate of uninsured residents.

Please remember that you do not have to verify income or eligibility for these programs. Eligibility and income are determined before enrollment by the Plan.

3.1 Social Mission Programs – Special Care

Special Care

Special Care was introduced in 1992 as a limited benefit product to further reduce the uninsured rate by making specific health benefits more affordable to thousands of low-and-moderate income, uninsured residents. It is a fixed-fee program where some services, such as preventive care benefits, and some office visits are paid at higher level. Specifics about payment levels can be found in Chapter 3, Unit 3, "Payment Methodology."

Today, thousands of Pennsylvanians are enrolled in Special Care.

Highmark Blue Shield determines eligibility upon enrollment for all Special Care members according to their income and family size. In addition, Highmark reviews eligibility of members annually.

Special Care benefits include:

- Hospital and Medical/Surgical
  - Surgery and anesthesia (inpatient or outpatient)
  - Emergency accident and medical treatment (exempt from Diagnostic Maximum)
  - Maternity and newborn care
  - Chemotherapy and radiation therapy
  - 21 days of inpatient care (hospital or medical) – renewable after 90 consecutive days out of the hospital
  - Outpatient diagnostic services ($1,000 annual maximum for hospital and medical surgical)
  - Hospital and surgery programs

Continued on next page

3.1 Social Mission Programs – Special Care, Continued

Special Care, (continued)

- Primary care and wellness
  - Four annual doctor visits per person ($10 copayment)
  - Comprehensive preventive care for children (physician visits and immunizations)
  - Routine annual mammogram and Pap smear for women age 40 and older and for any physician recommended mammogram for women under age 40. Benefit is exempt from the diagnostic maximum.

Special Care does not provide coverage for:

- Substance abuse treatment
- Mental health care
- Allergy testing and injections
- Prescription drugs
- Durable medical equipment and prosthetics
- Skilled nursing care

Physician reimbursement for Special Care is based on the Plan C fee schedule for most services. Preventive care is paid at UCR levels and certain outpatient medical services are paid at Plan 5000S levels. Highmark Blue Shield's Participating Providers agree to accept this allowance as payment-in-full for all eligible services.

3.1 Social Mission Programs - CHIP

CHIP – Children's Health Insurance Program of Pennsylvania

This program is administered on behalf of the Commonwealth of Pennsylvania Insurance Department by Highmark Blue Shield through the adultBasic/CHIP Administrative Units in Central and Western Pennsylvania

CHIP is modeled after the Caring Program for Children, which was pioneered by Highmark through its Caring Foundation more than twenty years ago. CHIP expanded in 2007 with the legislation to Cover All Kids. CHIP now offers coverage to every uninsured child in PA, regardless of income. The more a child's family earns, the more cost sharing they will have in the form of higher premiums and copays. CHIP covers children from birth through 18 years of age.

Free CHIP is funded through a portion of the state cigarette tax as well as federal funding and families owe nothing for their child's premium and there are no copayments for office/ER visits and drugs. Low-Cost CHIP was expanded to include three levels with varying costs based on family income. Families pay some of the cost of CHIP coverage for each level of Low-Cost CHIP and copays for office/ER visits and drugs. Low-Cost CHIP began receiving federal money in addition to state money when CHIP expanded under Cover All Kids. At-Cost CHIP provides health care coverage to children who are over the income limits for Free and Low-Cost CHIP. Families pay the full cost of CHIP coverage at this level and copays for office/ER visits and drugs.

In the Western Region, benefits are provided through the Western Region network, and in the Central Region through the PremierBlue Shield network.

One of the keystones of this program is that families are "held harmless" from balance billing when covered services are provided by a network provider. To achieve that, CHIP uses the PremierBlue Shield professional provider and facility network to provide services to these children in the Central Region and by the western region network in the Western Region. Prescription drugs are provided using the Premier Gold Network. Routine vision coverage is administered by Davis Vision and Dental coverage is provided by United Concordia's Advantage Network.

As with our commercial group programs, Highmark pays PremierBlue Shield network and Western Region network providers directly, and they agree to accept our payments as payment-in-full for covered services. Highmark Blue Shield sends payments for services of out-of-network providers directly to the child's parents, who are responsible for paying the charges.

Out-of-network providers are not obligated to accept Highmark's payment as payment in full. It is critical in all cases that members check the network status of their provider.

NOTE: This does not apply to emergency care.

Continued on next page

3.1 Social Mission Programs - CHIP, Continued

CHIP – Children's Health Insurance Program of Pennsylvania, continued

In the Central Region: Members can go outside the PremierBlue network and receive care at the lower level of coverage. Members who go outside of the PremierBlue network may be responsible for paying any difference between the out-of-network provider's actual charge and the Highmark payment. This occurs even when members are directed to an out-of-network provider by an in-network provider.

In the Western Region: Members must use the Western Region network providers to receive 100% coverage unless the care is pre-authorized.

Eligibility Requirements For CHIP

The adultBasic/CHIP Administrative Unit performs eligibility and enrollment functions for CHIP children. The Individual Markets area performs marketing and outreach for CHIP to locate children and educate the community about the CHIP program. Children must meet these eligibility guidelines:

- Be a resident of Pennsylvania prior to applying for this coverage (except newborns);
- Be a U.S. citizen, a permanent legal alien, or a refugee as determined by the U.S. Immigration and Naturalization Service;
- Be under age 19;
- Not be covered by any health insurance plan, self-insured plan or self-funded plan. And not be eligible for or covered by Medical Assistance offered through the Department of Public Welfare or other governmental health insurance;
- Be eligible based on family size and income;*
- For all new applicants whose annual income falls in the low-cost and at-cost CHIP ranges, they must also show that the child has been uninsured for six months, unless the child is under the age of two, the child has lost health insurance because a parent lost their job or the child is moving from another public insurance program; and,
- At-cost CHIP families must also show that access to coverage is unavailable and unaffordable

* Depending on income levels, children may be eligible for either Free or Low-Cost CHIP insurance. If eligible for Low-Cost or At-Cost CHIP insurance, families will be required to pay a monthly premium for their child's health insurance (as well as some co-pays).

How To Determine If A Child Is Covered Under CHIP

A child enrolled in CHIP will have the same Highmark insurance card as any commercial or group member.

You may use NaviNet, InfoFax, or OASIS to determine eligibility, coverage, and claim status.

Continued on next page

3.1 Social Mission Programs – CHIP, Continued

CHIP Covered Services

CHIP Hospital Benefits are detailed below:

■ Ambulatory services (in a non-hospital facility) • Chemotherapy • Diagnostic services • Emergency accident and medical care • Surgery	■ Outpatient hospital services • Clinic services (in a hospital-affiliated clinic) • Diagnostic services • Emergency accident and medical care • Radiation therapy, chemotherapy, dialysis treatment, and physical, occupational and speech therapy • Surgery
■ Inpatient hospital services • 90 days inpatient care per calendar year (combined limit with mental health and skilled nursing facility care) • Preadmission review is required • Transplant services	■ Home health care • Maximum 60 visits per calendar year ■ Durable medical equipment including wheelchairs, oxygen and hospital beds.
Medical-surgical ■ Anesthesia ■ Consultation • Limited to one per consultant per stay for inpatient • Unlimited outpatient ■ Diagnostic medical	■ Transplant surgery ■ Second surgical opinion • Only eligible outpatient consultation ■ Allergy testing • Consisting of percutaneous, intracutaneous, patch tests and immunotherapy

Continued on next page

3.1 Social Mission Programs – CHIP, Continued

CHIP Covered Services, (continued)

■ Emergency medical and accident • Within 48 hours of emergency • Includes follow-up care ■ Outpatient medical visits • Symptomatic	■ Routine lead screening ■ Mental health - 90 days inpatient care per calendar year (medical/surgical, SNF, and mental health combined) • Partial hospitalization (may exchange inpatient days for partials on 2:1 basis to obtain up to 180 partials) • 50 outpatient visits • Emergency psychiatric care

Other CHIP Covered Services

Medical-surgical

- Preventive pediatric
  - Follows Highmark Blue Shield Preventive Schedule
- Maternity (including prenatal and postnatal care)
- Routine newborn care (first 31 days)
- Oral surgery for the removal of partial and full bony impacted teeth
- Surgery
- Therapy services
- Substance abuse (follows Mandate)
  - Chemotherapy, radiation, dialysis treatment, and physical, occupational and speech therapy (PT, OT, ST limited to 60 visits)

Prescription drugs

- Open Formulary (copayments required for Low-Cost and At-Cost CHIP)

Hearing

- Hearing benefits
  - Hearing evaluation (once every calendar year)
  - Audiometric examination (once every calendar year)
  - Hearing aid (not more than one per year in any two calendar years)

Continued on next page

3.1 Social Mission Programs – CHIP, Continued

Other CHIP Covered Services, (continued)

Dental (administered by United Concordia)

- Diagnostic services
  - Routine exam (one every 6-month period)
  - Bitewing X-rays (once in any 12-month period)
  - Full mouth X-rays (once every 5-year period)

- Restorative services
  - Amalgam and resin restorations to restore diseased or accidentally broken teeth
  - Amalgam and composite restorations for all permanent and deciduous teeth
  - Resin, porcelain and full cast single crowns for permanent teeth

- Preventive services
  - Routine prophylaxis (one every 6-month period)
  - Topical fluoride application (once every 6-month period)
  - Space maintainers (within approved limits)
  - Sealants (within approved limits)

- General services
  - Palliative emergency treatment of an acute condition requiring immediate care
  - Simple extractions – as necessary
  - Pulpotomies covered for deciduous teeth
  - Administration of anesthesia (within limits)
  - Consultations (within limits and only during inpatient stay)

Vision (administered by Davis Vision**)**

- Eye examination and refraction – one every 6 months
- Frame – one every 12 months
- Lenses – single vision, bifocal, trifocal, aphakic – one pair every 6 months
- Contact Lenses (pair) – covered when medically necessary

Davis Vision network providers accept reimbursements as payment-in-full for standard services. Non-Davis Vision network providers are reimbursed at an out-of-network fee schedule.

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3.1 Social Mission Programs – CHIP, Continued

CHIP Claims Submission

All claims, except dental and vision claims, should be submitted just like any other Highmark Blue Shield claim. They may be submitted electronically or on a paper CMS 1500 claim form. Please note that in all cases, the child is the member. Report "Patient's relationship to insured" as "self." Do not report the name of the parent. Electronic claims are preferred. Submit your paper claims to:

What Region Am I?

In the Central Region ONLY:
Claims
P.O. Box 890173
Camp Hill, PA 17089-0173

In the Western Region ONLY:
Member Services
Penn Avenue Place
501 Penn Avenue
Pittsburgh, PA 15222

Dental
United Concordia Companies, Inc.
Claims Processing
P O Box 69421
Harrisburg, PA 17106-9421

Routine Vision
Davis Vision
Vision Care Claims Unit
PO Box 1501
Latham, NY 12110

CHIP Enrollment

What Region Am I?

If you know of children who may qualify for this program, please refer them to the appropriate telephone number:

Highmark adultBasic/CHIP Administrative Unit (Central PA ONLY)
1-866-727-5437
1-866-727-4938 for Hearing Impaired

Highmark adultBasic/CHIP Administrative Unit (Western PA ONLY)
1-800-543-7105
1-877-323-8480 for Hearing Impaired

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3.1 Social Mission Programs – CHIP, Continued

CHIP Enrollment, (continued)

Independence Blue Cross (Eastern PA ONLY)
1-800-464-KIDS
1-800-464-5437

Blue Cross of Northeastern Pennsylvania (Northeastern PA ONLY)
1-800-KIDS-199
1-800-543-7199

For More Information on CHIP

For more information on CHIP including the income guideline chart, a downloadable application, and the monthly premiums and copays, please click the appropriate region-specific link below:

What Region Am I?

Western Region Only
https://www.highmarkbcbs.com/socialmission/CHIPWest/west/index.html

Central Region Only
https://www.highmarkblueshield.com/socialmission/CHIPCentral/central/index.html

3.1 Social Mission Programs – adultBasic

adultBasic Health Insurance For Adult Pennsylvanians

This program is administered by Highmark Blue Shield through the adultBasic/CHIP Administrative Units in Central and Western Pennsylvania. The adultBasic program is a basic health insurance program for uninsured adults from 19 to 64 years of age who meet the eligibility and income guidelines.

adultBasic is funded through Pennsylvania's Tobacco Settlement. Benefits are available to qualified adults who are not eligible for Medical Assistance and who are not covered by a private or public health insurance plan. In the Western Region benefits are provided through the western region network in the western region and in the Central Region through the PremierBlue Shield network.

What Region Am I?

Enrollment in the program is dependent upon meeting the eligibility guidelines. Highmark offers adultBasic coverage in all 29 counties of western Pennsylvania and in 10 counties of central Pennsylvania including: Centre, Columbia, Fulton, Mifflin, Montour, Northumberland, Juniata, Schuylkill, Snyder, and Union.

General Characteristics

One of the keystones of this program is that the adults are "held harmless" from balance billing when covered services are provided by a network provider. To achieve that, adultBasic uses the PremierBlue Shield professional provider and facility network to provide services to these adults in the Central Region and the western region network in the Western Region. There are no dental, vision, hearing or prescription benefits with this program. Members can receive the Highmark Discount on prescription drugs filled at a Premier Gold participating pharmacy. The program does cover two classes of drugs 100% without copays – they are diabetic supplies and insulin and immunosuppressants related to transplant surgery.

As with our commercial group programs, Highmark pays PremierBlue Shield and Western Region network providers directly, and they agree to accept our payments as payment-in-full for covered services. Highmark Blue Shield sends payments for services of non-participating providers directly to the member, who is responsible for paying the charges. Care received outside of the Western Region network is non-reimbursable unless pre-authorized by the Western Region Network. Out-of-network providers are not obligated to accept Highmark's payment as payment in full. It is critical in all cases that members check the network status of their provider.

In the Central Region: Members can go outside the PremierBlue network and receive care at the lower level of coverage. Members who go outside of the PremierBlue network may be responsible for paying any difference between the out-of-network provider's actual charge and the Highmark payment. This occurs even when members are directed to an out-of-network provider by an in-network provider.

In the Western Region: Members must use the Western Region network providers to receive 100% coverage unless the care is pre-authorized.

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3.1 Social Mission Programs – adultBasic, Continued

Eligibility Requirements For adultBasic, (continued)

The adultBasic/CHIP Administrative Unit performs eligibility and enrollment functions for adultBasic. The Individual Markets area performs marketing and outreach for adultBasic to locate eligible adults and educate the community about the adultBasic program. Adults must meet these eligibility guidelines:

- Be a resident of Pennsylvania for 90 days prior to applying for this coverage (except newborns);
- Must be a U.S. citizen, a permanent legal alien or a refugee as determined by the U.S. Immigration and Naturalization Service;
- Not be covered by any health insurance plan, self-insured plan or self-funded plan;
- Not be eligible for or covered by Medical Assistance offered through the Department of Public Welfare or other governmental health insurance;
- Be uninsured for at least 90 days before date of enrollment, except if applicant or spouse are no longer employed or were on CHIP or Medicaid immediately before applying for adultBasic;
- Be eligible based on family size and income;*
- Be eligible based on age guidelines

The adultBasic program requires a monthly premium and has co-pays for office visits and ER services.

Wait List Information

Limited State funding through the Tobacco Settlement funds has resulted in the creation of a statewide wait list by the Pennsylvania Insurance Department. Until a slot opens in the program, an eligible adult will remain on the wait list. Eligible adults on the wait list may purchase adultBasic coverage at full cost while they are waiting.

How To Determine If An Adult Is Covered Under adultBasic

Adults enrolled in the adultBasic program have the same Highmark insurance card as any commercial or group member.

You may use NaviNet, InfoFax or OASIS to determine eligibility, coverage, claim status or service restrictions.

adultBasic Covered Services

adultBasic Hospital Benefits are detailed below:

3.1 Social Mission Programs – adultBasic, continued

adultBasic Covered Services, continued

Ambulatory services (in a non-hospital facility) • Chemotherapy • Diagnostic services • Emergency accident and medical care • Surgery	▪ Outpatient hospital services • Clinic services (in a hospital-affiliated clinic) • Diagnostic services • Emergency accident and medical care • Radiation therapy, chemotherapy, dialysis treatment, and physical, occupational and speech therapy • Surgery
Inpatient Hospital Services • Unlimited inpatient care • Preadmission review is required • Transplant services	• Home Health care, covered in lieu of hospitalization • Skilled nursing facility, covered in lieu of hospitalization
Medical-Surgical • Anesthesia • Consultation • Inpatient only (Limited to one consultant per stay) • Outpatient consultation unlimited • Diagnostic medical	Transplant surgery • Second surgical opinion • Only eligible outpatient consultation • Allergy testing • Testing covered but not extracts or treatment
• Emergency medical and accident • Within 48 hours or emergency • Includes follow-up care • Outpatient medical visits • Symptomatic	• Preventive care, Pap Smear, Gynecological Exam • Mammogram

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3.1 Social Mission Programs – adultBasic, continued Continued

Other adultBasic Covered Services

- Medical-Surgical
- Adult Immunizations
  - Follows Highmark Blue Shield Preventive Schedule
- Maternity (including prenatal and postnatal care)
- Routine newborn care (first 31 days)
- Surgery
- Therapy Services
- Chemotherapy, radiation, dialysis treatment, and physical, occupational and speech therapy (PT, OT, ST limited to 60 visits)

Other adultBasic Covered Services, continued

Prescription drugs.

- 100% coverage without copays for diabetic supplies and insulin and immunosuppressants related to transplants
- For all other drugs, Highmark discount if filled at Premier Gold participating pharmacy

NOTE: There may be copayments required and limits on visits or services under the adultBasic program.

adultBasic Claims Submission

All claims except dental and vision claims, should be submitted just like any other Highmark Blue Shield claim. They may be submitted electronically or on a paper CMS 1500 claim form. Submit your paper claim to:

What Region Am I?

In the Central Region ONLY:
Claims
P.O. Box 890173
Camp Hill, PA 17089-0173

In the Western Region ONLY:
Member Services
Penn Avenue Place
501 Penn Avenue
Pittsburgh, PA 15222

3.1 Social Mission Programs – adultBasic, continued continued

adultBasic Enrollment

If you know adults who may qualify for this program, please refer them to the appropriate telephone number:

Highmark adultBasic/CHIP Administrative Unit – **Central Region ONLY**
1-866-727-5437 or 1-866-727-4938 for Hearing Impaired

What Region Am I?

Highmark adultBasic/CHIP Administrative Unit – **Western Region ONLY**
1-800-543-7105 or 1-877-323-8480 for Hearing Impaired

Independence Blue Cross – **Eastern Region ONLY**
1-800-464-KIDS or 1-800-464-5437

Blue Cross of Northeastern Pennsylvania – **Northeastern Region ONLY**
1-800-KIDS-199 or 1-800-543-7199

For More Information on adultBasic

For more information on adultBasic please click the appropriate region-specific link below:

What Region Am I?

Western Region Only
https://www.highmarkbcbs.com/socialmission/ABCWest/west/index.html

Central Region Only
https://www.highmarkblueshield.com/socialmission/ABCCentral/central/index.html

3.1 Traditional Fee-For-Service Programs using the PremierBlue Shield Network

Overview	Payments made under the following products are based on the lesser of the PremierBlue Shield fee schedule allowance or the provider's charge. PremierBlue Shield preferred providers agree to accept the PremierBlue Shield allowance as full payment, except for the copayment, deductible or coinsurance amounts, which are the patient's liability.
Basic 100	Most covered services are payable at 100 percent of the PremierBlue Shield allowance.
Comprehensive And Wraparound Major Medical	Comprehensive and wraparound major medical includes coverage for basic and major medical type services (such as office visits or durable medical equipment) in one comprehensive benefit package. Most programs have an annual deductible and 20 percent coinsurance, which the member is responsible for paying to the provider.

3.1 Medigap Coverage

Medigap Overview

Medigap coverage is health insurance that supplements Medicare's benefits by filling in some of the coverage gaps. These policies only work with the original Medicare Part B Plan. Medigap policies pay most of the coinsurance amounts for Medicare eligible services.

Medigap Coverage

In August 1990, the federal government passed a law (OBRA 90) requiring all states to standardize individual (also called non-group or direct pay) Medigap policies. The law standardized the Medigap policies sold to individuals so consumers could easily compare policies and premiums and make informed decisions.

The National Association of Insurance Commissioners (NAIC) developed 10 standardized Medigap plans, including a basic policy referred to as a "core" benefit package or Plan A. States were permitted to limit the number of plans available to consumers in their state. The standardized plans are identified by letters A through J.

If Payment Under The Supplemental Coverage Has Not Been Received

If you do not submit claims electronically, and payment under the supplemental coverage has not been received within 30 days after the Medicare payment and you have checked claim status, send a copy of the EOMB statement to:

Highmark Blue Shield
Medigap Claims
P.O. Box 898845
Camp Hill, PA 17089-8845

- Please do not highlight any information on the EOMB statement. Use an asterisk (*) or some other form of notation to indicate the patient whose claims need to be processed under their supplemental coverage.
- The member's contract identification number and correct address should be on the EOMB statement; otherwise, please submit a completed CMS 1500 claim form.
- In the case of Medicare electronic remittance, a screen print of the electronic remittance and a copy of the CMS 1500 claim form should be sent to the address previously listed.
- The beneficiary's Highmark Blue Shield agreement number and correct address should appear in the upper left hand corner of all documents submitted for processing.

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3.1 Medigap Coverage, Continued

MedigapBlue

The Blue Plans in Pennsylvania offer six of the ten standardized plans, under the name of MedigapBlue Plans A, B, C, E, H and I.

Benefits Available With Each Of The Six Available Plans

This chart outlines the benefits provided in each of the six available plans:

Service	Plan A	B	C	E	H	I
Basic benefits	X	X	X	X	X	X
Skilled nursing facility coinsurance			X	X	X	X
Part A inpatient hospital deductible		X	X	X	X	X
Part B deductible			X			
Foreign travel emergency			X	X	X	X
Prescription drugs					X*	X*
Preventive Care (first $120 each calendar year some tests and services not covered by Medicare)				X		
Part B Excess						X

**After satisfying the annual deductible, Plan H pays 50 percent of the costs of prescription drugs up to a maximum amount per year.*

Medigap Supplemental General Information

On Sept. 8, 1990, the Medicare Overcharge Measure (MOM) Act was passed. This prevents the majority of all health care providers in the state of Pennsylvania from billing Medicare beneficiaries any amount in excess of the Medicare reasonable charge.

There are certain providers and suppliers who may charge beneficiaries for the difference between the billed amount and the Medicare allowance. You should contact the appropriate Medicare office for a listing of those types of providers.

When a member is enrolled in Medicare Part B and has supplemental coverage through Signature 65 or MedigapBlue, Medicare is the primary carrier. Submit the claim to the member's Medicare carrier first for processing.

3.1 Signature 65

Overview

Signature 65 is designed to supplement Medicare Part B covered services. Under this contract, Highmark Blue Shield will pay 20 percent of the Medicare Part B allowance, after the Medicare annual deductible has been satisfied.

Core Benefits

Signature 65 is a Highmark Blue Shield group product that provides coverage for the following core benefits:

- Medicare Part A deductible
- Hospital coinsurance for approved Medicare benefits
- 365 additional hospital days, of which up to 30 can be used for inpatient mental health or substance abuse treatment
- The first three pints of blood per calendar year
- Medicare Part B coinsurance

Carve-Out

There are many groups that prefer to purchase the same benefits for their retired employees over age 65 (those with Medicare Part B) as they do for their active employees. In these arrangements, claims are processed by Medicare first, then through Highmark Blue Shield. Any payment made by Medicare is subtracted (carved-out) from the payment made by Highmark Blue Shield. Payment is made only for those services eligible under the group's Basic Blue Shield benefits, even if the service was eligible under Medicare Part B.

3.1 BlueCard and BlueCard PPO: The 'Out Of Area' program

Overview

The BlueCard® program was developed by the Blue Cross Blue Shield Association to facilitate the national delivery of health care services to members of all Blue Plans when they travel or live outside of their Home Plan area. It is most commonly used in situations in which an employer group with headquarters in one Plan area has employees located in one or several other Plan areas.

At this time, BlueCard® benefits can be delivered in these ways:

- As an indemnity product
- As a Preferred Provider Organization (PPO) product
- As a Point-of-Service (POS) product
- As a Health Maintenance Organization (HMO) product

In Pennsylvania, the BlueCard networks include:

- Participating Provider network (supports all BlueCard programs for members that usually live outside their Blue Plan's service area with traditional, POS and HMO coverage.)
- PremierBlue Shield network (supports the BlueCard PPO programs for members that usually live outside their Blue Plan's service area in a PPO plan)

Definition: Home Plan and Host Plan

For a member with coverage through BlueCard®, the Plan area in which the employer group's headquarters is located is considered the member's **Home Plan**.

The **Host Plan** is the Blue Plan serving the area where the employee resides or is visiting at the time the services are rendered.

Submitting Claims

All claims for BlueCard® members should be submitted to the Host Plan – in this case, to Highmark Blue Shield – unless you contract with the member's Home Plan (i.e., the Plan that issued the member's identification card). If you do contract with the member's Home Plan, the claim should be submitted to that Plan.

What Region Am I?

EXCEPTION: The BlueCard® Program does not apply within the 21-county Central Pennsylvania and Lehigh Valley area where Highmark Blue Shield markets in the same area as another Blue Plan. If you treat a Highmark Blue Shield member who resides within the 21 counties, you must send your claim to Highmark Blue Shield, even if you also participate with the other Blue Plan.

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3.1 BlueCard and BlueCard PPO: The 'Out Of Area' Program, Continued

For More Information On BlueCard

For complete information on BlueCard, please visit the BlueCard Information Center of the Provider Resource Center for complete information on the program.

Also, for your reference, please visit Unit 3.5 of the Highmark Blue Shield Office Manual solely dedicated to BlueCard.