

Networks and Coverage Programs

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A. Pennsylvania Blue Shield participating and preferred provider networks

Introduction

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

Following the network information is a description of the coverage programs that are serviced by these networks.

Blue Shield contracts with health care professionals for a variety of networks in order to service the benefit programs requested by its customers. These programs range from Blue Shield's traditional medical-surgical program to managed care.

The types of health care professionals that Blue Shield may contract with under its traditional products are defined by state law. These include:

- Doctors of medicine;
- Doctors of osteopathy;
- Dentists;
- Podiatrists;
- Optometrists;
- Doctors of chiropractic;
- Nurse midwives;
- Physical therapists;
- Independent clinical laboratories;
- Licensed psychologists;
- Certain certified registered nurses;
- Licensed speech pathologists;
- Audiologists; and,
- Teachers of the hearing impaired

To learn how to enroll in Blue Shield's professional provider networks, see Section 5, "How to become a Network Provider." The programs that these networks support, payment mechanisms and claims submission procedures can be found in other sections of this guide.

Roles and obligations

As a participant in any of Blue Shield's networks, professional providers agree to a set of regulations that articulate their obligations to Blue Shield members. 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.
- 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.
- Blue Shield will encourage members to obtain health care services from network providers, which could increase the provider's patient base.
- Network providers will refer their patients to network providers when referrals are necessary.

Participating provider network

Blue Shield has agreements with more than 40,000 participating providers — eight out of every 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 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.

- Blue Shield participating providers agree to perform services for members according to the Regulations for Participating Providers, Pennsylvania state laws, the corporate bylaws governing Pennsylvania Blue Shield and subscription agreements and master contracts.
- Participating providers accept 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 Blue Shield's members.
- Participating providers are eligible to become actively involved with Blue Shield as corporate professional members and as members of the company's various professional committees and advisory councils.
- This network services our traditional Blue Cross Blue Shield programs, including traditional BlueCard.

PremierBlue Shield network

This is Blue Shield's statewide selectively contracted preferred provider 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.

The application for this credentialed network requests information about a provider's qualifications to practice quality medicine, practice location, 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; however, currently there are no gatekeeper products using this network. Members are free to choose any network provider to receive maximum benefits.

This network supports a variety of coverage programs. (See Page 5 for a complete listing). PremierBlue Shield also supports the BlueCard PPO programs, and is used by other carriers who have made an arrangement with Blue Shield. The Federal Employee Program is the largest customer that utilizes this network.

PremierBlue Shield providers agree to perform services for members according to the Regulations for PremierBlue Shield Providers, Pennsylvania state laws, the corporate bylaws governing Pennsylvania 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.

Preferred provider network

In 1986, Blue Shield implemented a statewide network called the Preferred Provider network. This network supported various preferred provider products throughout the state but is now being phased out and replaced by other networks. The original Access Care program in northeastern Pennsylvania still utilizes this network. This program is being gradually replaced by Access Care II.

Central Pennsylvania Point-of-Service network

This is a selectively contracted network of health care providers in the 21 county area of Adams, Berks, Centre, Columbia, Cumberland, Dauphin, Franklin, Fulton, Juniata, Lancaster, Lebanon, Lehigh, Mifflin, Montour, Northampton, Northumberland, Perry, Schuylkill, Snyder, Union and York.

Network providers include PCPs and specialists. PCPs include family practitioners, general practitioners, internists and pediatricians. Members choose a PCP who has agreed to provide all primary or general medical care in addition to acting as coordinators of specialty care. Specialists agree to provide specialty care on a referral basis.

This network supports the Point-of-Service program offered by Capital Blue Cross and Pennsylvania Blue Shield. This program is no longer actively marketed; however, a few members have retained coverage.

Central Pennsylvania Point-of-Service network providers agree to accept the Blue Shield UCR allowance (see Section 4, “Payment Mechanisms,” for a discussion of the UCR payment mechanism) as payment-in-full for covered services, less any applicable deductibles and/or coinsurance. The member is responsible for deductibles, coinsurance and/or copayments.

More detail on program requirements is included in the provider guide for this program. Call (800) 572-5751 for a copy.

Hershey HealthStyle network

This is a selectively contracted network of health care providers created solely for the Hershey Foods Corporation in the 11 county area of Berks, Carbon, Cumberland, Dauphin, Juniata, Lancaster, Lebanon, Luzerne, Perry, Schuylkill and York.

The network supports only the HealthStyle program offered by Capital Blue Cross and Pennsylvania Blue Shield to Hershey Foods Corporation.

Network providers include PCPs and specialists. PCPs include family practitioners, general practitioners, internists and pediatricians. Members choose a PCP who has agreed to provide all primary and general medical care in addition to acting as coordinator of specialty care. Specialists agree to provide specialty care on a referral basis.

The HealthStyle program also recognizes Centers for Selected Services. These are facilities that provide specialized care for certain services or procedures, such as heart and kidney transplants, heart surgery and carotid endarterectomy. These centers include the Blue Cross and Blue Shield Association’s Blue Quality Transplant Network and Milton S. Hershey Medical Center. PCPs may make a referral for specialized procedures, like those mentioned above, to either an acute care in-network hospital or a Center for Selected Services.

HealthStyle network providers agree to accept the PremierBlue Shield allowance as payment-in-full for covered services, less any applicable deductibles and/or coinsurance. The member is responsible for deductibles, coinsurance and/or copayments.

More detail on program requirements is included in the provider guide for this program. Call Provider Services at (800) 892-3033 for a copy.

Access Care II network

This network is a subset of the PremierBlue Shield network. Eligible health care providers must be enrolled in PremierBlue Shield and must have active admitting privileges with one of the network facilities. The listing of facilities can be found on the Blue Cross of Northeastern Pennsylvania website at www.bcnepa.com.

The network supports the Access Care II program in northeastern Pennsylvania. Network providers agree to accept the PremierBlue Shield allowance as payment-in-full for covered services, less any applicable deductibles and/or coinsurance. The member is responsible for deductibles, coinsurance and/or copayments.

Radiology preferred provider network

This network of preferred radiologists was developed to support a radiology preferred provider program offered only in the Lehigh Valley. Radiologists in Berks, Carbon, Lehigh and Northampton counties were contracted by Blue Shield to perform specific conventional, outpatient and non-emergency diagnostic X-rays. Network providers agree to accept the radiology preferred program allowance as payment-in-full for covered services, less any applicable deductibles and/or coinsurance.

Members enrolled in this program are encouraged to go to any of the preferred radiologists to have an X-ray service performed. These members carry identification cards that contain the radiology preferred provider program logo.

Dual networks

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 Pennsylvania 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 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. The participating provider may collect any applicable coinsurance or deductibles from the member.

PENNSYLVANIA BLUE SHIELD MEDICAL-SURGICAL PROGRAMS

Traditional Fee-For-Service Programs			Managed Care Programs				
Products supported by the participating provider network		Products supported by the PremierBlue Shield provider network		Fee for service programs		Capitated programs	
Basic UCR products	Fee schedule products	Basic PremierBlue Shield products		PPO products	POS products	POS products	HMO*
UCR 100	Plan B	Basic 100		CustomBlue (PremierBlue Shield network)	Central POS (POS network)	HealthOne (HealthOne network)	
UCR 80/20	Plan C	Basic 80/20		Access Care II (Access Care II network)	Hershey Foods HealthStyle (Hershey HealthStyle network)	CommunityBlue (CommunityBlue network)	
Blue Shield 80	1800S	Comprehensive/Wraparound major medical		Access Care (Preferred network)		SelectBlue (KHPW network)	
Comprehensive/ Wraparound major medical	5000S			PreferredBlue (KHPW network)			
COMPLETEcare	Social Mission programs: Special Care BlueCHIP			FEP (PremierBlue Shield network)			
				Radiology PPO (Radiology PPO network)			

* Each HMO throughout the state offers comprehensive packages of physician, hospital and preventive care. See Pages 28 - 29 for details.

B. Coverage programs

Overview

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

The chart on Page 5 illustrates the relationship between each program and its supporting network.

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

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.

Changes will be communicated in *Policy, Review and News (PRN)* or special mailings.

Traditional fee-for-service programs using the participating provider network

UCR programs

Most fee-for-service programs are supported by the participating provider network and reimbursed based on the UCR allowance. (See the "Payment Mechanisms" section for a discussion of the UCR payment mechanism.)

When a member enrolled under this program receives services, 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, regardless of the member's income.

Blue Shield 100 (also called UCR 100 or UCR full payment)

The Blue Shield UCR 100 program is currently Blue Shield's most popular fee-for-service program. Most covered services are reimbursed at 100 percent of the UCR allowance.

Blue Shield 80/20 (also called UCR 80/20)

Blue Shield pays 80 percent of the UCR allowance, or 80 percent of the amount charged, whichever is less. The member is responsible for the 20 percent coinsurance.

- Blue Shield notifies members in this program that they are responsible for paying the 20 percent coinsurance to a participating provider within 60 days.
- The sum of the payments — 80 percent by Blue Shield and 20 percent by the member — constitutes payment-in-full.

Blue Shield 80 (also called UCR under-income)

Blue Shield no longer actively markets Blue Shield 80, but a limited number of members retain this coverage.

- Payment is 80 percent of the UCR allowance that constitutes payment-in-full to participating providers, except for amounts exceeding any maximums for services performed for low-income members with Blue Shield 80 coverage.
- Income limits (for service benefits, see “Service benefits aid members” on Page 8) are \$2,500 for an individual; \$4,500 for a family.

Comprehensive and wraparound major medical programs

- Comprehensive programs combine Blue Cross, Blue Shield and major medical coverages into a single package of benefits.
- Wraparound programs combine 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.

Cost sharing provisions may vary depending on the particular features of the specific group’s contract.

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.

Participating providers accept Blue Shield’s UCR allowance as full payment for covered services. However, they may bill members for the difference between the UCR allowance and the actual payment made under the program.

Typical covered services

Comprehensive and wraparound major medical contracts include services that normally are covered under Blue Shield’s major medical benefit. Examples of such services are home and office visits, drugs, injections and outpatient psychiatric and psychological services.

These services should be billed to Blue Shield, instead of asking the patient to pay the full charge at the time the service is performed. 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.

Claims procedures

A participating provider who performs an eligible service for a member should first submit a claim to Blue Shield for the services. Blue Shield will send the participating provider the appropriate payment and an Explanation of Benefits (EOB) statement, indicating the exact dollar amount for which the member may be responsible.

The member's EOB also identifies the member's payment responsibility. If you request any payment toward a covered service before receiving the EOB, you may have to make a refund to the member.

COMPLETEcare

Highmark Blue Cross Blue Shield offers a comprehensive health care program in the 29 county area of Western Pennsylvania. The program, COMPLETEcare, provides full service benefits for the individual who is self-employed and/or is not covered by a group employee health care program. This program also targets individuals just graduating from college and those people between jobs.

This program has a pre-existing condition limitation of 12 months for any condition for which a physician gave medical advice or treatment in the last five years.

Medical-surgical benefits within this comprehensive program are based on the UCR provider payment mechanism.

Fee schedule programs

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

The allowances payable for services covered under these programs are listed in Appendix B of the *Procedure Terminology Manual (PTM)*.

The various fee schedule programs have different provider reimbursement levels and member income specifications. 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.

Service benefits aid members

Blue Shield offers medical-surgical programs that provide a fee schedule reimbursement method. The plans include a service benefit provision. This means that participating providers agree to accept Blue Shield's allowance as full payment based on the type of program or, for low-income programs, the member's eligibility.

Blue Shield also markets indemnity programs that do not have a service benefits provision. Under these programs, a set allowance is made for benefits, up to the maximum, and the provider may bill the member for amounts over the allowance. (See the indemnity payment mechanism described in Section 4, "Payment Mechanisms")

The service benefits provision of our fee schedule programs ensure that they offer protection to low-income individuals.

- 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 of the program.

- The income limits are tied to premium rates and provider reimbursement levels in such a way that members are eligible to receive service benefits under programs 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 Section 4, “Payment Mechanisms,” for further details.)

Income limits for fee schedule programs

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 previous to the date of service.

Any difference between a non-participating provider’s charge and the Blue Shield fee schedule allowance is the responsibility of the member. Blue Shield makes payment for services of non-participating providers directly to the member, who is responsible for paying the provider.

The income limits are:

Plan	Single income	Family income
Plan 5000S	\$18,000	\$36,000
Plan C	\$12,000	\$24,000
Plan 1800S	\$6,000	\$12,000
Plan B	\$4,000	\$6,000

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, Blue Shield will make the final determination.

For members above the income limits, participating providers may bill them for the difference between their fee and the Blue Shield fee schedule allowance for covered services.

Social Mission Programs

Pennsylvania Blue Shield’s social mission programs are:

- Special Care
- BlueCHIP (the Children’s Health Insurance Program)

These are fixed-fee programs. Some services, such as preventive care benefits, and some office visits are paid at higher levels. Specifics about payment levels may be found in Section 4, “Payment Mechanisms.”

Health care providers make the programs possible

It is only through a partnership with our providers that these programs are successful and Pennsylvania Blue Shield can continue its social mission to provide health care coverage to as many Pennsylvanians as possible. 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.

Special Care

Blue Cross and Blue Shield introduced Special Care 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.

Today more than 64,000 Pennsylvanians are enrolled in Special Care.

Blue Cross and Blue Shield determines eligibility for all Special Care members according to their income and family size.

Special Care benefits include:

- Basic Blue Cross and Blue Shield
 - Surgery and anesthesia (inpatient or outpatient)
 - Inpatient diagnostic services
 - Emergency accident and medical treatment
 - 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 (\$1000 annual maximum)
 - Hospital and surgery review programs
- Primary care and wellness
 - Four annual doctor visits per person (\$10 copayment)
 - Comprehensive preventive care for children (physician visits, immunizations, pathology)
 - Routine annual mammogram and Pap smear

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. Blue Shield's participating providers agree to accept this allowance as payment-in-full for all eligible services.

Allowances for services covered under these programs are listed in Appendix B of the *PTM*.

Children's Health Insurance Program of Pennsylvania (BlueCHIP)

This program is administered as BlueCHIP by Pennsylvania Blue Shield and the state's Blue Cross Plans, through their respective Caring Foundations.

The Children's Health Insurance Program of Pennsylvania is modeled after the Caring Programs for Children. The first Caring Program, the Western Pennsylvania Caring Foundation for Children, was created in 1985 by Highmark Blue Cross Blue Shield. It was duplicated in 1992 by Independence Blue Cross and Pennsylvania Blue Shield to form the Independence Blue Cross and Pennsylvania Blue Shield Care Foundation for Children.

Both Foundations were created to provide free and low-cost comprehensive health care coverage to eligible children in Pennsylvania. The program covered children from birth through 18 years of age.

The BlueCHIP program is funded through a portion of the state cigarette tax as well as federal funding. The program offers free coverage to children birth through 18 years of families whose income is at or below 200 percent of the Federal Poverty Guidelines (for a family of four the maximum annual income is \$34,100). For children birth to 19 years of families whose income is between 200 percent and 235 percent of the Federal Poverty Guidelines (for a family of four the maximum annual income is \$39,900), the program is offered at a low cost.

Today more than 100,000 children are enrolled in the statewide program.

Benefits are available to qualified children whose families are not eligible for Medical Assistance and who are not covered by a private or public health insurance plan.

Enrollment in the program is dependent upon children meeting the eligibility guidelines as outlined in the Children's Health Care Act.

One of the keystones of this program is that the children are "held harmless" from balance billing when covered services are provided by a participating provider.

To achieve that, BlueCHIP utilizes our participating provider network to provide professional services to these children.

As with our conventional programs, Blue Shield pays participating providers directly, and they agree to accept our payments as payment-in-full for covered services.

Blue Shield sends payments for services of non-participating providers directly to the child's parents, who are responsible for paying the charges.

Eligibility requirements for BlueCHIP

The Caring Foundations in each region locate children, verify eligibility and handle enrollment. Children eligible for enrollment must:

- Be a resident of Pennsylvania for at least 30 days prior to applying for this coverage (except newborns);
- Be a United States citizen or lawfully admitted alien with permanent status;
- 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;*
- Be eligible based on the age guidelines.

** Depending on income levels, children may be eligible for either free or subsidized insurance. If eligible for subsidized insurance, families will be required to pay a monthly premium for their child's health insurance.*

How to determine if a child is covered under BlueCHIP

The group number, which appears on the child's BlueCHIP card, will identify which program the child is in — and thus which payment level is applicable for most services not reimbursed at UCR.

BlueCHIP covered services

Hospital benefits

- | | |
|---|---|
| <ul style="list-style-type: none"> ■ Ambulatory services (In a non-hospital facility) <ul style="list-style-type: none"> • Chemotherapy • Diagnostic • Emergency accident and medical care • Surgery
 ■ Inpatient hospital services <ul style="list-style-type: none"> • 90 days inpatient care per calendar year • Preadmission review is required • Transplant services | <ul style="list-style-type: none"> ■ Outpatient hospital services <ul style="list-style-type: none"> • 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
 ■ Home health care <ul style="list-style-type: none"> • Maximum 60 visits per calendar year
 ■ Durable medical equipment including wheelchairs, oxygen and hospital beds. |
|---|---|

Medical-surgical

- | | |
|---|---|
| <ul style="list-style-type: none"> ■ Anesthesia
 ■ Consultation <ul style="list-style-type: none"> • Inpatient only • Limited to one per stay
 ■ Diagnostic medical
 ■ Emergency medical and accident <ul style="list-style-type: none"> • Within 48 hours of emergency • Include follow-up care
 ■ Outpatient medical visits <ul style="list-style-type: none"> • Symptomatic | <ul style="list-style-type: none"> ■ Transplant surgery
 ■ Second surgical opinion <ul style="list-style-type: none"> • Only eligible outpatient consultation
 ■ Allergy testing <ul style="list-style-type: none"> • Consisting of percutaneous, intracutaneous, patch tests and immunotherapy
 ■ Routine lead screening
 ■ Mental health – administered through Magellan Behavioral Health for mental/substance abuse <ul style="list-style-type: none"> • 90 days inpatient care per calendar year (medical/surgical and mental health combined) • Partial hospitalization • 50 outpatient visits • Emergency psychiatric care |
|---|---|

BlueCHIP covered services

Medical-surgical

- Preventive pediatric
 - Benefits limited in accordance with predefined schedule
- Maternity (including prenatal and postnatal care)
- Routine newborn care
- Oral surgery for the removal of partial and full bony impacted teeth
- Surgery
- Therapy services
 - Chemotherapy, radiation, dialysis treatment, and physical, occupational and speech therapy
- Substance abuse – administered through Magellan Health Services Inc.
 - 30 days inpatient care per calendar year
 - 30 days outpatient care
 - Seven days per admission (4 admission per lifetime) inpatient detoxification

Prescription drugs

- Prescription drug benefits
- Diabetic related supplies, glucose monitors and immunosuppressants.

Hearing

- Hearing benefits
 - Hearing evaluation (once every calendar year)
 - Audiometric examination (once every calendar year)
 - Hearing aid (once in any two calendar years per ear)
 - Audiologists and hearing aid suppliers, as well as other non-participating providers, need to report hearing services provided for BlueCHIP children on a special children's hearing claim form (No.1517). This form acts as a one-time contract with a provider who is not participating with Blue Shield. When signed by the provider, it permits us to make direct payment to the provider, who, in turn, agrees to accept our allowance as full payment. An Explanation of Benefits statement (EOB) is sent with each check for services provided to BlueCHIP children. A participating provider has the option of reporting services on the children's hearing claim form, the 1500A claim form or electronically.

Dental

- Diagnostic services
 - Routine exam (one every 6-month period)
 - Bitewing X-rays (once every 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 (for premature loss of deciduous second molars)
 - Sealants; For children 5 through 9 years of age on permanent first molars, For children age 10 through 14 on permanent second molars – one service sealant per tooth, no repairs
- General services
 - Palliative emergency treatment of an acute condition requiring immediate care
 - Simple extractions – as necessary
 - Pulpotomies covered for deciduous teeth only
 - Root canal therapy for permanent teeth only
 - Anesthesia in conjunction with a covered service

BlueCHIP covered services

Vision

- Eye examination and refraction – once every 6 months
 - Participating providers accept allowance as payment-in-full.
- Frames – standard – once every 12 months
 - Use procedure code V2020
 - Participating providers may bill the member for the difference between their charge and the \$55 allowance.
- Lenses – single vision, bifocal, trifocal, aphakic – one pair every six months
 - Refer to your Blue Shield *PTM* for procedure codes to report lenses.
 - Participating providers accept allowance as payment-in-full.
- Contact lenses (pair) – covered only when medically necessary
 - Refer to your Blue Shield *PTM* for procedure codes to report contact lenses
 - Participating providers accept allowance as payment-in-full.

BlueCHIP coverage and payment levels

Coverage eligibility	Payment levels	
	Free program	Low-cost program
Income	No greater than 185 percent of Federal poverty level	200 percent to 235 percent of Federal poverty level
Ages eligible	Birth through 18 years	Birth through 18 years
Medical-surgical, emergency, routine	Plan C	Plan 5000S
Psychiatric	Magellan Health Services	Magellan Health Services
Substance abuse	Magellan Health Services	Magellan Health Services
Preventive benefits	UCR	UCR
Outpatient medical	Plan C, except codes 99211-99215 pay at Plan 5000S	Plan 5000S
Dental emergency, preventive, routine	UCR	UCR
Vision emergency, preventive, routine	UCR	UCR
Hearing emergency, preventive, routine	Hearing program fee schedule	Hearing program fee schedule

BlueCHIP claims submission

All claims, except hearing and vision claims, should be submitted just like any other Blue Shield claim. They may be submitted electronically or on a paper 1500A or HCFA 1500 claim form. Please note that in all cases, the child is the member. Report “Patient’s relationship to insured” (Block 7 of the claim form) as “self.” Do not report the name of the parent. Submit your paper claims to:

Medical-surgical

Pennsylvania Blue Shield
PO Box 890062
Camp Hill, Pa. 17089-0062

Vision

Clarity Vision, Inc.
PO Box 890500
Camp Hill, Pa. 17089-0500

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

BlueCHIP hearing benefit claims

BlueCHIP also covers medical examinations for hearing problems, audiological tests and hearing aids, when medically necessary. However, the claim submission for audiologists and hearing aid suppliers requires a unique provider contract and claim form.

We expect most primary care practitioners to do a basic hearing examination as part of a routine visit.

If primary care practitioners suspect a hearing problem, they may perform more extensive testing, such as audiometry, if it is available in the office. Bill Blue Shield for the testing using the appropriate code from the *PTM*.

If the child is referred to a specialist for further testing, the specialist also should bill Blue Shield for these services.

Audiologists and hearing aid suppliers are not eligible to participate with Blue Shield.

Consequently, in order to provide benefits to BlueCHIP children while holding them harmless from out-of-pocket expenses, the provider must complete and sign the special children's hearing claim form No. 1517, (see sample form Pages 17 - 18) which will commit the provider to accept Blue Shield's payment for the reported services.

Submit the children's hearing claim form to:

Pennsylvania Blue Shield
PO Box 890062
Camp Hill, Pa. 17089-0062

Although the children's parents are sent a form with their enrollment package, we ask that you remind the patients that this form is necessary and that they should seek services only from providers who will agree to sign it, thereby accepting Blue Shield's payment.

You may order a supply of these forms (form No. 1517) by contacting:

Pennsylvania Blue Shield
Shipping Control Department
PO Box 890089
Camp Hill, Pa. 17089-0089
(717) 763-3256

BlueCHIP vision benefit claims

BlueCHIP also covers eye examinations and refractive services, post-refractive services and frames and lenses.

- Any licensed provider acting within the scope of his or her license may provide eye examination and refraction services.
- Those who dispense may also supply post-refractive products.
- Optical suppliers may provide post-refractive products.

Blue Shield makes payment directly to participating providers.

- Participating providers agree to accept UCR allowances as payment for covered services.

- If a member obtains services from a non-participating provider, payment is sent to the member. Any difference between the provider's charge and the Blue Shield payment is the responsibility of the member.
- If frames and lenses are prescribed by an ophthalmologist, but supplied and billed by an optical supplier, Blue Shield will make payment to the member. Any difference between the optical supplier's charge and the Blue Shield payment is the responsibility of the member.

These are special reporting requirements for frames.

Standard frames — A standard frame is defined as a frame for which the charge is \$55 or less. If a member chooses a standard frame, the participating provider must accept Blue Shield's UCR allowances as full payment. Standard frames should be reported using procedure code V2020.

Deluxe frames — (charge of more than \$55). If a member chooses a deluxe frame, payment is made at the standard frame UCR allowance. The participating provider can bill the member for the difference between the standard frame allowances (\$55) and the charge for the deluxe frame.

When you submit a claim for deluxe frames, you must itemize the allowance for standard frames and the difference between the standard frame allowance and the cost of the deluxe frames. Report the deluxe frame differential using procedure code V2025.

Report eye examinations and refractions and post-refractive products on Clarity Vision's vision claim form (form No. 15). See Section 13, "Vision," for guidelines on completing the vision claim form. Send vision claim forms to:

Clarity Vision, Inc.
PO Box 890500
Camp Hill, Pa. 17089-0500

To obtain vision claim forms, contact:

Pennsylvania Blue Shield
Shipping Control Department
PO Box 890089
Camp Hill, Pa. 17089-0089
(717) 763-3256

BlueCHIP enrollment

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

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

Blue Cross of Western Pennsylvania
(800) KIDS-105
(800) 543-7105

ATTACH
RECEIPT
S HERE
Pennsylvania BlueShield
 An Independent Licensee of the Blue Cross and Blue Shield Association
CHILDREN'S HEARING CLAIM FORM
 Please Mail To: **PENNSYLVANIA BLUE SHIELD**
P.O. BOX 890062
CAMP HILL, PA 17089-0062

Please Print or Type (see reverse side for instructions)

PATIENT & INSURED (SUBSCRIBER) INFORMATION								<i>(Read instructions before completing or signing this form)</i>							
1. PATIENT'S/INSURED'S NAME (First, Middle, Last)				2. PATIENT'S DATE OF BIRTH / /		3. PATIENT'S/INSURED'S ID (include any letters)									
4. PATIENT'S/INSURED'S ADDRESS				5. PATIENT'S SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE											
TELEPHONE NUMBER ()				6. PATIENT'S RELATIONSHIP TO INSURED <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER											
7. OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number				8. WAS CONDITION RELATED TO A. PATIENT'S EMPLOYMENT <input type="checkbox"/> YES <input type="checkbox"/> NO B. AN ACCIDENT <input type="checkbox"/> AUTO <input type="checkbox"/> OTHER											
The Patient named above has been identified as needing medically necessary and appropriate hearing care services and/or supplies. If you desire to provide this service, complete the billing information below, sign this form, attach a copy of your bill and mail to Pennsylvania Blue Shield, P.O. Box 890062, Camp Hill, PA 17089-0062.															
9. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g., public health agency)															
10. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, RELATED DIAGNOSIS TO PROCEDURE IN COLUMN E BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE															
1. 2. 3. 4.															
11.															
A. DATE OF SERVICE FROM TO		B. PLACE OF SERVICE		C. TOS		D. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES, OR SUPPLIES FURNISHED FOR EACH DATE GIVEN. PROCEDURE CODE (IDENTIFY) <i>Explain Unusual Services or Circumstances</i>		E. DIAGNOSIS CODE		F. CHARGES		G. DAYS OR UNITS		H. PERFORMING PROVIDER	
								12. TOTAL CHARGE		13. AMOUNT PAID		14. BALANCE DUE			
By signing this Agreement, you agree to accept Pennsylvania Blue Shield's maximum applicable fee schedule amount as payment in full for the services or supplies provided. Payment will be made directly to you by Pennsylvania Blue Shield. You will receive an Explanation of Benefits from Pennsylvania Blue Shield which clearly identifies all Patients whose claims were processed and includes a check from Pennsylvania Blue Shield for covered services performed. Services or supplies provided pursuant to this Agreement are subject to retrospective utilization review by Pennsylvania Blue Shield. By signing this form, you agree to refund any payments to Pennsylvania Blue Shield that are found improper. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.															
15. SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statements on the reverse apply to this bill and are made a part hereof.)								16. HAS FEE BEEN PAID? <input type="checkbox"/> YES <input type="checkbox"/> NO				17. PHYSICIAN OR SUPPLIER NAME, ADDRESS, ZIP CODE, AND PROVIDER NUMBER			
SIGNED _____ DATE _____								18. YOUR SOCIAL SECURITY NUMBER							
								19. YOUR EMPLOYER ID NUMBER							
								21. YOUR TELEPHONE NUMBER							
20. YOUR PATIENT'S ACCOUNT NUMBER															

* Place of Service on the back

1517 C 12/95

SIGNATURE OF PHYSICIAN

I certify that the services reported on this form were medically necessary for the patient and were performed under my supervision by my employee. If the services were performed under my supervision by someone other than my employee, I have described the circumstances in item 10D. I understand that certain types of supervised services may not be covered. I will provide documentation as necessary to establish the validity of the claim.

PLACE OF SERVICE CODES

- | | |
|---------------------------------|--|
| 1 - (IH) - Inpatient Hospital | 8 - (SNF) - Skilled Nursing Facility |
| 2 - (OH) - Outpatient Hospital | 9 - - Ambulance |
| 3 - (O) - Doctor's Office | 0 - (OL) - Other Locations |
| 4 - (H) - Patient's Home | A - (IL) - Independent Laboratory |
| 5 - - Day Care Facility (PSY) | B - - Other Medical Surgical Facility |
| 6 - - Night Care Facility (PSY) | C - (RTC) - Residential Treatment Center |
| 7 - (NH) - Nursing Home | D - (STF) - Specialized Treatment Facility |

Capital Blue Cross
(800) KIDS-101
(800) 543-7101

Independence Blue Cross
(800) 464-KIDS
(800) 464-5437

Traditional fee-for-service programs using the PremierBlue Shield network

Payments made under the following products are based on the lesser of the PremierBlue Shield fee schedule allowance or the doctor's charge. PremierBlue Shield preferred providers agree to accept the PremierBlue Shield allowance as full payment, except when reduced by 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.

Basic 80/20

Most covered services are payable at 80 percent of the PremierBlue Shield allowance. The member is responsible for 20 percent coinsurance.

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.

Medigap coverage

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.

Security 65

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.

Blue Cross and Blue Shield Plans in Pennsylvania offer four of the ten standardized plans, under the name of Security 65 Plans A, B, C and H.

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

Service	Plan			
	A	B	C	H
Basic benefits	X	X	X	X
Skilled nursing facility coinsurance			X	X
Part A inpatient hospital deductible		X	X	X
Part B deductible			X	
Foreign travel emergency			X	X
Prescription drugs				X*

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

Blue Shield presently offers no plan that covers Part B excess doctor charges, at-home recovery or preventive care.

Here are brief summaries of these four plans.

Plan A

Provides a basic plan of supplemental benefits that include hospitalization services once Medicare benefits end and the 20 percent coinsurance for doctors' services (after the annual Medicare Part B deductible has been satisfied). This plan also covers the first three pints of blood each calendar year.

Plan B

Provides the basic supplemental benefits in Plan A. It also provides coverage for the annual Medicare Part A inpatient hospital deductible.

Plan C

Provides the supplemental benefits in Plan A, plus:

- The annual Medicare Part A inpatient hospital deductible;
- The Medicare Part B medical services annual deductible;
- Skilled nursing facility services coinsurance; and
- Foreign travel emergencies after satisfying an annual deductible.

Plan H

Provides for the basic plan of supplemental benefits in Plan A, plus:

- The annual Medicare Part A inpatient hospital deductible;
- Skilled nursing facility services coinsurance;
- Foreign travel emergencies after satisfying an annual deductible;
- Fifty percent for prescription drugs up to a maximum amount per year (after the annual drug deductible).

As of July 30, 1992, Blue Cross and Blue Shield no longer offered 65 Special to non-group (direct-pay) members. Instead, all new non-group applicants must be enrolled in the Security 65 plan of their choice.

The guidelines for Security 65 processing of Medicare Part B covered services can be similar to those for Blue Shield 65 Special.

65 Special

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

65 Special/Security 65 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 65 Special or Security 65, Medicare is the primary carrier. Submit the claim to the member's Medicare carrier first for processing.

Most claims are considered automatically for supplemental benefits

In most cases, providers do not need to submit separate claims to Blue Shield for supplemental benefits. If HGSAdministrators, Empire Medicare Services or United HealthCare processes the Medicare Part B claims for services provided for your patients, the claims are sent automatically to Blue Shield for consideration for your patient's supplemental benefits.

After the Medicare Part B claims have finalized, payment under your patient's supplemental coverage will be processed automatically within three weeks. If payment under the supplemental coverage has not been received within the three week period after the Medicare payment, send a copy of the Explanation of Medicare Benefits notice to:

Pennsylvania Blue Shield
Medigap Claims
PO Box 898845
Camp Hill, Pa. 17089-8845

- Please do not highlight any information on the Explanation of Medicare Benefits 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 Explanation of Medicare Benefits statement; otherwise, please submit a completed 1500A claim form.
- In the case of Medicare electronic remittance, a screen print of the electronic remittance and a copy of the 1500 claim form should be sent to the address previously listed.
- The beneficiary's Blue Shield agreement number and correct address should appear in the upper left hand corner of all documents submitted for processing.

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 Blue Shield. Any payment made by Medicare is subtracted (carved-out) from the payment made by 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.

Managed care fee-for-service programs (Preferred Provider Programs)

Preferred provider programs (commonly referred to as PPOs)

Blue Shield's PPOs are offered in most areas of Pennsylvania. These programs are based on the preferred provider payment mechanism (see Section 4, "Payment Mechanisms"), designed to help groups establish control over health care costs, while continuing to provide service benefits to their members.

Blue Shield offers a variety of preferred provider programs in different regions. Covered services may vary among programs and often reflect customer-specific needs and wishes. However, all the programs have a preferred provider payment mechanism as a common feature.

Some of the main preferred provider programs offered by Blue Shield are described in this section. These descriptions provide a general overview of the PPOs. All services are subject to specific contract coverage and limitations.

CustomBlue

CustomBlue is a comprehensive preferred provider program that includes benefits for hospitalization and medical-surgical services, including office visits and preventive benefits. CustomBlue uses the PremierBlue Shield network of preferred professional providers.

(Note: In some cases, customers have purchased CustomBlue with the participating network. Their identification cards indicate the specific network associated with the member's program.)

- Members are not required to obtain a referral to see a specialist.
- Members are not required to select a primary care physician.
- Members have the ability to choose any provider when seeking care; however, the product is designed to reward members who use network providers.
- Services performed by network providers are reimbursed at a higher payment level than services performed by out-of-network providers.
- Most services by out-of-network providers are subject to an annual deductible and coinsurance, which is the member's responsibility.

CustomBlue medical management requirements

Preadmission certification and presurgical certification are obtained by calling The Precertification Center at (800) 441-2330. Case management is also included to help ensure that members who suffer from chronic or long-term illnesses receive the most beneficial care in the most appropriate setting, in an effort to maximize health care benefits.

CustomBlue claims submission

Claims may be filed either electronically or on a paper 1500A or HCFA 1500 claim form. Send paper claim forms to:

Pennsylvania Blue Shield
PO Box 890062
Camp Hill, Pa. 17089-0062

Access Care II

Access Care II is a comprehensive preferred provider program that uses a select network of hospitals, doctors and health care professionals. Benefits are provided for hospitalization and medical-surgical services, including office visits and preventive care services.

- The program does not require members to select a primary care physician. There are no referrals needed to see a specialist. However, members are encouraged to seek care from network providers.
- The network is made up of PremierBlue Shield providers who have admitting privileges at Blue Cross of Northeastern Pennsylvania's preferred hospitals.
- Network providers are reimbursed for services at a higher percentage of the plan allowance than non-preferred providers. Most services by non-preferred providers are subject to an annual deductible and coinsurance, which is the member's responsibility to pay.

Access Care II medical management requirements

Access Care II includes elements of managed care, such as preadmission certification, presurgical certification, precertification for home health care services, home infusion therapy services and substance abuse services. Request precertification through Blue Cross of Northeastern Pennsylvania at (888) 338-2211. Care management is also included.

Access Care II claims submission

Claims may be filed electronically or on a paper 1500A or HCFA 1500 claim form. Send paper claim forms to:

Pennsylvania Blue Shield
PO Box 890062
Camp Hill, Pa. 17089-0062

Access Care

Access Care is a preferred provider program that includes hospitalization and medical-surgical services. Certain services, such as office visits and preventive care are eligible when rendered by a preferred provider. Preferred providers are those health care providers who have signed a Pennsylvania Blue Shield Preferred Provider Agreement.

- Reimbursement for network and out-of-network services is based upon the preferred provider allowance. Network providers agree to accept this allowance as full payment.
- Out-of-network providers can bill their patients for any amounts exceeding the plan payment.

Access Care medical management requirements

Access Care includes preadmission and presurgical certification, which can be obtained by calling Blue Cross of Northeastern Pennsylvania at (800) 638-0505.

Access Care claims submission

Claims may be filed electronically or on a paper 1500A or HCFA 1500 claim form. Send paper claim forms to:

Pennsylvania Blue Shield
PO Box 890062
Camp Hill, Pa. 17089-0062

PreferredBlue

PreferredBlue is a preferred provider organization (PPO) that uses the Keystone Health Plan West physician network. Members may choose to receive services from any provider, but services rendered by a preferred provider are reimbursed at the in-network level.

Benefits are provided for hospitalization and medical-surgical services, including routine gynecological examinations and immunizations. Benefit plans may vary by group. Certain limitations, restrictions or exclusions may apply.

Services received from providers within the PreferredBlue network are reimbursed at the in-network level.

- When a member elects to receive services from an out-of-network provider, the claim is reimbursed at an out-of-network level.
- The member may be required to file his or her own claim for services received out-of-network and may be responsible for the difference between the Plan payment and the provider's charge.

Depending on the member's benefit plan, he or she may be required to pay a copayment, coinsurance or deductible for certain services.

- Deductibles are usually applied to all out-of-network services, as well as certain designated in-network services.
- Coinsurances may apply to both in and out-of-network services.

PreferredBlue care management

- In-network care management is provider driven, which requires the provider to contact Healthcare Management prior to an inpatient admission to a hospital or facility.
- Out-of-network care management is member driven, which requires the member to contact Healthcare Management prior to an inpatient admission to a hospital or facility.

Eligible services are reimbursed based on the Keystone Health Plan West fee schedule.

Federal Employee Program (FEP)

The Federal Employee Program (FEP) is a comprehensive preferred provider program that includes benefits for hospitalization and medical-surgical services — including office visits and preventive benefits.

There are two benefit programs offered to federal employees; standard option and high option. FEP uses the PremierBlue Shield network of preferred professional providers.

- There are no referrals required.
- Members have the ability to choose any PremierBlue Shield provider; however, the program is designed to reward members who use network providers.

- Services performed by preferred providers are reimbursed at a higher payment level than services performed by out-of-network providers.
- Most services are subject to an annual deductible and coinsurance.

FEP managed care requirements

Preadmission certification is required to avoid penalties.

Precertification can be obtained by calling one of the following:

Blue Cross of Northeastern Pennsylvania	(800) 638-0505
Highmark Blue Cross Blue Shield	(800) 258-8809
Capital Blue Cross	(800) 441-2330
Independence Blue Cross	(800) TO-ADMIT

FEP claims submission

All federal employee claims can be filed either electronically or on a 1500A or HCFA 1500 claim form. Send paper claim forms to:

Pennsylvania Blue Shield
PO Box 898854
Camp Hill, Pa. 17089-8854

Radiology Preferred Provider Program

The Radiology Preferred Provider Program serves the Lehigh Valley area. It is comprised of a network of preferred radiologists selected by Blue Shield to perform specific radiology services.

Services subject to the Radiology PPO are conventional, outpatient and non-emergency diagnostic X-rays.

- Under this program, when a doctor prescribes a radiology PPO service, the patient is encouraged to go to any of the preferred radiologists to have the X-ray service performed.
- The preferred radiologist will send the results back to the prescribing doctor.

Your patients are responsible for notifying you about their membership in this PPO by showing you their identification card.

- The card outlines the radiology services to this program and tells you what procedures to follow.
- The card also contains a list of preferred radiologists.

Please refer to the Appendix for a sample identification card.

Questions about the Radiology PPO can be directed to Blue Shield's customer service at (800) 345-3806.

Managed care fee-for-service programs (Point of Service)

Point-of-service products

Blue Shield has developed several point-of-service (POS) products in response to our customers' desire to provide quality health care benefits to their employees at a reasonable cost — while preserving the employee's right to use the physician of their choice.

POS products integrate features of managed care and indemnity fee-for-service products:

- Each member must select a PCP who is responsible for coordinating his or her care. The PCP is responsible for making referrals to network specialists and coordinating inpatient admissions. PCPs are network physicians who practice general or family medicine, pediatrics or internal medicine.
- The member will obtain maximum benefits by having care performed or referred by their primary care physician.
- Alternatively, members may elect to receive care without a referral from their PCP at a greater cost to themselves.

Network obstetricians and gynecologists play a unique role :

- Members may seek gynecological and maternity care from network obstetricians/gynecologists without PCP coordination.
- When a network obstetrician/gynecologist provides gynecological and maternity care, the member will receive the higher benefit level.

Here are the POS products offered by Blue Shield:

Central Pennsylvania Point of Service

This program is offered in the Capital Blue Cross service area and is supported by a unique preferred provider network.

Although this program is no longer actively marketed there may be a few members who retained coverage. Network providers may refer to the *Point-of-Service Provider Guide* supplied to network participants for details on the program's referral process, covered benefits, precertification requirements and more. Call (800) 572-5751 for a copy of the guide.

Hershey Foods Corporation HealthStyle Point of Service

The HealthStyle POS program was designed specifically for Hershey Foods Corporation. The program uses a select network of providers who are primarily located where Hershey employees reside. This includes Berks, Carbon, Cumberland, Dauphin, Juniata, Lancaster, Lebanon, Luzerne, Perry, Schuylkill and York counties.

Network providers accept the PremierBlue Shield allowance as payment-in-full. Details of the program may be found in *HealthStyle, Hershey's Managed Care Program Provider Guide* supplied to network providers or by calling Provider Services at (800) 892-3033.

Managed care capitated programs (Point of Service products)

HealthOne

HealthOne POS, the premier POS program in the Capital Blue Cross service area, is supported by the HealthOne network.

This program is offered to both small and large group customers.

HealthOne PCPs are reimbursed at a per member/per month capitation arrangement. HealthOne specialists are reimbursed on a fee-for-service basis.

You can find program details in the *HealthOne Provider Guide*.

CommunityBlue Point of Service

CommunityBlue POS is a managed care, gatekeeper product, where members select a PCP from the

CommunityBlue provider network. It is available only in Western Pennsylvania. All physicians, including PCPs and specialists, in the Keystone Health Plan West network who have active or admitting privileges at any CommunityBlue participating hospitals are included in the CommunityBlue network.

- PCPs may be pediatricians, internists, family practitioners or general practitioners. All services must be provided by or coordinated through the PCP with the exception of obstetrics/gynecology, mental health, substance abuse or services provided by “Blues on Call” (BOC), a support and information line. Specialists may provide follow up care within 60 days after the initial referral from the PCP or BOC.
- Some services require prior authorization.
- Female members may self refer to a CommunityBlue network obstetrician/gynecologist for all gynecological or maternity services.
- Members may bypass the PCP and may self refer to any provider of his or her choice and receive the lower self-referred level of payments for covered services.
- Self-referred care is usually covered with a deductible and coinsurance at least 20 percent more than the coordinated care level. The member may be responsible for copayments on PCP and specialist office visits, emergency room services and mental health outpatient visits for coordinated care, as well as on prescription drugs.
- The network utilized is the CommunityBlue network of selected tertiary/community hospitals selected for their exceptional care; located in Allegheny, Armstrong, Beaver, Butler, Fayette, Greene, Lawrence, Washington and Westmoreland counties. Primary care physicians are participating in the Keystone Health Plan West network and have admitting privileges to the CommunityBlue network hospitals.

Reimbursement to PCPs is based on a capitation rate. All Keystone Health Plan West participating providers accept the Keystone Health plan fee allowance as payment-in-full even if they are non-participating in the CommunityBlue network. *Non-Keystone providers, who are Blue Shield participating providers, accept the Blue Shield fee allowance as payment-in-full.* Non-Keystone, non-Blue Shield participating providers are paid charges for coordinated care. Self-referred care is paid at the Blue Shield UCR allowance with the member responsible for payment of the remaining balance.

SelectBlue

SelectBlue is a POS product, which uses the Keystone Health Plan West network of professional providers. This product allows the member to receive a higher level of payment when care is coordinated by the PCP or to receive a lower level of payment when a member bypasses the PCP and self refers to any provider for covered health care services.

Each member selects a PCP from the Keystone Health Plan West network. PCPs may be pediatricians, internists, family practitioners or general practitioners. Care is coordinated by the PCP or “Blues on Call.” For coordinated care services, the member may be responsible for copayments for PCP and specialist office visits, emergency room services and prescription drugs. Members may bypass their PCP by going directly to any provider of his or her choice. However, they will receive a lower level of payment for covered services. Self-referred care is usually covered with an annual deductible and coinsurance at least 20 percent more than the coordinated care level. Female members are permitted to self refer to a participating obstetrician/gynecologist of choice for all gynecological and maternity care and still receive the higher level of payment. Mental health and substance abuse treatment is covered at the coordinated level when the member contacts the plan for services (both inpatient and outpatient.) All preventive routine physicals and immunizations are included in the program. Specialists are permitted to provide follow up care within 60 days following the initial PCP referral. Disease state management programs are an integral covered benefit.

Reimbursement for network providers is based on Keystone Health Plan West fee allowance for both coordinated and self-referred services. *Blue Shield participating providers are reimbursed the UCR allowance for both coordinated and self-referred services.* Non-participating providers are reimbursed at charge for coordinated care and the UCR allowance for self-referred services. PCP payment is capitated except for selected fee for service procedures. Specialists are paid on a fee for service basis.

All members who fail to select a PCP will have all services considered at the self-referred payment level with the exception of the routine annual gynecological examination, emergency and maternity care.

Managed care capitated programs (Health Maintenance Organizations)

Health Maintenance Organizations

Blue Shield partners with Capital Blue Cross to offer a Health Maintenance Organization (HMO) option to our customers in Central Pennsylvania, and also holds wholly owned HMOs in the state. Each HMO offers a comprehensive package of physician, hospital and preventive care.

Contracted providers, called primary care physicians, provide routine medical care for their members. Other contracted providers include specialists in cardiology, cardiovascular/thoracic surgery, gastroenterology, internal medicine, obstetrics-gynecology, ophthalmology, orthopedic surgery, otolaryngology, pediatric surgery, radiology, general surgery and urology.

Each HMO pays a monthly capitation to its primary care physicians for each member's primary care and preventive services. Primary care physicians authorize both referrals for specialty care and hospitalizations.

Keystone Health Plan West, Inc.

Operational since 1986, Keystone Health Plan West, Inc. (KHPW) serves the 29 counties in Western Pennsylvania. This health plan is wholly owned by Highmark Inc., Pennsylvania Blue Shield's parent company.

KHPW offers a variety of HMO products including KeystoneBlue HMO, KeystoneBlue Individual HMO, CommunityBlue HMO and SecurityBlue HMO.

For more information about care and coverage developments please visit www.highmark.com or call (800) 345-7808.

SecurityBlue HMO is Highmark Blue Cross Blue Shield's Medicare+Choice HMO. It has been operational since 1995.

Call (800) 547-3627 for more information about SecurityBlue.

Keystone Health Plan Central, Inc.

Formed in 1983, Keystone Health Plan Central (KHPC), Inc. serves over 183,000 members and 966 employer groups in the South Central Pennsylvania and Lehigh Valley areas. This health plan is jointly owned by Highmark, Inc. and Capital Blue Cross.

For information about authorizations, referrals, changes to capitation, changes to fee schedules, provider profile, etc., please write to:

Keystone Health Plan Central, Inc.
PO Box 898812
Camp Hill, Pa. 17089-8812

You can call KHPC for general provider information or to precertify a procedure at:

(717) 763-3894 (general provider number)

(800) 547- 2273 (precertification)

Fax your referrals to KHPC at:

(800) 929-0557

HealthGuard of Lancaster, Inc.

HealthGuard of Lancaster, Inc. has been operational since December 1983 in Lancaster County. This health plan is wholly owned by Highmark Inc. For more information please write to or call:

HealthGuard of Lancaster, Inc.
280 Granite Run Drive
Lancaster, Pa. 17601
(717) 560-9049

Preventive Care 2000 program

Blue Shield encourages members to receive the recommended preventive care. Blue Shield's CustomBlue PPO and Access Care II PPO products include Preventive Care 2000 as part of the standard benefit package. Experience-rated basic Blue Shield and comprehensive major medical group customers have the option of adding Preventive Care 2000 to their benefits plan.

Preventive Care 2000 covers periodic physical exams and diagnostic testing for adults and children as listed in the schedule on Page 30. Covered services are updated periodically based on changes in medical guidelines and protocols. Benefits are only provided under basic Blue Shield when care is received from a professional provider.

The procedure codes for covered preventive services are provided in the Preventive Services section in the beginning of the *PTM*. Use these codes for reporting preventive care for routine services on asymptomatic patients.

Coverage for childhood immunizations

Blue Shield provides coverage for childhood immunizations based on the requirements of the Childhood Immunization Insurance Act (Act 35 of 1992). This mandate requires insurers to cover childhood immunizations that conform with the standards of the Advisory Committee on Immunization Practices (ACIP) of the Center for Disease Control, as determined by the Pennsylvania Department of Health. Immunizing agents and medically necessary booster doses are covered.

Pediatric care (birth through age 17)	
Periodic physical exam	0 to 1 month 2 to 3 months 4 to 5 months 6 to 8 months 9 to 11 months 12 to 14 months 15 to 17 months 18 to 24 months (One exam at each age range, unless otherwise indicated)
Urinalysis	Birth - 6 years 11 - 17 years (One test during each specified age range)
Hemoglobin or hematocrit	Birth - 12 months 1 - 4 years 5 - 12 years 14 - 17 years (One test during each age range)
Rubella titer test	11 - 17 years (One per lifetime)
Tuberculosis (TB) test	4 - 7 years 13 - 15 years (One test during each age range)
Childhood immunizations	(Such as the following, as required by Pennsylvania State law) Diphtheria, Tetanus, Pertussis (DTP); Measles Mumps, Rubella (MMR); Polio; Hepatitis B (Hib); Varicella (chicken pox)
Adult care (ages 18 and over)	
Periodic physical exam	18 - 49 years (<i>one exam every three years</i>) 50 years and older (<i>annually</i>)
Fecal occult blood test	50 years and older (<i>annually</i>)
Blood cholesterol test	18 - 49 years (<i>one test every 3 years</i>) 50 years and older (<i>annually</i>)
Adult tetanus and diphtheria toxoid (Td)	18 years and older (<i>one every 10 years</i>)
Rubella titer test and immunization	18 - 49 years (<i>once per lifetime</i>)
Influenza vaccine	50 years and older (<i>annually</i>)
Pneumococcal vaccine	65 years and older (<i>once every five years</i>)
Urinalysis	18 - 49 years (<i>one test every three years</i>) 50 years and older (<i>annually</i>)
Complete blood count (CBC)	18 - 49 years (<i>one test every three years</i>) 50 years and older (<i>annually</i>)
Flexible sigmoidoscopy	50 years and older (<i>annually</i>)
Prostatic specific antigen (PSA)	50 years and older (<i>annually</i>)
Screening mammography	40 years and older (<i>annually</i>)
Routine gynecological exam and pap test	No age limit (<i>annually</i>) (As required by Pennsylvania state law)

Major medical

Major medical benefits supplement Blue Cross and Blue Shield 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 Blue Cross and Blue Shield basic contracts and provides coverage for additional services, such as:

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

Major medical claims

If, during a calendar year, the member's or dependent(s)' expenses exceed the deductible, the member should complete a major medical claim form. The claim should be submitted, along with itemized bills, to the Blue Cross Plan through which the member is enrolled.

Concurrent major medical claims

Concurrent major medical processing was developed to simplify the claims filing process. Concurrent processing eliminates the need for members to file separate claims for their basic medical-surgical and major medical services. This processing arrangement is currently only available in the Independence Blue Cross service area.

With concurrent major medical processing, services for both basic medical-surgical and major medical process automatically at the same time using only one claim form. When participating providers perform services, they are paid directly with one check for eligible medical-surgical and major medical services. Payment for services performed by non-participating providers and services eligible only under major medical coverage will be issued with one check to the member.

This method differs from a process called “piggybacking” which processes medical-surgical and major medical services consecutively and two separate checks are issued.

The “out of area” program: BlueCard® and BlueCard PPO

BlueCard links participating health care providers and the independent Blue Cross and Blue Shield Plans across the country through a single electronic network for professional outpatient and inpatient claims processing and reimbursement.

- It allows network participating and PPO Blue Cross and Blue Shield providers in every state to submit claims for traditional and PPO patients who are enrolled through another Blue Plan to their local Blue Cross and Blue Shield plan.
- BlueCard applies to all inpatient, outpatient and professional services. The BlueCard program does not apply to:
 - Federal Employee Program (FEP)
 - Medicare supplemental
 - Prescription drugs
 - Stand-alone dental (without an accompanying medical-surgical program)
 - Vision and hearing
 - Fee schedule products

In Pennsylvania, the BlueCard networks include:

- Participating provider network (supports all BlueCard programs for members that usually live outside their Blue Cross and Blue Shield Plan’s service area with traditional coverage)
- PremierBlue Shield network (supports the BlueCard PPO programs for members that usually live outside their Blue Cross and Blue Shield Plan’s service area in a PPO plan)

Please see the BlueCard information in Section 7, “Claims Submission and Billing Information,” for information about how to identify BlueCard members, how to submit BlueCard claims and how BlueCard claims are processed.