CareFirst
Family of health care plans

2. Product Descriptions

To help you navigate through the manual, look for icons that indicate the relevant provider type as shown below.
Any content that is not marked with an icon applies to all provider types.

Ancillary Institutional Professional

Overview

CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst) offer a comprehensive portfolio of health insurance products and administrative services to 3.4 million individuals and groups in Maryland, Washington, D.C. and Northern Virginia. This section explains the various types of policies our members may have.

BlueChoice® Products

BlueChoice Health Maintenance Organization

BlueChoice is a health maintenance organization (HMO) product that requires the member to select a primary care provider (PCP) who provides routine care and coordinates specialty care through referrals. When members use in-network providers, they have the lowest out-of-pocket costs. If members need care from a specialist, the PCP provides a referral to a specialist. Some BlueChoice policies also have deductibles. Be sure to check member benefits through the self-service tools.

Referrals

Unless otherwise stated, all office services not rendered by a PCP require a written referral. A written referral is valid for a maximum of 120 days and limited to three visits except for standing referral situations.

Decisions to issue additional referrals rest solely with the PCP.

Additional information about covered services and benefits guidelines is available through the Medical Policy Reference Manual.

Note: Referrals are not needed for emergency and urgent care services.

- Lab and radiology services performed by CareFirst BlueChoice providers (a physician's order or prescription is required). Laboratory services should be directed to LabCorp.
- Gynecological and obstetrical care (except infertility services) as long as the care is provided by a CareFirst BlueChoice OB/GYN

Standing referrals

Members with conditions requiring long-term specialized care may receive a standing or condition management referral that applies to an authorized treatment period or period review.

BlueChoice Open Access

Members who have BlueChoice Open Access must follow the requirements of BlueChoice but have the flexibility to receive specialty care without a referral from their PCP.

BlueChoice Advantage

BlueChoice Advantage has the same requirements of BlueChoice. However, these members also have out-of-network coverage allowing members to see a non-participating provider, and there is no referral required to see a specialist.

BlueChoice Opt-Out Plus Open Access

Members who have BlueChoice Opt-Out Plus Open Access must follow the requirements of BlueChoice Open Access, but they also have out-of-network coverage and the ability to see a non-participating provider. If a member sees a non-participating provider, they may be subject to balance billing and filing their own claims in addition to higher out-of-pocket costs.

Preferred Provider Organization

BluePreferred® Preferred Provider Organization

BluePreferred is a Preferred Provider Organization (PPO) product which allows members to seek care from our network of PPO providers, as well as from providers outside the PPO network through their out-of-network benefits. Members who utilize providers outside the PPO network will incur higher out-of-pocket expenses. The selection of a PCP and referrals are not required.

Exclusive Provider Organization

Exclusive Provider Organization (EPO) works much like the PPO. However, the member does not have out-of-network benefits. With the exception of emergency services, if they seek care from a provider outside the PPO network, their claims are denied.

HealthyBlue®

HealthyBlue HMO, HealthyBlue 2.0, HealthyBlue Advantage and HealthyBlue PPO offer the same basic requirements and benefit structures of the products noted above. However, they also offer online tools and resources that give the member the flexibility to manage their healthcare and wellness goals.

Blue High Performance Network® (BlueHPN®)

BlueHPN is a curated network that provides national access through other Blues' plans high-performing networks. In CareFirst's service area, BlueHPN products will use the BlueEssential network. If you are a participating BlueEssential provider, you may see BlueHPN and BlueEssential members and still be considered an in-network provider.

BlueHPN Products

BlueHPN plans will have in-network benefits only except for urgent and emergent care. Plans will use the PPO network for emergent care. Also, BlueChoice rules apply to the BlueHPN plans. For example, members must use LabCorp and receive a prior authorization for non-freestanding services.

Note: The University of Maryland Downtown Campus will be considered in-network for certain services only.

Federal Employees Health Benefit Plan/ Federal Employee Program®

Overview

All federal government employees and qualified retirees are entitled to health insurance benefits under the Federal Employees Health Benefits (FEHB) Program.

Federal employees are given a wide range of insurance options, from catastrophic coverage plans with high deductibles to HMOs. Some plans are offered nationwide while others offer coverage regionally.

The Federal Employee Program® (FEP®), also known as the Service Benefit Plan (SBP), has been part of the FEHB Program since its inception in 1960. For Maryland, Washington, D.C. and Northern Virginia, this fee-for-service plan is administered by CareFirst. More than 50 percent of all federal employees and retirees nationwide have chosen to receive their healthcare benefits through FEP. These members and their families receive health coverage through the local Blue Plan where they reside.

Note: Providers can find helpful tips in the FEP Cheat Sheet and the FEP Job Aid.

FEP Benefit Plan Options

In 2019, FEP introduced a new coverage option for the first time since the beginning of the FEHB Program – FEP Blue Focus. The options now available to federal employees and retirees include:

- The Standard Option PPO which allows FEP members to seek covered services from both preferred/in-network and non-participating providers. When members use preferred PPO providers, their out-of-pocket expenses, such as coinsurance and copayment amounts, will be less.
- The Basic Option PPO has a lower premium than the Standard Option and no deductibles, but members must use participating preferred providers to receive benefits.
- The FEP Blue Focus is also a PPO product that uses the same network as the Standard and Basic options with no out-of-network benefits, except in certain situations such as emergency care. The core benefits, which provide coverage for all essentials of good preventive health, are the base of the program. The core benefits are covered at little or no cost to members when they use the PPO provider.

Learn more about the benefit plans at https://www.fepblue.org/benefit-plans.

How to Identify an FEP Policy

Members who are part of Blue Cross Blue Shield Association (BCBSA) FEP can be identified by the following:

- The letter "R" in front of their member ID number instead of a three-letter alpha prefix
- The BlueCross BlueShield (BCBS) FEP logo on their ID card.
- A thin blue border around the FEP Blue Focus ID card perimeter, which distinguishes it from the Standard Option card, which has a solid white border, and the Basic Option card, which has shaded blue font. Samples of each card are shown below.

SAMPLE: Standard Option ID card

Front of card:

Back of card:

SAMPLE: Basic Option ID card

Front of card:

Back of card:

SAMPLE: FEP Blue Focus ID card

Front of card:

Back of card:

Verifying Eligibility and Benefits

Eligibility and benefits can be verified through CareFirst Direct and the Provider Integrated Voice Response (PIVR) for FEP services being rendered in Maryland, Washington, D.C. and Northern Virginia. Preferred providers are expected to utilize their self-service tools for eligibility, claim status, benefits, prior authorizations and remittance retrieval. Service representatives are available to assist with more complex issues and any information not available using the self-service tools such as the PIVR or the CareFirst Direct provider portal.

FEP Claim Submissions

Electronic transactions and online communications have become integral to healthcare. To support our paperless initiative and improve your claims processing experience, CareFirst strongly encourages participating and non-participating providers to submit claims electronically.

This applies to the following types of claims:

- Initial

- Corrected (Institutional and Professional only)
- Late Charge (Institutional only)
- Interim (Institutional only)
- Medicare Secondary (Institutional and Professional only)

Certain claims require additional documentation and cannot be submitted electronically. However, we urge you to take advantage of the convenience provided by filing electronically, whenever possible.

When you submit your claims electronically, you can track your claims submissions, help save on administrative costs and improve your claims process. If you currently do not submit claims electronically or need assistance, please contact one of our preferred clearinghouses.

Claims for FEP members should be submitted to the local Blue Plan where services were rendered. Each local plan is responsible for processing and paying claims for services received within that area. CareFirst participating providers should submit all claims for FEP members to CareFirst, except for the following:

- Lab providers should file FEP claims in the state where the lab tests were performed, not where the specimen is drawn. The provider location is determined by the mailing address.
- Durable Medical Equipment (DME) providers should file FEP claims in the state where the provider is located, not where the DME supplies are delivered. The provider locations are determined by the mailing address.
- Facilities (UB/8371 billers) must submit claims for FEP members to the facility's local Blue Cross plan.

Reminders for all:

- When obtaining prior authorization for baby, it should start from the baby's date of birth.
- If mom and/or baby stay beyond what is considered a normal/routine length of stay, prior authorization is required for both.
- Length of stay calculation starts on date of delivery.
- For more information on submitting mom and baby claims, refer to our Mother and Baby Claims – Billing Guide.

These rules apply to CareFirst covered members only. These rules do not apply to CareFirst Administrators, National Capital Area Accounts, NetLease accounts or Out-of-State/Blue Card accounts.

Facility Claims Quick Tip	
Number	Type of bill
111	Inpatient Hospital
131	Outpatient Hospital
2XX	Skilled Nursing Facility
3XX	Home Health Care
720	Dialysis Center
831	Ambulatory Surgical Center

Coordinating Benefits with Medicare

Medicare is the federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease. The Traditional Medicare Plan (Traditional Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is the primary payor.

When the patient is enrolled in Traditional Medicare along with FEP, providers still need to adhere to their contract agreement for CareFirst. For example, you must continue to obtain prior approval for some prescription drugs and organ/issue transplants before we will pay benefits. However, you do not have to pre-authorize inpatient hospital stays when Medicare Part A is the primary payor.

When CareFirst FEP is the primary payor, we process the claim first. When the Traditional Medicare Plan is the primary payor, Medicare processes the claim first. In most cases, the claim will be coordinated automatically, and CareFirst will then provide secondary benefits for the covered charges.

- **Institutional claims for FEP members with Medicare Part B but no Medicare Part A:** This procedure applies to federal retirees who are not enrolled in Medicare Part A. In these situations, CareFirst is primary for Part A charges while Medicare is primary for Part B charges. In most cases, the Part B claims will cross over electronically to CareFirst. FEP requires all charges related to an episode of care are paid as one claim. The following guidelines will assist you in submitting FEP Medicare Supplemental claims:
  - Submit Part B charges to Medicare.
  - Once Medicare has processed, submit all charges as an inpatient claim (Type of Bill XXX7 is helpful) with the Medicare B Summary Notices to FEP.

- Any Part B services originally processed/paid by FEP will be voided (retracted) and all charges will be processed/reprocessed on the inpatient claim.
- For Washington, D.C. and Northern Virginia facilities only, a DRG payment is made (Medicare Part B payment is deducted from the full DRG amount and CareFirst pays the difference).

CVS Caremark® Drug Prior Authorization

The FEP Director's Office in conjunction with CVS Caremark[1] has a pilot program known as Novologix® for certain prescriptions that require pre-authorization. Before submitting claims for drugs listed on the Novologix or Prior Approval Drug List, providers must seek pre-authorization through CVS Caremark. After CVS Caremark gives the provider an approval letter, a copy of the letter must be submitted with their claim (paper or electronic).

Telemedicine

FEP utilizes a vendor, Teladoc®[2], to provide telemedicine services.

Advance Benefit Determination

Providers may request an Advanced Benefit Determination (ABD) for certain services that do not typically require prior authorization. Services that may qualify for an ABD are as follows:

- Outpatient procedures
- Surgical procedures
- High-cost DME or Prosthetics

Procedures involving drugs that do not require a prior authorization but require medical review (excludes those drugs requiring prior authorization by Novologix) **Note:** If any of the above criteria is met and the service is not one listed in the CareFirst Provider Manual as needing prior authorization providers may contact CareFirst's provider services line to initiate an ABD request.

- Maryland: 800-854-5256
- Washington, D.C./Metropolitan Area: 202-488-4900

To initiate the request, you will be required to provide the following to the provider service associate:

- Provider's full name
- Provider office contact name
- Provider's phone number (to be used when the decision is made)
- Provider's fax number (to be used to send the official letters of decision)
- Provider's Tax ID Number
- Member's ID number
- Patient Name

[1] CVS is an independent company providing pharmacy benefit management services to CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. members.

[2] Teladoc is an independent company provider telehealth services to CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. members.

- Patient Date of Birth
- Procedure Code(s)
- Diagnosis Code(s)

- Place of Service (e.g., inpatient hospital, outpatient hospital, etc.)
- Type of service for review (e.g., life threatening illness, high cost DME/prosthetics, outpatient procedure)

Please include the following required documents:

- A description of patient's history and medical necessity for service
- Related clinical documentation
- Literature supporting treatment protocols (if not standard protocol)

For More Information

For more information on the BCBS FEP, please visit www.fepblue.org.

Reminders

Providers are required to report the most appropriate place of service on claim submissions. To ensure proper processing and reimbursement for your claims, please make sure you are accurately selecting the appropriate place of service code for all claims submitted.

Federal Employee Program Prior Authorization Requirements

FEP has precertification and prior authorization requirements for all products.

Inpatient admissions

Prior authorization is required for in-patient hospital, residential treatment center and skilled nursing facility (SNF) admissions. The only exception to this process is routine maternity admissions, meaning those that do not exceed 48 hours for a vaginal delivery or 96 hours for a Cesarean delivery. The admission time of 48 hours or 96 hours does not begin until the baby is delivered. For maternity admissions exceeding these timeframes, notification is required within two business days.

FEP applies a $500 penalty if an authorization is not obtained for inpatient hospital admissions within the appropriate timeframe. However, the penalty is imposed on the provider in the form of reduced payment. In the event of an emergency inpatient hospital admission, notification is required within two business days.

Note: Basic Option and FEP Blue Focus plans **do not** have a benefit for SNF.

Other services requiring pre-authorization

Pre-authorization is also required for certain services for FEP members as indicated by the FEP medical policy.

For the FEP Blue Focus product, FEP applies a $100 penalty if an authorization is not obtained for any of the services listed in the chart below. The penalty is imposed on the provider in the form of reduced payment if a claim is received, and the service is determined to be covered and medically necessary based on medical review. The provider may not bill this amount to the member.

Services Requiring Prior Authorization	Standard and Basic	FEP Blue Focus
Genetic Testing		
BRCA screening or diagnostic testing	X	X
Large genomic rearrangements of the BRCA1 and BRCA2 genes screening or diagnostic testing	X	X
Genetic testing for the diagnosis and/or management of an existing medical condition		X
Surgical services		
Outpatient surgery for morbid obesity	X	X
Outpatient surgical correction of congenital anomalies	X	X
Outpatient surgery needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth	X	X
Gender reassignment surgery	X	X
Breast reduction or augmentation not related to treatment of cancer		X
Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint (TMJ)		X
Orthopedic procedures: hip, knee, ankle, spine, shoulder and all orthopedic procedures using computer-assisted musculoskeletal surgical navigation		X
Reconstructive surgery for conditions other than breast cancer		X
Rhinoplasty		X
Septoplasty		X

Services Requiring Prior Authorization	Standard and Basic	FEP Blue Focus
Varicose vein treatment		X
Other services		
Outpatient intensity-modulated radiation therapy (IMRT)	X	X
Cardiac rehabilitation		X
Cochlear implants		X
Prosthetic devices (external), including microprocessor-controlled limb prosthesis, electronic and externally powered prosthesis		X
Pulmonary rehabilitation		X
Radiology, high technology including: ■ Magnetic resonance imaging (MRI) ■ Computed tomography (CT) scan ■ Positron emission tomography (PET) scan **Note:** High technology radiology related to immediate care of a medical emergency or accidental injury does not require prior approval.		X
Specialty DME, rental or purchase, to include: ■ Specialty hospital beds ■ Deluxe wheelchairs, power wheelchairs and mobility devices and related supplies		X
Gene therapy and cellular immunotherapy, (e.g., CAR-T and T-Cell receptor therapy)	X	X
Air Ambulance Transport (non-emergency)	X	X
Outpatient sleep studies performed outside the home	X	
Applied behavior analysis (ABA)	X	X

Services Requiring Prior Authorization	Standard and Basic	FEP Blue Focus
All covered organ/tissue transplants, except kidney and corneal transplants	X	X
Blood or marrow stem cell transplants	X	X
Clinical trials for certain blood or marrow stem cell transplants	X	X
Transplant travel	X	X
Maternity care		X

Reimbursement for Injectables, Vaccines and Administration

Covered vaccines and injectables are reimbursed and administered according to an established fee schedule. Newly recommended vaccines are eligible for reimbursement as of the recommendation effective date made by any of the following:

- The U.S. Preventive Services Task Force
- The American Academy of Pediatrics
- The Advisory Committee on Immunization Practices

Note: Benefits for vaccinations and immunizations are contractually determined, including vaccines necessary for international travel as determined by the Centers for Disease Control. Providers should ensure that benefits are available prior to rendering these services.

General Exclusions—Services, Drugs and Supplies

Important note: Although we may list a specific service as a benefit, we will not cover the service unless we determine the service is medically necessary to prevent, diagnose or treat an illness, disease, injury or condition.

A list of FEP general exclusions can be located in the medical policies or in the Member's FEP SBP Brochure.

Helpful Hints

- Providers may appeal any part of a claim within six months of payment or denial.
- PPO claims must be submitted within 365 days of the first service date.
- Peer-to-peer is an option for the ordering or treating provider to discuss as denied pre-service request, not a denied claim.
- Service representatives are trained to handle many complex issues. In the event an inquiry needs to be researched or escalated, please request a reference number and timeframe for resolution. You can find the phone number for your service representative on your remittance notice.

- Many national accounts, processed through the National Account Service Company (NASCO) system, and members with federal employee program benefits, may defer to policies developed by the Blue Cross and Blue Shield Association. For these accounts, when there is no policy on a specific service, CareFirst's Medical Policy Reference Manual will apply.

BlueCard® Program

Introduction: BlueCard Program Makes Filing Claims Easy

As a participating provider of CareFirst, you may render services to patients who are National Account members of other Blue Plans and who travel or live in CareFirst's service area.

This section describes the advantages of the program and provides information to make filing claims easy. This section offers helpful information about:

- Identifying members
- Verifying eligibility
- Obtaining pre-certifications/pre-authorizations
- Filing claims

What is the BlueCard Program?

Definition

BlueCard is a national program that enables members of one BCBS Plan to obtain healthcare service benefits while traveling or living in another BCBS Plan's service area. The program links participating healthcare providers with the independent BCBS Plans across the country and in more than 200 countries and territories worldwide through a single electronic network for claims processing and reimbursement.

The program lets you submit claims for patients from other BCBS Plans, domestic and international, to CareFirst.

CareFirst is your sole contact for claims payment, adjustments and issue resolution.

BlueCard program advantages to providers

The BlueCard Program lets you conveniently submit claims for members from other Blue Plans, including international Blue Plans, directly to CareFirst. CareFirst will be your only point of contact for all your claims-related questions.

Products included in BlueCard

A variety of products and claim types are eligible to be delivered via BlueCard; however not all Blue Plans offer all these products to their members

- Traditional (indemnity insurance)
- PPO
- EPO
- Point of Service (POS)
- HMO
    - HMO claims are eligible to be processed under the BlueCard Program

- Blue Cross Blue Shield Global® Core claims
- Stand-alone vision
- Stand-alone prescription drugs

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

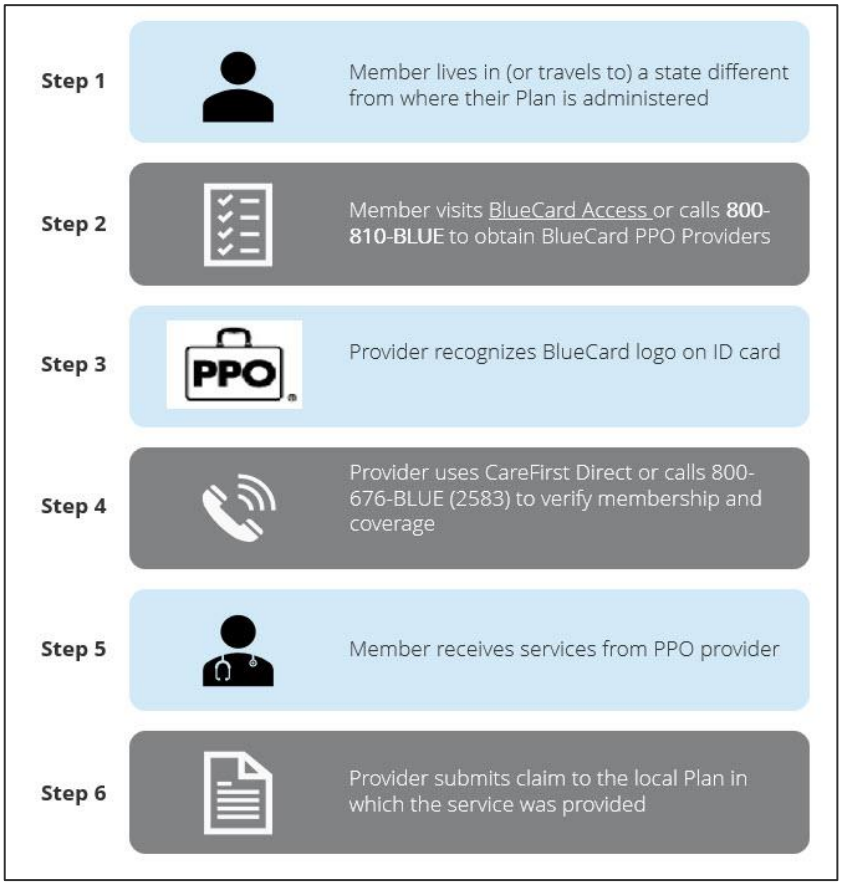
Products excluded from BlueCard

The following claims are excluded from the BlueCard Program:

- Standalone dental
- Vision delivered through an intermediary model (using a vendor)
- Self-administered prescription drugs delivered through an intermediary model (using a vendor)
- The Federal Employee Program (FEP)

Note: Please follow CareFirst billing guidelines when submitting BlueCard claims.

How the BlueCard Program Works



In the example above, a member has PPO coverage through BlueCross BlueShield of Tennessee. There are two scenarios where that member might need to see a provider in another plan's service area, in this example, Maryland:

- If the member was traveling in Maryland.

- If the member resided in Maryland and had employer-provided coverage through BlueCross BlueShield of Tennessee.

In either scenario, the member can obtain the names and contact information for BlueCard PPO providers in Maryland by calling the BlueCard Access Line at 800-810-BLUE (2583). The member can also obtain information on the Internet, using the BlueCard National Doctor and Hospital Finder available at www.bcbs.com.

Note: Members are not obligated to identify participating providers through either of these methods, but they are responsible for going to a PPO provider if they want to access PPO in-network benefits.

When the member makes an appointment and/or sees a Maryland BlueCard PPO provider, the provider may verify the member's eligibility and coverage information via the BlueCard Eligibility Line at 800-676-BLUE (2583) or by using CareFirst Direct. The provider also may obtain this information via a Health Insurance Portability and Accountability Act (HIPAA) electronic eligibility transaction if the provider has established electronic connections for such transactions with the local Plan, CareFirst.

After rendering services, the provider in Maryland files a claim locally with CareFirst. CareFirst forwards the claim to BlueCross BlueShield of Tennessee and adjudicates the claim according to the member's benefits and the provider's arrangement with CareFirst. When the claim is finalized, BlueCross BlueShield of Tennessee issues an explanation of benefit (EOB) to the member, and CareFirst issues the explanation of payment or remittance advice to its provider and pays the provider.

How to identify members: member ID cards

When members of Blue Plans arrive at your office or facility, be sure to ask them for their current Blue Plan membership identification card.

The main identifier for out-of-area members is the prefix. The ID cards may also have a:

- PPO in a suitcase logo, for eligible PPO members.
- PPOB in a suitcase logo, for PPO members with access to the BlueCard PPO Basic network.
- Blank suitcase logo.
- An BlueHPN in a suitcase logo with the Blue High Performance Network℠ (BlueHPN℠) name in the upper right or lower left corner, for BlueHPN EPO members.

Important facts concerning member IDs:

- A correct member ID number includes the prefix (first three positions) and all subsequent characters, up to 17 positions total. This means that you may see cards with ID numbers between 6 and 14 numbers/letters following the prefix.
- Do not add/delete characters or numbers within the member ID.
- Do not change the sequence of the characters following the prefix.
- The prefix is critical for the electronic routing of specific HIPAA transactions to the appropriate Blue Plan.
- Members who are part of the FEP will have the letter "R" in front of their member ID number.

Examples of ID numbers:

ABC1234567 — Alpha Prefix

ABC1234H567 — Alpha Prefix

ABC12345678901234 — Alpha Prefix

As a provider servicing out-of-area members, you may find the following tips helpful:

- Ask the member for the most current ID card at every visit. Since new ID cards may be issued to members throughout the year, this will ensure you have the most up-to-date information in the member's file.
- Verify with the member that the ID number on the card is not their Social Security Number. If it is, call the BlueCard Eligibility line 800-676-BLUE (2583) to verify the ID number.
- Make copies of the front and back of the member's ID card and pass this key information on to your billing staff.
- Remember that member ID numbers must be reported exactly as shown on the ID card and must not be changed or altered. Do not add or omit any characters from the member ID numbers.

Remember: Member ID numbers must be reported exactly as shown on the ID card and must not be changed or altered. Do not add or omit any characters from the member ID numbers.

How to identify members: prefix

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

To ensure accurate claim processing, capture all ID card data. If the information is not captured correctly, you may experience a delay with claim processing. Do **not** make up prefixes.

Note: Do not assume that the member's ID number is their social security number. All Blue Plans replaced social security numbers on member ID cards with an alternate, unique identifier. A sample ID card is listed below.

BlueCard ID Cards have a suitcase logo, either as an empty suitcase or as a PPO in a suitcase or an BlueHPN in a suitcase.

The PPO in a suitcase logo indicates that the member is enrolled in either a PPO product or an EPO product. In either case, you will be reimbursed according to CareFirst's PPO provider contract.

Please note: EPO products may have limited benefits out-of-area. You can find any benefit limits on the back of the EPO ID card.

The PPOB in a suitcase logo indicates that the member has selected a PPO or EPO product, from a Blue Plan, and the member has access to a new PPO network, referred to as BlueCard PPO Basic. Providers will be reimbursed for covered services in accordance with your CareFirst contract.

The empty suitcase logo indicates that the member is enrolled in one of the following products: Traditional, HMO or POS. For members having traditional or HMO coverage, you will be reimbursed according to your CareFirst contract.

Some Blue ID cards don't have any suitcase logo on them:

- The ID cards for Medicaid.
- SCHIP, if administered as part of State's Medicaid.
- Medicare Complementary and Supplemental products, also known as Medigap.

Government-determined reimbursement levels apply to these products.

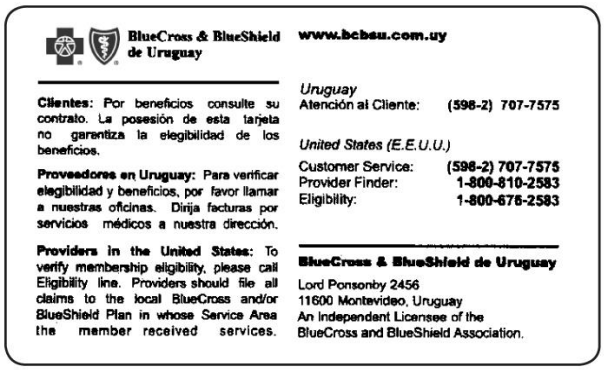
While CareFirst routes all these claims for out-of-area members to the member's Blue Plan, most of the Medicare Complementary or Medigap claims are sent directly from the Medicare intermediary to the member's plan via the established electronic crossover process.

How to identify international members

Occasionally, you may see identification cards that are from members of international licensees or that are for international-based products. International Licensees products are provided through GeoBlue® and the Blue Cross Blue Shield Global Core portfolio; however, always check with CareFirst as the list of international licensees and products may change.

ID cards from these licensees and for these products will also contain three-character prefixes and may or may not have one of the benefit product logos referenced in the following sections. Please treat these members the same as you would domestic Blue Plan members (e.g., do not collect any payment from the member beyond cost-sharing amounts such as deductible, coinsurance and copayment) and file their claims to CareFirst. See below for sample ID cards for international members and products.

Example of an ID card from an international licensee:



Examples of ID cards for international products

Illustration A – GeoBlue:

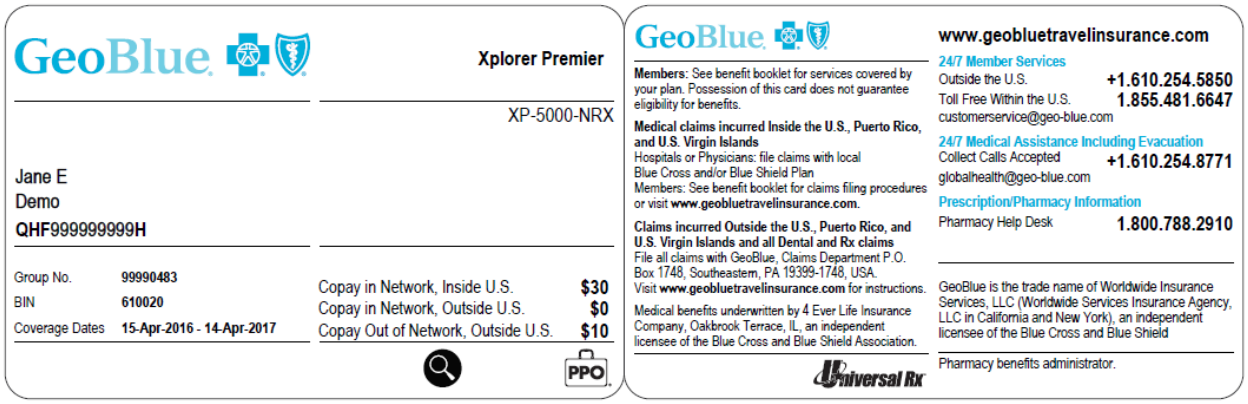


Illustration B – BlueCross BlueShield Global Core portfolio:

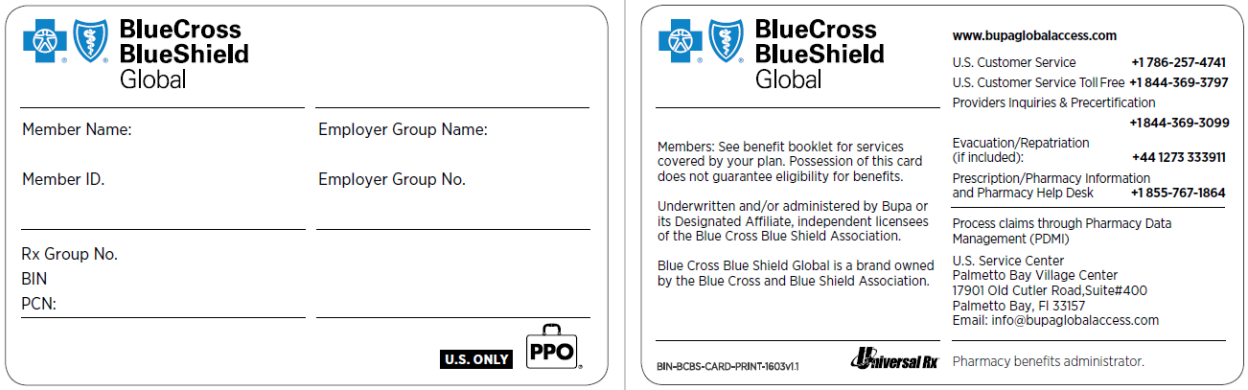
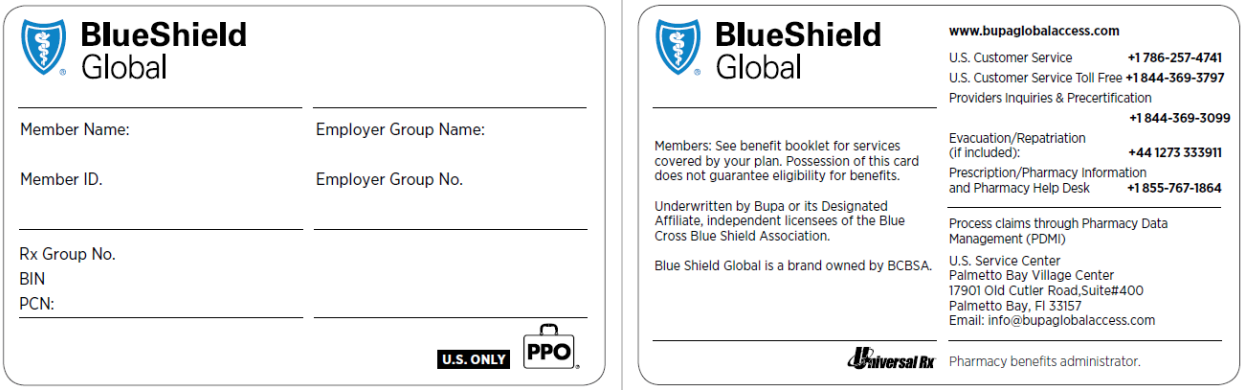


Illustration C – Shield-only ID card:



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

Canadian ID cards

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

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

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

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

Source: http://www.blucross.ca/en/contact.html

Consumer Directed Healthcare and healthcare debit cards

Consumer Directed Healthcare (CDHC) is a term that refers to a movement in the healthcare industry to empower members, reduce employer costs and change consumer healthcare purchasing behavior.

Health plans that offer CDHC provide the member with additional information to make an informed and appropriate healthcare decision using member support tools, provider and network information and financial incentives.

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

Some cards are stand-alone debit cards that cover eligible out-of-pocket costs, while others also serve as a health plan member ID card. These debit cards can help you simplify your administration process and can potentially help:

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

In some cases, the card will display the Blue Cross and Blue Shield trademarks, along with the logo from a major debit card such as MasterCard® or Visa®.

Below is a sample stand-alone healthcare debit card:

Below is a sample combined healthcare debit card and member ID card:

The cards include a magnetic strip allowing providers to swipe the card to collect the member's cost-sharing amount (i.e., copayment). With healthcare debit cards, members can pay for copayments and other out-of-pocket expenses by swiping the card though any debit card swipe terminal. The funds will be deducted automatically from the member's appropriate HRA, HSA or FSA account.

Helpful Tips:

- Using the member's current member ID number, including the prefix, carefully determine the member's financial responsibility before processing payment. Check eligibility and benefits electronically through CareFirst Direct or by calling 800-676-BLUE (2583).
- All services, regardless of whether you've collected the member responsibility at the time of service, must be billed to CareFirst for proper benefit determination and to update the member's claim history.
- Please do not use the card to process full payment up front. If you have any questions about the member's benefits, please contact 800-676-BLUE (2583). For questions about the healthcare debit card processing instructions or payment issues, please contact the toll-free debit card administrator's number on the back of the card.

Limited benefits products

Verifying Blue patients' benefits and eligibility is important, now more than ever, since new products and benefit types entered the market. Patients may have traditional Blue PPO, HMO, POS or other coverage,

typically with high lifetime coverage limits (i.e., $1million or more), and you may now see patients whose annual benefits are limited to $50,000 or less.

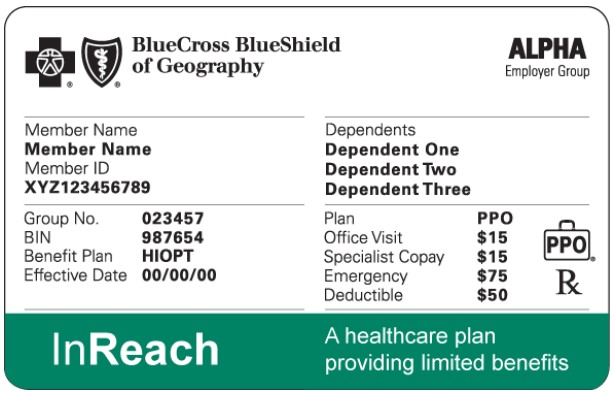
Currently CareFirst doesn't offer such limited benefit plans to our members; however, you may see patients with limited benefits who are covered by another Blue Plan.

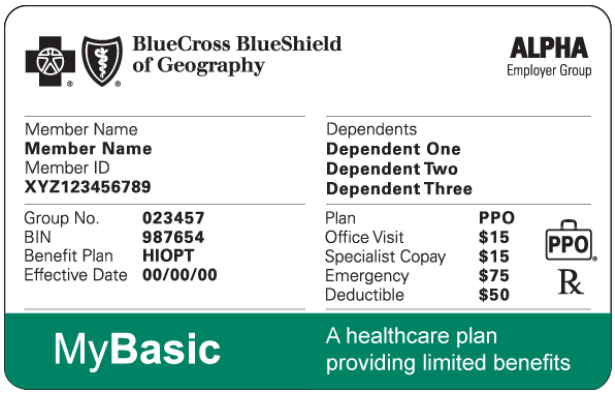
How to recognize members with limited benefits products

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

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

An example is listed below:





How to find out if the patient has limited benefit coverage

In addition to obtaining a copy of the patient's ID card, and regardless of the benefit product type, we recommend that you verify patient's benefits and eligibility and collect any patient liability.

You may do so electronically by using CareFirst Direct eligibility inquiry or may call the 800-676-BLUE (2583) eligibility line for out-of-area members.

Both electronically and via phone, you will receive patient's accumulated benefits to help you understand the remaining benefits left for the member.

Use these helpful tips below to verify the patient's benefits:

- In addition to obtaining a copy of the member's ID card, regardless of the benefit product type, always verify eligibility and benefits electronically with CareFirst Direct or by calling 800-676-BLUE (2583). You will receive the member's accumulated benefits to help you understand their remaining benefits.
- If the cost of service extends beyond the member's benefit coverage limit, please inform your patient of any additional liability they might have.
- If you have questions regarding a Blue Plan's limited benefits ID card/product, please contact CareFirst.

If the cost of services extends beyond the patient's benefit coverage limit, inform the patient of any additional liability they might have.

What should I do if the patient's benefits are exhausted before the end of their treatment?

Annual benefit limits should be handled in the same manner as any other limits on the medical coverage. Any services beyond the covered amounts of the number of treatments are the member's liability.

Who do I contact if I have additional questions about Limited Benefit Plans?

If you have any questions regarding Limited Benefits Products, contact CareFirst. You can find our contact information in the Provider Quick Reference Guide.

Coverage and eligibility verification

For BlueCard members, submit an electronic inquiry through CareFirst Direct or call BlueCard Eligibility 800-676-BLUE (2583) to verify the patient's eligibility and coverage:

- CareFirst Direct: You can receive real-time responses to your eligibility requests for out-of-area members between 6:00 a.m. and Midnight CDT, Monday through Saturday.
- Phone: Call BlueCard Eligibility 800-676-BLUE (2583)
  - English and Spanish speaking phone operators are available to assist you.
  - Blue Plans are located throughout the country and may operate on a different time schedule than CareFirst. You may be transferred to a voice response system linked to customer enrollment and benefits outside that plan's regular business hours.
  - The BlueCard Eligibility line is for eligibility, benefit and pre- authorization inquiries only. It should not be used for claim status. See the Claims Filing section for claim filing information.

Utilization review

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

Participating providers must:

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

General information on pre-authorization/pre-certification information can be found on the Out-of-Area member Medical Policy and Pre-Authorization/Pre-Certification Router at carefirst.com/preauth utilizing the three-letter prefix found on the member ID card.

You may also contact the member's plan on the member's behalf. You can do so by:

- Calling BlueCard Eligibility 800-676-BLUE (2583) and asking to be transferred to the utilization review area.
  - When pre-authorization/pre-certification for a specific member is handled separately from eligibility verifications at the member's Blue Plan, your call will be routed directly to the area that handles pre-authorization/pre-certification. You will choose from four options depending

on the type of service for which you are calling (Medical/Surgical, Behavioral Health, Diagnostic Imaging/Radiology and Durable/Home Medical Equipment and Supplies (D/HME)).

- If you are inquiring about both eligibility and pre-authorization/pre-certification through 800-676-BLUE (2583), your eligibility inquiry will be addressed first. Then you will be transferred, as appropriate, to the pre-authorization/pre-certification area.

- Submit an electronic pre-authorization request through CareFirst Direct.
- The member's Blue Plan may contact you directly regarding clinical information and medical records prior to treatment or for concurrent review or disease management for a specific member.

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

Electronic provider access

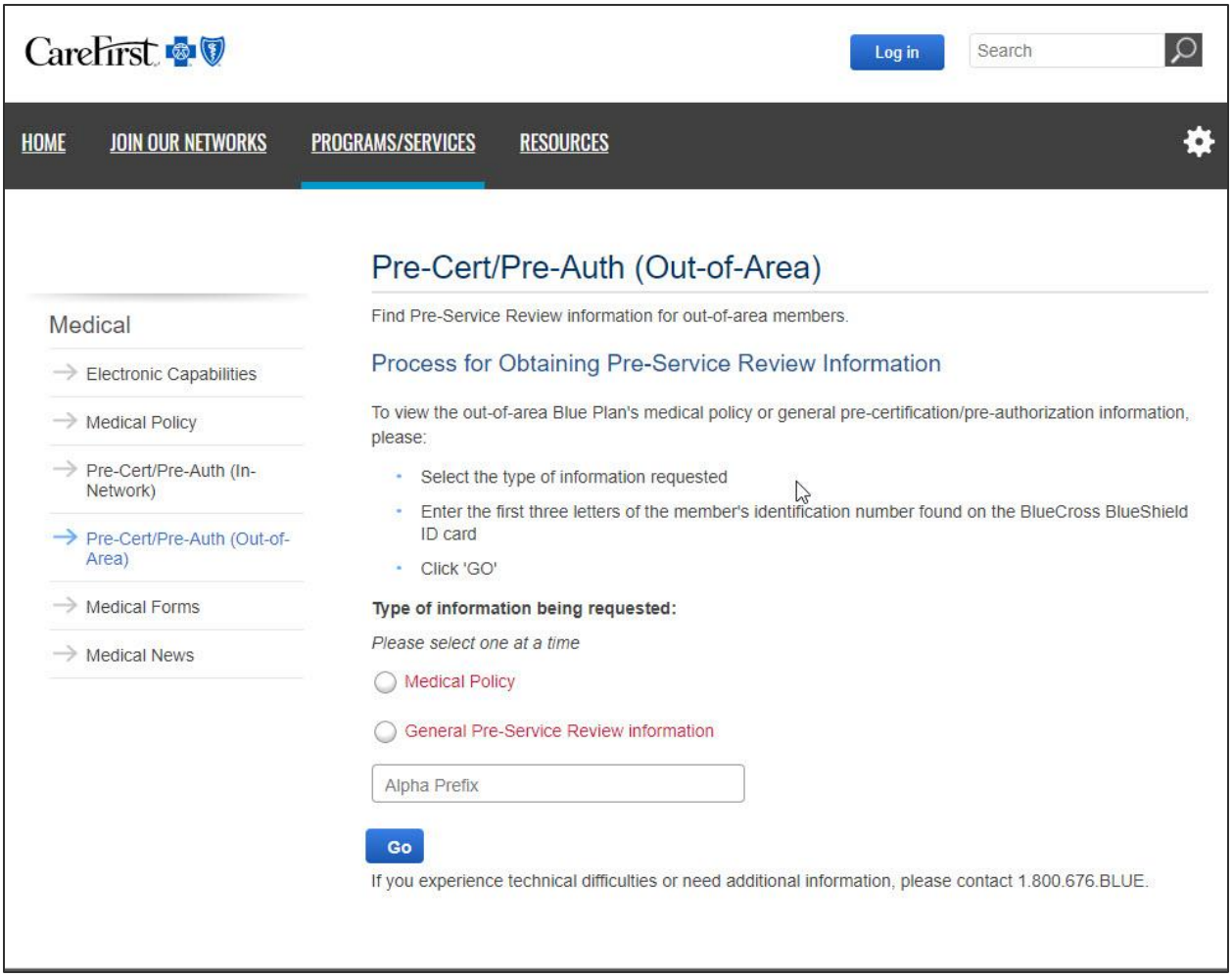
Electronic Provider Access (EPA) gives providers the ability to access out-of-area member's Blue Plan (Home Plan) provider portals to conduct electronic pre-service review. The term pre-service review is used to refer to pre-notification, pre-certification, pre-authorization and prior approval, amongst other pre-claim processes.

EPA enables providers to use their local Blue Plan provider portal (CareFirst Direct) to gain access to an out-of-area member's Home Plan provider portal, through a secure routing mechanism. Once in the Home Plan provider portal, the out-of-area provider has the same access to electronic pre-service review capabilities as the Home Plan's local providers.

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

Using the EPA Tool

The first step for providers is to go to CareFirst Direct and log-in. Then select the menu option, ***Pre-Service Review for Out-of-Area Members (includes notification, pre-certification, pre-authorization and prior approval.)***



Next, you will be asked to enter the prefix from the member's ID card. The prefix is the first three characters that precede the member ID.

Note: You can first check whether pre-certification is required by the Home Plan by either:

- Sending a service-specific request through CareFirst Direct.
- Accessing the Home Plan's pre-certification requirements pages by using the medical policy router as noted above.

Entering the member's prefix from the ID card automatically routes you to the Home Plan EPA landing page. This page welcomes you to the Home Plan portal and indicates that you have left CareFirst's portal. The landing page allows you to connect to the available electronic pre-service review processes. Because the screens and functionality of the Home Plan pre-service review processes vary widely, Home Plans may include instructional documents or e-learning tools on the Home Plan landing page to guide you through conducting an electronic pre-service review. The page also includes instructions for conducting pre-service review for services where the electronic function is not available.

The Home Plan landing page may look similar across Home Plans but will be customized to the particular Home Plan based on the electronic pre-service review services they offer.

Provider financial responsibility for pre-service review for BlueCard members

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

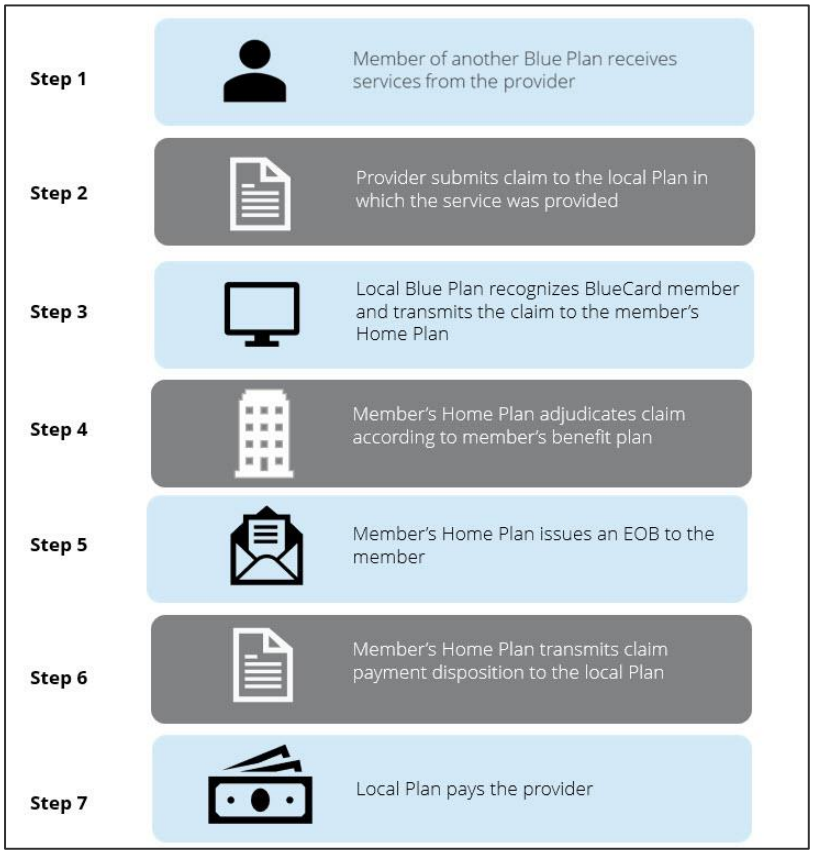
- Notify the member's Blue Plan within 48 hours when changes or modifications to the original pre-service review occurs
- Obtain pre-service review for emergency and/or urgent admissions within 72 hours.

Failure to contact the member's Blue Plan for pre-service review or for a change or modification of the pre-service review will result in a penalty or denial of the claim information for in-patient facility services. The BlueCard member must be held harmless and cannot be balance-billed if required pre-service review has not occurred, unless the member signed a written consent to be billed prior to rendering the service.

Claims Filing

How claims flow through BlueCard

Below is an example of how claims flow through BlueCard:



After the member of another Blue Plan receives services from you, file the claim with CareFirst. We will work with the member's plan to process the claim, and the member's plan will send an EOB to the member. We will send you an explanation of payment or the remittance advice and issue the payment to you under the terms of our contract and based on the members benefits and coverage.

Use these helpful tips to improve your claim experience:

- Ask members for their current member ID card and regularly obtain new photocopies of it (front and back). Having the current card enables you to submit claims with the appropriate member information (including prefix) and avoid unnecessary claims payment delays.
- Check eligibility and benefits electronically through CareFirst Direct or by calling 800-676-BLUE (2583). Be sure to provide the member's prefix.
- Verify the member's cost sharing amount before processing payment. Please do not process full payment upfront.
- Indicate any payment you collected from the patient on the claim.
    - On the 837 electronic claim submission form check field AMT01=F5 patient paid amount; on the CMS 1500 locator 29 amount paid; on UB92 locator 54 prior payment; on UB-04 locator 53 prior payment.
- Submit all Blue claims to CareFirst. Be sure to include the member's complete ID number when you submit the claim. This includes the three-character prefix. Submit claims with only valid prefixes; claims with incorrect or missing prefixes and member ID numbers cannot be processed.
- Do not send duplicate claims. Sending another claim, or having your billing agency resubmit claims automatically, slows down the claims payment process and creates confusion for the member.
- Check claims status by using CareFirst Direct.

Medicare Advantage claims: overview

Medicare Advantage (MA), also known as Medicare Part C, is the program alternative to standard Medicare Part A and Part B fee-for-service coverage, generally referred to as Traditional Medicare.

MA offers Medicare beneficiaries several product options (like those available in the commercial market), including HMO, PPO, POS and private fee-for-service (PFFS) plans.

All MA plans must offer beneficiaries at least the standard Medicare Part A and B benefits, but many offer additional covered services as well (e.g., enhanced vision and dental benefits).

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

MA plans may allow in- and out-of-network benefits, depending on the type of product selected. Providers should confirm the level of coverage — by calling 800-676-BLUE (2583) or submitting an electronic inquiry — for all MA members prior to providing service, since the level of benefits, and coverage rules, may vary depending on the MA plan.

Below are the types of MA Plans:

Medicare Advantage HMO

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

Medicare Advantage POS

An MA POS program is an option available through some Medicare HMO programs. It allows members to determine — at the point of service — whether they want to receive certain designated services within

the HMO system or seek such services outside the HMO's provider network (usually at greater cost to the member). The MA POS plan may specify which services will be available outside of the HMO's provider network.

Medicare Advantage PPO

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

Blue MA PPO members have in-network access to Blue MA PPO providers.

Medicare Advantage PFFS

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

The MA Organization, rather than the Medicare program, pays for services rendered to such members. Members are responsible for cost-sharing, as specified in the plan, and balance-billing may be permitted in limited instances where the provider is a network provider, and the plan expressly allows for balance billing.

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

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

Medicare Advantage Medical Savings Account (MSA)

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

Ancillary claims

Ancillary providers include Independent Clinical Laboratory (Lab), D/HME and Specialty Pharmacy providers. File claims for these providers as follows and refer to the detailed claims filing charts here:

- Independent Clinical Lab
    - The plan whose state the specimen was drawn based on the location of the referring provider.

- D/HME
  - The plan in whose state the equipment was shipped to or purchased at a retail store.
- Specialty Pharmacy
  - The plan in whose state the ordering physician is located.

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

- The ancillary claim filing rules apply regardless of the provider's contracting status with the Blue Plan where the claim is filed.
- Providers are encouraged to verify member eligibility and benefits by contacting the phone number on the back of the member ID card or calling 1-800-676-BLUE (2583), prior to providing any ancillary service.
- Providers that utilize outside vendors to provide services (ex. sending blood specimen for special analysis that cannot be done by the lab where the specimen was drawn) should utilize in-network participating ancillary providers to reduce the possibility of additional member liability for covered benefits. You can find a list of in-network participating providers online by using the Find a Doctor Tool.

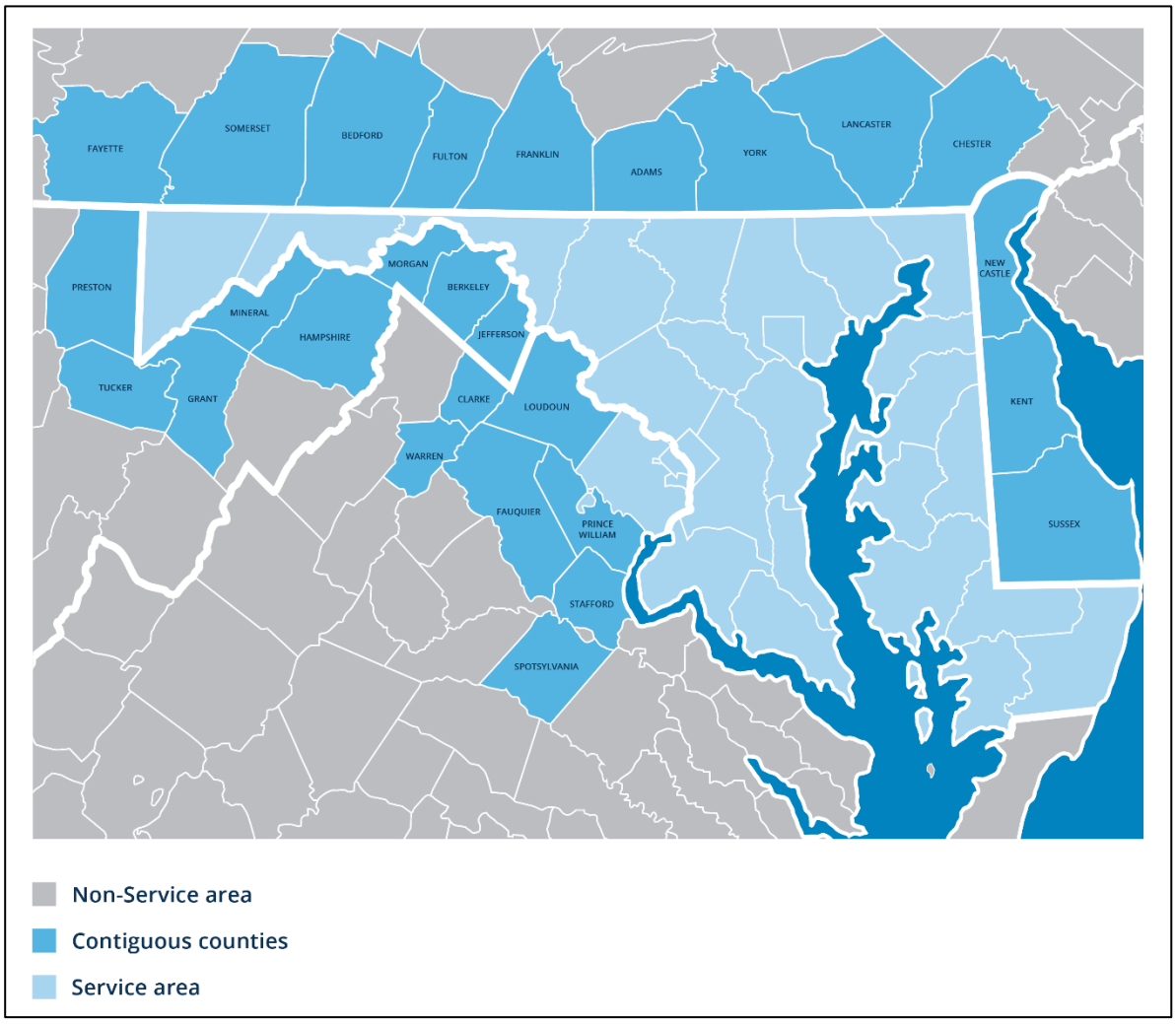
Air ambulance claims

Claims for air ambulance services must be filed to the Blue Plan where the point of pickup ZIP code is located.

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

- The air ambulance claims filing rules apply regardless of the provider's contracting status with the Blue Plan where the claim is filed.
- Where possible, providers are encouraged to verify member eligibility and benefits by contacting the phone number on the back of the member ID card or calling 800-676-BLUE (2583).
- Providers are encouraged to utilize in-network participating air ambulance providers to reduce the possibility of additional member liability for covered benefits. You can find a list of in-network participating providers online by using the Find a Doctor Tool.
- Members are financially liable for air ambulance services not covered under their benefit plan. If is the provider's responsibility to request payment directly from the member for non-covered services.

Contiguous counties/overlapping service areas



Contiguous Counties

Claims filing rules for contiguous area providers are based on the permitted terms of the provider contract, which may include:

- Provider location (i.e., which plan service area is the providers office located).
- Provider contract with the two contiguous counties (i.e., is the provider contracted with only one or both service areas).
- The member's home plan and where the member works and resides (i.e., is the member's home plan with one of the contiguous counties plans).
- The location of where the services were received (i.e., does the member work and reside in one contiguous county and see a provider in another contiguous county).

Overlapping service areas

Submitting claims in overlapping service areas is dependent on what plan(s) the provider contracts within that state, the type of contract the provider has (ex. PPO, traditional) and the type of contract the member has with their Home Plan.

- If you contract with all local Blue Plans in your state for the same product type (i.e., PPO or Traditional), you may file an out-of-area Blue Plan member's claim with either plan.
- If you have a PPO contract with one Blue Plan, but a traditional contract with another Blue Plan, file the out-of-area Blue Plan member's claim by product type.
    - For example, if it's a PPO member, file the claim with the plan that has your PPO contract.
- If you contract with one plan but not the other, file all out-of-area claims with your contracted plan.

Medical records

Blue Plans have made many improvements to the medical records process to make it more efficient and are able to send and receive medical records electronically with other Blue Plans. This method significantly reduces the time it takes to transmit supporting documentation for our out-of-area claims, reduces the need to request records multiple times and significantly reduces lost or misrouted records.

Under what circumstances may the provider get requests for medical records for out-of-area members?

- As part of the pre-authorization process — if you receive requests for medical records from other Blue Plans prior to rendering services, you will be instructed to submit the records directly to the member's plan that requested them. This is the only circumstance where you would not submit them to CareFirst.
- As part of claim review and adjudication — these requests will come from CareFirst in the form of a letter, fax, email or electronic communication requesting specific medical records and include instructions for submission.

BlueCard medical record process for claim review

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

Helpful ways you can assist in timely processing of medical records

- If the records are requested following submission of the claim, forward all requested medical records to CareFirst.
- Follow the submission instructions given on the request, using the specified physical or email address or fax number. The address or fax number for medical records may be different than the address you use to submit claims.
- Include the cover letter you received with the request when submitting the medical records. This is necessary to make sure the records are routed properly once received by CareFirst.
- Please submit the information to CareFirst as soon as possible to avoid further delay.
- Only send the information specifically requested. Frequently, complete medical records are not necessary.
- Please do not proactively send medical records with the claim. Unsolicited claim attachments may cause claim payment delays.

Adjustments

Contact CareFirst if an adjustment is required. We will work with the member's Blue Plan for adjustments; however, your workflow should not be different.

Appeals

Appeals for all claims are handled through CareFirst. We will coordinate the appeal process with the member's Blue Plan, if needed.

Claim payment

- If you have not received payment for a claim, do not resubmit the claim because it will be denied as a duplicate. This will cause member confusion because of multiple EOBs. CareFirst's standard time for claims processing is 30 days from the date of receipt or sooner. However, claim processing times at various Blue Plans vary.
- If you do not receive your payment or a response regarding your payment, please check CareFirst Direct or CareFirst on Call to check the status of your claim.
- In some cases, a member's Blue Plan may pend a claim because medical review or additional information is necessary. When resolution of a pended claim requires additional information from you, CareFirst may ask you for the information or give the member's plan permission to contact you directly.

Claim status inquiry

CareFirst is your single point of contact for all claim inquiries. Claim status inquiries can be done by utilizing CareFirst Direct or CareFirst on Call.

Calls from members and others with claim questions

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

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

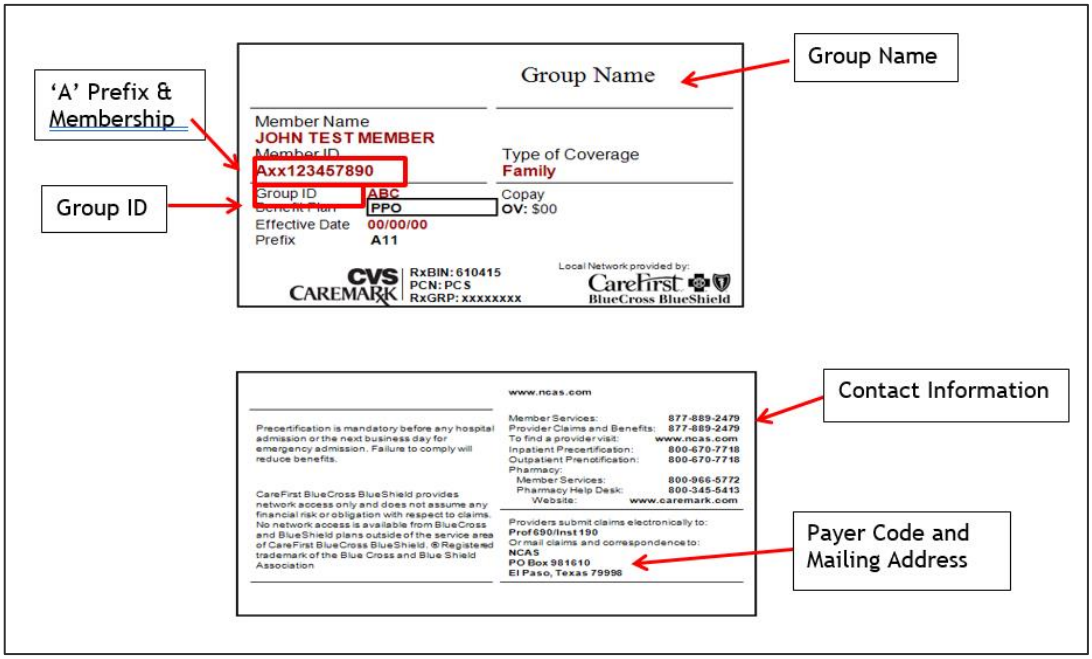
Network Lease/Third Party Administrators

Network Lease

CareFirst jointly administers, with third-party administrators (TPAs), self-insured employers, and health and welfare funds, the Network Lease claims product. This product enables employers to utilize the CareFirst network of providers while still being able to design and administer their health benefits. CareFirst is actively involved and responsible for collecting and pricing claims, training and maintenance of the provider networks. The TPAs are responsible for issuing ID cards, handling claims adjudication, benefit and claims inquiries, correspondence, appeals, etc. Participating providers agree to accept the CareFirst allowance as payment in full for services rendered, less any deductibles and coinsurance amounts.

Member identification

The member will have a unique ID card with the CareFirst logo and the logo of the group (self-insured employer or health and welfare fund). The prefix on the ID card begins with an "A" followed by two numeric characters. EOBs, checks and vouchers will usually have the CareFirst logo and the logo of the group (self-insured employer or health and welfare fund).



Claims submission

Providers should submit claims electronically following the instructions that appear on the reverse side of the member's ID card.

Electronic claims

- Should be submitted to CareFirst.
- Professional providers should use payer code 580.
- Institutional providers should use payer code 190.

The above payer codes should be used for submission of claims for all members with an "A" prefix. Contact your clearinghouse for specific details on how to submit the payer code correctly. Some clearinghouses may use a different format that is then translated and sent to CareFirst.

Paper claims

- Should be submitted to the TPA using the address on the back of the ID card.
- The address will differ for each TPA.
- The member's "A" prefix should be included on the claim form along with the member's ID number in the following locations:
  - Professional claims submitted on a HCFA 1500 – Box 1a.
  - Institutional claims submitted on a UB-04 – Field 60.
- The member's group number should be included in the following locations:
  - Professional claims submitted on a HCFA 1500 – Box 11.
  - Institutional claims submitted on a UB04 – Field 62.

Correspondence

Correspondence should be submitted directly to the TPA using the address on the back of the member's ID card. This address will differ for each TPA.

Claim status and service inquiries

To obtain information about benefits, claim status, claim adjudication, deductibles or coinsurance:

- Contact the TPA's phone number on the back of the member's ID card, or
- Refer to the CareFirst TPA Prefix List for contact information.

Note: National Claims Administrative Services network lease groups (A11) should refer to www.ncas.com or the back of the member's ID card for contact information.

CFA, LLC dba CareFirst Administrators and National Claims Administrative Services

CFA, LLC dba CareFirst Administrators

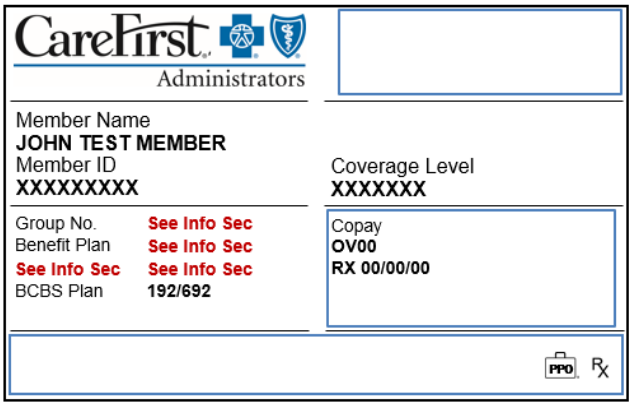
CFA, LLC dba CareFirst Administrators is a wholly owned subsidiary of CareFirst, Inc. CFA is Blue-Branded and operates under an independent license from the BCBSA. CFA provides administrative services to self-funded employer groups whose plans are governed by the Employee Retirement Income Security Act of 1974. This allows members to take advantage of local plan networks for out-of-area services. Products are customized using the BCBS national network of providers.

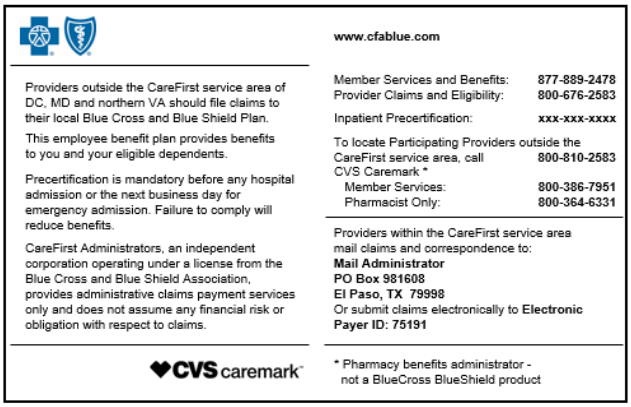
CFA provides administrative services only and does not assume any financial risk or obligation with respect to healthcare benefit claims for the self-insured portion of the plan. Though CFA offers access to the CareFirst provider network, specific requirements of member's health benefits vary and may differ than the procedures outlined in this manual.

For specific patient eligibility and benefit information, CFA offers a member health ticket online. Providers should refer to this information for details on their patient. The health ticket includes some of the member's responsibilities such as their copays, deductibles, out-of-pocket and retail pharmacy amounts. The member health tickets for CFA members can be located by accessing www.cfablue.com or https://www.cfacustomer.com/Default.asp.

CFA also has an interactive voice response system (IVR), 877-889-2478 that providers can access for patient benefits, eligibility and claims information. Providers can also use CareFirst Direct or CareFirst on Call for eligibility and claim status.

CFA members' identification cards carry the CFA logo. Contact information for claims and correspondence is listed on the back of the card.





Claims should be submitted electronically using payer code 75191. Correspondence and paper claims should be submitted to:

CareFirst Administrators
P.O. Box 981608
El Paso, TX 79998

For more information, refer to www.cfablue.com.

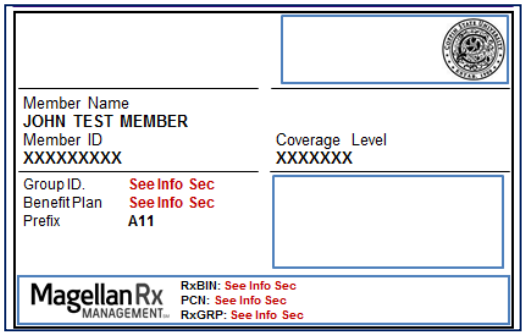
NCAS

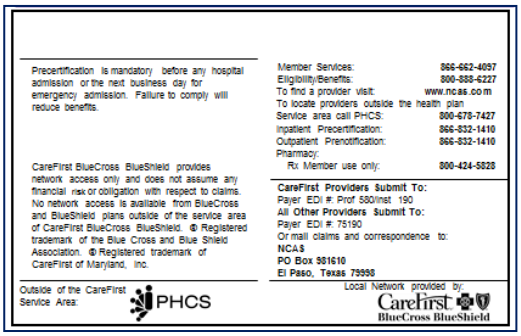
National Claims Administrative Services (NCAS) is part of CFA, LLC dba CareFirst Administrators. NCAS is a non-blue branded national TPA for companies headquartered throughout the United States with members who have access to the CareFirst provider network. CareFirst shares administrative duties with the employer groups or TPA.

NCAS is responsible for benefits eligibility and claims processing. For specific patient eligibility and benefit information, NCAS offers a member health ticket online. Providers should refer to this information for details on their patient. The member health tickets for NCAS members can be located by accessing www.ncas.com or at https://www.ncascustomer.com/Default.asp.

NCAS has an IVR, 877-889-2479, that providers can access for patient benefits, eligibility and claims information. NCAS membership information is not available through the CareFirst Direct portal.

CFA members' ID cards will have a dual logo that shows both CareFirst and the TPA. Contact information and mailing addresses are listed on the back of the card.





Claims for NCAS should be submitted electronically using payer code 580 for professional claims and payer code 190 for institutional claims. Correspondence and paper claims should be mailed to:

NCAS
P.O. Box 981610
El Paso, TX 79998

For more information, visit www.NCAS.com.