BlueCross BlueShield of Illinois

Blue Cross Medicare Advantage HMO Non-Delegated Model℠

Provider Manual 2025

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation,
a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

June 2025

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Section 1: Welcome to Blue Cross and Blue Shield of Illinois

Blue Cross and Blue Shield of Illinois Medicare Advantage plans are health plans provided by Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an Independent Licensee of Blue Cross and Blue Shield Association. HCSC is a Medicare Advantage Organization (MAO) with a Medicare contract (H3822) with the Centers for Medicare and Medicaid Services (CMS). Enrollment in HCSC's plans depends on contract renewal.

This provider manual applies to providers who have agreed to participate in our MA Health Maintenance Organization (HMO) Non-Delegated network. The relationship of the provider to BCBSIL is that of independent contractor. This provider manual is applicable only to the operation of the MA HMO Non-Delegated network. Provider agrees to comply and will require its providers to comply through a written agreement, with all terms and conditions of this provider manual.

Providers that are contracted with one of the participating IPAs or Individually Contracted Providers are eligible to participate in the MA HMO Non-Delegated network.

The provider manual explains the policies and procedures of BCBSIL. It provides you and your office staff with helpful information as you serve MA HMO Non-Delegated members. The information is intended to provide guidance for some of the situations your office will encounter while participating in the MA HMO Non-Delegated network.

Refer to the glossary of terms for certain definitions of capitalized terms used in this provider manual.

This MA HMO Non-Delegated plan maintains and monitors a network of providers, including medical groups, physicians, hospitals, skilled nursing facilities, ancillary and other healthcare providers including Individually contracted providers through which members obtain covered services. The MA HMO Non-Delegated plan is for Medicare beneficiaries who are not eligible for a dual care special needs plan.

Members who select our HMO Plan are required to designate a Primary Care Physician, or one will be selected for them. Members of our MA HMO Plan with a non-delegated PCP may self-refer to specialty care participating providers.

Section 2: General Information

Eligibility and Benefits
Eligibility and benefits for members should be verified prior to every scheduled appointment. Eligibility and benefit quotes include membership verification, coverage status and other important information, such as applicable copayment, coinsurance, and deductible amounts. Every member will be supplied with an appropriate identification card and the provider shall be responsible for verifying the identity of the member (e.g., government issued photo identification or other proof of identity). The identity of the member must be verified each time services are provided. When services may not be covered, before services are rendered, members must be notified by you and provide consent to you in writing that they may be billed directly by you if non-covered benefit and elective service is rendered. If services rendered are denied for medical necessity, the member is not liable for payment of those services and cannot be billed for payment.

Verification of Coverage
At each office visit, your office staff should:

- Ask for the member's identification (ID) card.
- Copy both sides of the ID card and keep a copy with the patient's file.
- Determine if the Member is covered by another health plan; if so, record information for coordination of benefits purposes.
- Refer to the member's ID card for the appropriate telephone number to verify eligibility, deductible, coinsurance, copayments, and other benefit information or use your preferred vendor to check these items online.
- Inform Members that as a provider, you will recommend that Members be admitted to Participating Providers, including facility and ancillary services, unless an emergency exists that precludes safe access to a participating provider.
- Inform the member that he or she will receive in-network benefits only when services are performed at or by a participating provider.
- Provider office should use best efforts to ensure the provider is referring a member to the BCBSIL network of MA HMO Non-Delegated providers and shall instruct members to check provider participation prior to services being rendered.
- Members may have out of network (OON) benefits; refer to the current Evidence of Coverage (EOC) posted on the BCBSIL website for specific details.

Note: To obtain benefits and eligibility information and/or claims processing status for MA HMO Non-Delegated plans call 877-774-8592 or use your preferred vendor to check these items online.

ID Cards
Each MA HMO Non-Delegated plan member will receive an ID card containing the member's name, ID number, and information about his or her benefits. The 3-digit prefix numbers for the MA HMO Non-Delegated plan include but may not be limited to XOD, JLX or XOJ. For information on vision, dental, hearing, transportation, and fitness providers, providers should advise members to contact the customer service telephone number on the back of their ID cards or visit Blue Access for Members (BAMSM).

MA HMO Non-Delegated ID Card samples:


BlueCross BlueShield of Illinois

Blue Cross Medicare Advantage (HMO-POS)℠

Name: SAMPLECARD
ID: XOJ123456789
Plan (80840): 9101000211

Office Visit: $
Specialist: $
Emergency Room: $

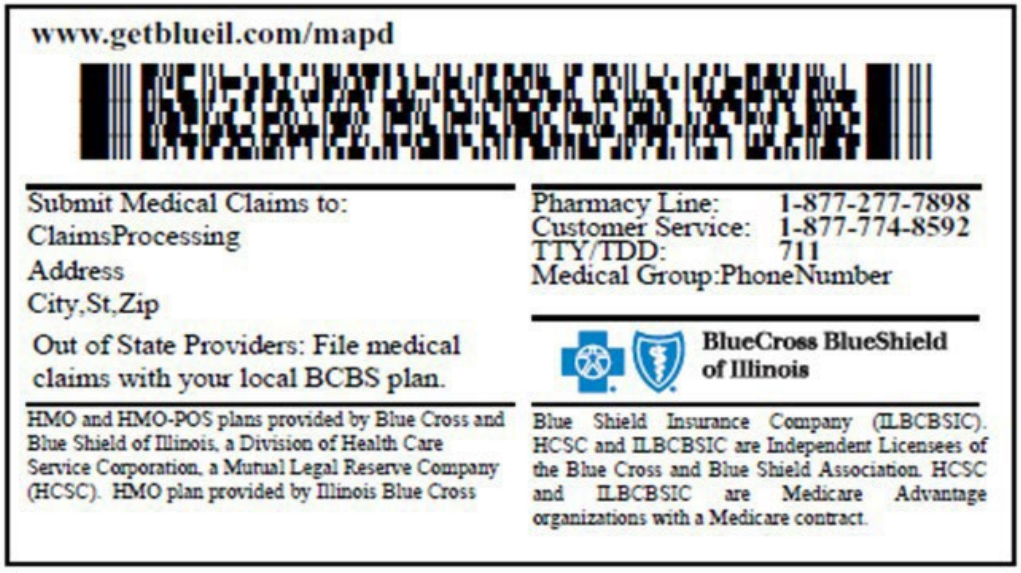
RxBin: RXBIN
RxPCN: RXPCN
RxGrp: RXGROUP
RxID: RXID

Plan:Blue Cross Medicare Advantage Basic Plus(HMO-POS)

PCP: JohnSmithMD
PCP Phone #: 1-312-123-4567

H3822 007

MEDICARE ADVANTAGE POS MedicareRx Prescription Drug Coverage


www.getblueil.com/mapd

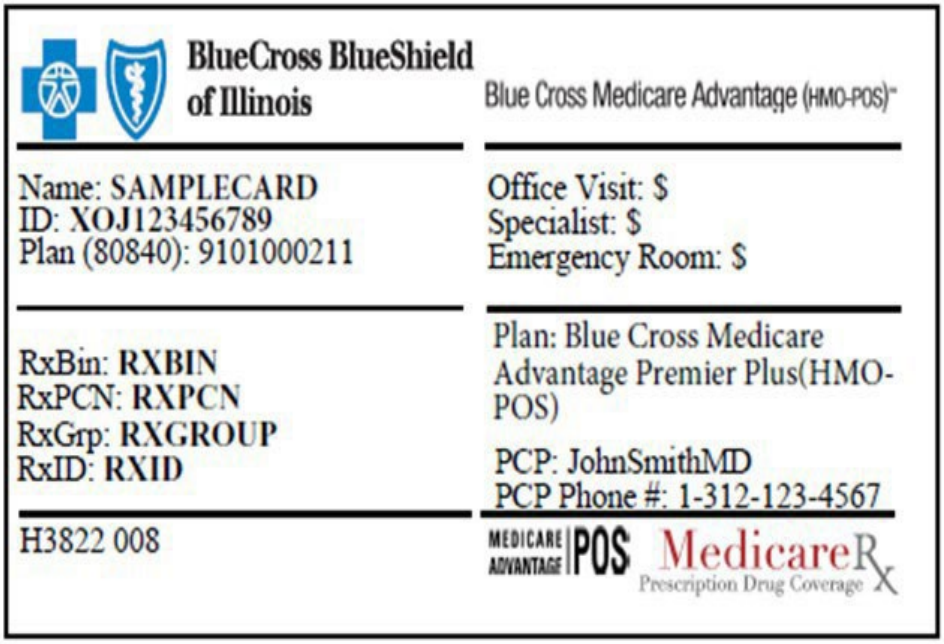
Submit Medical Claims to:
ClaimsProcessing
Address
City,St,Zip

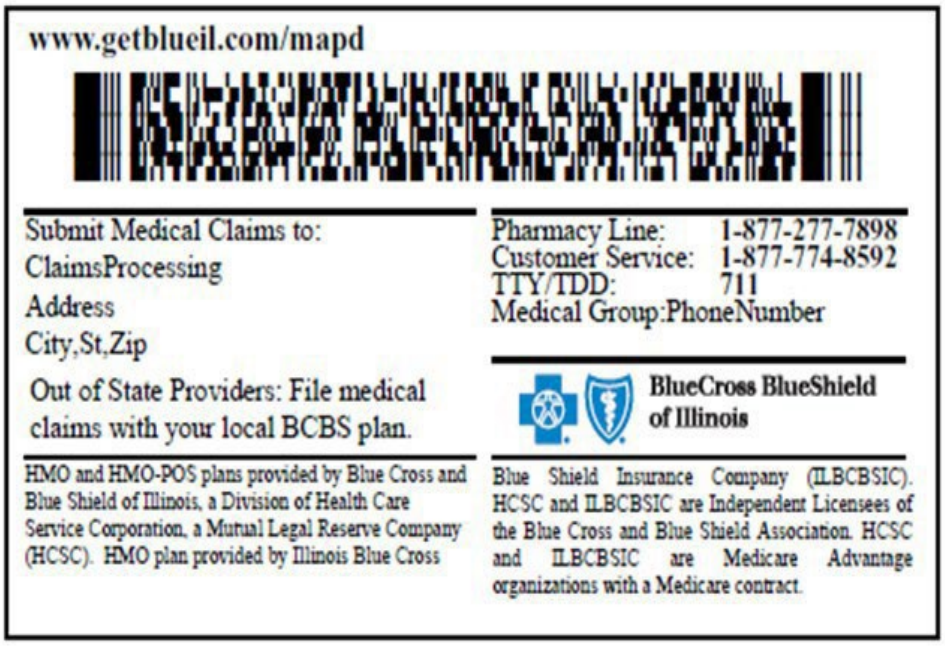
Out of State Providers: File medical claims with your local BCBS plan.

Pharmacy Line: 1-877-277-7898
Customer Service: 1-877-774-8592
TTY/TDD: 711
Medical Group:PhoneNumber

BlueCross BlueShield of Illinois

HMO and HMO-POS plans provided by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). HMO plan provided by Illinois Blue Cross Blue Shield Insurance Company (ILBCBSIC). HCSC and ILBCBSIC are Independent Licensees of the Blue Cross and Blue Shield Association. HCSC and ILBCBSIC are Medicare Advantage organizations with a Medicare contract.


BlueCross BlueShield of Illinois
Blue Cross Medicare Advantage (HMO-POS)℠
Name: SAMPLECARD
ID: XOJ123456789
Plan (80840): 9101000211
Office Visit: $
Specialist: $
Emergency Room: $
RxBin: RXBIN
RxPCN: RXPCN
RxGrp: RXGROUP
RxID: RXID
Plan: Blue Cross Medicare Advantage Premier Plus(HMO-POS)
PCP: JohnSmithMD
PCP Phone #: 1-312-123-4567
H3822 008
MEDICARE ADVANTAGE POS
MedicareRx
Prescription Drug Coverage


www.getblueil.com/mapd
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BlueCross BlueShield of Illinois

Blue Cross Medicare Advantage (HMO)*

Name: SAMPLECARD
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Plan (80840): 9101000211

Office Visit: $
Specialist: $
Emergency Room: $

RxBin: RXBIN
RxPCN: RXPCN
RxGrp: RXGROUP
RxID: RXID

Plan: Blue Cross Medicare Advantage Basic (HMO)

PCP: JohnSmithMD
PCP Phone #: 312-123-4567

H3822 012

MEDICARE ADVANTAGE HMO MedicareRx Prescription Drug Coverage

www.getblueil.com/mapd

Submit Medical Claims to:
ClaimsProcessing
Address
City, St,Zip

Pharmacy Line: 1-877-277-7898
Customer Service: 1-877-774-8592
TTY/TDD: 711
Medical Group:Phone Number

Out of State Providers: File medical claims with your local BCBS plan.

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BlueCross BlueShield of Illinois

Blue Cross Medicare Advantage (HMO)™

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H3822 001

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Section 3: Credentialing

Through the credentialing process, we review and validate the professional qualifications of physicians and certain other providers who apply for participation in our networks. This process ensures that providers meet our professional standards.

Credentialing and Recredentialing of Participating Health Care Providers
The Medicare Advantage plans continuously review and evaluate information about participating providers, recredentialing them every three years. The credentialing guidelines are subject to change, based on industry requirements and the Medicare Advantage plans' standards.

Credentialing and Recredentialing of Participating Institutional Providers
The Medicare Advantage plans continuously review and evaluate information about participating Institutional Providers and recertify them every three years. The certification guidelines for credentialing and recredentialing institutions are subject to change, based on industry requirements and the Medicare Advantage plans' standards.

Our credentialing requirements are derived from and in compliance with the State of Illinois and the National Committee for Quality Assurance credentialing standards. Learn more about Credentialing.

Section 4: Claims

Claim Requirements
Provider must submit claims to BCBSIL within 180 days of the date of service, electronically or using the standard CMS-1500 or UB-04 claim form as discussed below. Services billed beyond 180 days from the date of service are not eligible for reimbursement, and therefore no payments may be sought by provider from the member for untimely claims submitted after the 180-day filing deadline.

Claims must be submitted on an industry standard CMS-1500 or UB-04 claim form or in a HIPAA compliant 837 file, and include the following items:

- Member's name;
- Member's date of birth and gender;
- Member's ID number (as shown on the Member's ID card, include but may not be limited to the 3-digit alpha prefix XOD, JLX or XOJ).
- Member's group number
- Indication of: 1) job-related injury or illness, or 2) accident-related illness or injury, including pertinent details;
- ICD-10 diagnosis codes;
- CPT® procedure codes;
- Rendering;
- Date(s) of service(s);
- Charge for each service;
- Provider's Tax Identification Number (TIN);
- Provider NPI number;
- Name and address of provider;
- Signature of provider providing services; and,
- Place of service code. service code.

BCBSIL will process electronic claims consistent with the requirements for standard transactions set forth in 45 C.F.R. Part162 (Code of Federal Regulations). Any electronic claims submitted to BCBSIL must comply with those requirements.

Submitting Claims
Claims should be submitted electronically through the Availity Essentials or your preferred web vendor for processing. For information on electronic filing of claims, contact Availity Essentials at 800-282-4548 or visit our website at bcbsil.com. Registered users will have a dropdown menu on the Availity Essentials website for Medicare Advantage selection.

The MA Electronic Payer ID # for Provider is (66006). The EFT trace number for electronic payment will start with a source code of "M" instead of "C."

835 Electronic Remittance Advice (ERA) files will be distributed to the address/Receiver ID associated with the billing Provider's Tax ID, rather than being distributed to multiple locations/receivers. Paper Provider Claim Summaries (PCS) s will be sent by mail for all government program claims to non- ERA receivers.

Paper claims must be submitted on the standard CMS-1500 (physician/professional provider) or UB- 04 (facility) claim form to:

Blue Cross Medicare Advantage c/o Provider Services
PO Box 3686
Scranton, PA 18505

Claims containing required information and submitted in accordance with these guidelines will be paid within 30 days. In the event BCBSIL requires additional information to process the claim, BCBSIL will notify provider as appropriate.

Duplicate claims may not be submitted prior to the applicable 30-day claim payment period. Any corrected claims should be submitted with proper identified coding.

BCBSIL may automatically cancel a Provider Record ID that does not have any claim dates of service within a 24 month time period. Terming of the Provider Record ID might also result in termination of associated networks. Provider record IDs are specific to billing/rendering NPIs and Tax Identification Numbers.

Coordination of Benefits
If a member has coverage with another plan that is primary to Medicare, that claim should first be submitted for processing to the primary plan. The amount payable by the MA HMO Non-Delegated plan will be governed by the amount paid by the primary plan and Medicare secondary payer laws, rules, policies, and regulations.

Claim Review and Overpayment Recoveries
Provider may dispute an organizational determination by requesting a claim review, utilizing the BCBSIL claim review form. A claim review is not a provider appeal, contracted providers under MA HMO Non-Delegated do not have post claim appeal rights. Providers may only dispute claim decisions. If you have questions regarding claim reviews, please contact the MA Provider Customer Service Department at the number listed on the Key Contacts page or your assigned Provider Network Consultant found on the BCBSIL website under Provider Network Consultant Assignments.

Provider agrees to provide BCBSIL notice of any overpayments identified by provider promptly after identifying such overpayment and shall refund BCBSIL any amounts due to BCBSIL immediately after identifying such overpayments. BCBSIL has the right to recover any amounts owed by provider, for any reason, by way of offset or recoupments from current or future amounts due from BCBSIL to provider. Providers that have overpayments identified will be sent a refund letter in the mail. Providers may submit the requested refund amount and voluntary refunds to the following lockbox address:

Health Care Service Claims Overpayment
29068 Network Place
Chicago, IL 60673-1290

Balance Billing
An important protection for members when they obtain covered services in a MA plan is that they do not pay more than MA HMO Non-Delegated plan allowed cost sharing.

You may not bill a Member for a Non-Covered Services unless:

a. You have informed the member in advance that the service(s) are not covered by their Evidence of Coverage, and,
b. The member has agreed in writing before the services are rendered to pay for the non-covered; and,
c. If CMS has an allowed amount on the standard fee for service schedule posted for your locality, you may not balance bill for monies above and beyond 100% of CMS for the locality where services are rendered.

Coding Related Updates
Provider acknowledges and agrees that BCBSIL may, add, delete, modify, or otherwise change rules or processes, in accordance with correct coding guidelines and other industry-standard methodologies, including, but not limited to, CMS, CPT, McKesson, and Cotiviti coding process edits and rules.

Section 5: Benefits and Member Rights

Non-Discrimination
The MA HMO Non-Delegated plan and provider, may not establish rules for eligibility of any individual for enrollment under the terms of the MA HMO Non-Delegated plan, or condition coverage, or the provision of health care services, based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, or source of payment, or based on any of the following health status-related factors (42 C.F.R.§ 422.110) in relation to the individual or a dependent of the individual:

a. Health status.
b. medical condition (including both physical and mental illnesses).
c. claims experience.
d. receipt of health care.
e. medical history.
f. genetic information.
g. evidence of insurability (including conditions arising out of acts of domestic violence);
h. disability; and,
i. any other health status-related factor determined appropriate by the Secretary of the Department of Health and Human Services ("HHS").

Additionally, the MA HMO Non-Delegated plan and Provider, must comply with Section 1557 of the Patient Protection and Affordable Care Act, Title VI of the Civil Rights Act of 1964, The Age Discrimination Act of 1975, Section 508 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act, Titles VI and XVI of the Public Health Service Act and the Genetic Information Nondiscrimination Act of 2008.

Third-Party Premium Payments
Premium payments for individual plans are a personal expense to be paid for directly by individual and family plan subscribers. In compliance with Federal guidance, Blue Cross and Blue Shield of Illinois will accept third-party payment for premium directly from the following entities:

(1) the Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act; (2) Indian tribes, tribal organizations, or urban Indian organizations; and (3) state and federal Government programs.

BCBSIL may choose, in its sole discretion, to allow payments from not-for-profit foundations, provided those foundations meet nondiscrimination requirements and pay premiums for the full policy year for each of the Covered Persons at issue. Except as otherwise provided above, third-party entities, including hospitals and other health care providers, shall not pay BCBSIL directly for any or all an enrollee's premium.

Confidentiality
Provider, their providers, employees, subcontractors and delegees, must comply with all state and federal laws concerning confidentiality of members' protected health information (PHI) and personally identifiable information (PII). MA HMO Non-Delegated plan members have the right to privacy and confidentiality of their PHI and PII.

Medical records should be maintained in a manner designed to protect the confidentiality of PHI and PII and in accordance with applicable state and federal laws, rules, and regulations. All consultations or discussions involving the member or his or her treatment should be conducted discreetly and professionally in accordance with all applicable state and federal laws, including the privacy and security rules and regulations of the Health Insurance Portability Insurance Portability and Accountability Act of 1996 (HIPAA). All Providers, practice personnel, employees, subcontractors' employees, subcontractors and delegees must be trained on HIPAA Privacy and Security regulations.

Provider must ensure there is a policy, procedure, or process in place for maintaining confidentiality of Members' medical records and other PHI as defined under HIPAA; and that the practice and its providers are following those procedures and/or obtaining appropriate authorization from Members to release information or records where required by applicable state and federal law. Procedures should include protection against unauthorized/inadvertent disclosure of all confidential medical information, including PHI. Every Provider is required to provide members with information regarding their privacy practices and to the extent required by law, with their Notice of Privacy Practices (NPP). Employees, subcontractors Employees, subcontractors and delegees who have access to Member records, PHI, PII and other confidential information are required to sign a Confidentiality Statement.

Examples of confidential information include, but are not limited to, the following:

a. Medical records;
b. Communications between a member and a provider regarding the member's medical care and treatment;
c. All PII and PHI as defined under the federal HIPAA privacy regulations, and/or other state or federal laws;
d. Any communication with other clinical persons involved in the member's health, medical health, medical and mental care (i.e., diagnosis, treatment and any identifying information such as name, address, Social Security Number (SSN), etc.).
e. Member transfer to a facility for treatment of drug abuse, alcoholism, mental or psychiatric problem; and
f. Any communicable disease, such as AIDS or HIV testing that is protected under federal or state law.

The NPP informs the member of their member rights under HIPAA and how the provider, and/or BCBSIL may use or disclose the member's PHI. HIPAA regulations require each covered entity, as defined by HIPAA, including provider, to provide a NPP to each new patient or member. Provider also agrees to create and maintain all member records and information in an accurate and timely manner, and to ensure timely access by member to records and information that pertain to them. In the event of an unauthorized disclosure by provider, provider agrees to immediately notify BCBSIL of such disclosure verbally and in writing at the following address:

Blue Cross and Blue Shield of Illinois Legal Division, 28th Floor
300 E. Randolph Street
Chicago, IL 60601

Plan Benefits
The MA HMO Non-Delegated plan provides benefits for Parts A and B ("Original Medicare") covered items and services that are medically necessary. MA HMO Non-Delegated plan benefits are offered uniformly to all members residing in the plan service area and are offered at a uniform premium, with uniform benefits and cost- sharing.

Exceptions

The following circumstances are exceptions to the rule that MA HMO Non-Delegated plans must cover the costs of benefits, which are also covered under Original Medicare:

a. Hospice – Original Medicare, and not BCBSIL, will pay hospice services received by a MA HMO Non-Delegated plan member.
b. Inpatient Stay During which a Member's Enrollment Ends - BCBSIL is required to continue to cover inpatient services of the non-plan enrollee if the individual was a MA HMO Non-Delegated plan member at the beginning of an inpatient stay. Note that incurred non-inpatient services are paid by Original Medicare or the new MA Plan that the enrollee joined as of the effective date of the new coverage. Member cost- sharing for the inpatient Hospital stay is based on the cost-sharing amounts as of the date of admission into the Hospital.
c. Skilled Nursing Facility (SNF) Cases Involving Enrollment and Disenrollment – If a member enrolls or
d. disenrolls from a MA HMO Non-Delegated plan during the dates of service for a SNF stay, the facility will submit a split claim to BCBSIL and to Original Medicare. If the member is in a SNF during December in a plan that does not require a prior qualifying three (3) day Hospital stay and then joined Original Medicare on January1, the stay continues to be considered a covered stay (if medically necessary).
e. Clinical Trials – Original Medicare, and not BCBSIL, pays for the costs of routine services provided to a MA HMO Non-Delegated plan member who joins a qualifying clinical trial. BCBSIL pays the member the difference between the Original Medicare cost-sharing incurred for qualifying clinical trial items and services and BCBSIL's in- network cost sharing for the same category of items and services. The Clinical Trial National Coverage Determination (NCD) defines what routine costs mean and clarifies when items and services are reasonable and necessary. All other Medicare rules apply. Go to the Medicare Clinical Trial Policies page on the CMS website for more information.

Access and Availability

24-Hour Coverage
Provider is expected to provide coverage for MA HMO Non-Delegated plan members 24 hours a day, 7 days a week. When a provider is unable to provide services, the provider must ensure that he or she has arranged for coverage from another participating provider. Hospital emergency rooms or urgent care centers are not substitutes for covering participating providers.

Refer to the Blue Cross Medicare Advantage Non-Delegated HMO Provider Finder® to locate participating providers. You may also contact the Provider Customer Service Department at the number listed on the back of the member's ID card with questions regarding which participating providers are available in the network.

Provider Access and Availability Guidelines

The following access and availability guidelines should be followed by providers to ensure timely access to medical care and behavioral health care:

a) Routine and preventative care within 30 business days
b) Services that are not emergency or urgently needed, but require medical attention, within 7 business days.
c) Urgent, but non-emergent care within 24 hours of request
d) Urgently needed services or emergency – immediately

The guidelines above also apply to behavioral health services and substance use disorder services.

Adherence to member access guidelines will be monitored through BCBSIL office site visits and the tracking of complaints and grievances related to access and availability, which are reviewed by our Quality Improvement Committee.

Hours of Operation

Hours of operation must not discriminate against MA members relative to other members. Provider will treat all MA HMO Non-Delegated plan members with equal dignity and consideration as their non- BCBSIL MA patients.

Provider's standard hours of operation shall allow for appointment availability during:

a. Early Morning Hours or Evening Hours three or more times per week; and,
b. Weekend office hours two or more times per month.

For purposes of this section, Early Morning Hours means the hours beginning at 7 a.m. and ending at 9 a.m. Evening Hours means the hours beginning at 6 p.m. and ending at 9 p.m.

All Members should normally be seen within 30 minutes of a scheduled appointment or be informed of the reason for delay (e.g., emergency cases) and be provided with an alternative appointment.

After-hours access shall be provided to assure a response to after-hours phone calls. Individuals who believe they believe they have an Emergency Medical Condition should be directed to immediately to immediately seek Emergency Services.

Member Rights

MA HMO Non-Delegated plan members have specific rights and responsibilities when it comes to their care. The member rights and responsibilities are provided to members in the member's Evidence of Coverage and are outlined below.

Members have the right to:

- Be treated with fairness with fairness, respect, and dignity;
- Have information provided in a way that works for them including information that is available in alternate languages and formats;
- See BCBSIL Provider, receive Covered Services, and have their prescriptions filled in a timely manner;
- Privacy and to have their private health information protected;
- Information about BCBSIL, its network of participating providers, their providers, their covered services, and their rights and responsibilities;
- Know their treatment choices and participate in decisions about their health care;
- Use advance directives (such as a living will or a durable health care power of attorney);
- Make complaints about BCBSIL or the care provided and feel confident it will not affect the way they are treated;
- Appeal medical appeal medical or administrative decisions BCBSIL has made by using the grievance or appeal process;
- Make recommendations about BCBSIL member rights and rights and responsibilities policies;
- Talk openly about care needed for their health, regardless of cost or benefit coverage, as well as the choices and risks involved; and,
- Receive all information in a way members understand and without additional cost.

Members also have certain responsibilities. These include the responsibility to:

- Become familiar with their coverage and the rules they must follow to get care as a member;
- Tell BCBSIL, provider, and other participating providers, if they have any additional health insurance coverage or prescription drug coverage;
- Tell their PCP and other health care providers that they are enrolled with BCBSIL;
- Give their PCP and other providers complete and accurate information to care for them, and to follow the treatment plans and instructions that they and their providers agree upon;
- Understand their health problems and help set treatment goals that they and their provider agree to;
- Ask their PCP and other providers questions about treatment if they do not understand;
- Make sure their doctors know all the drugs they are taking, including over-the-counterdrugs, vitamins, and supplements;
- Act in a way that supports the care given to other patients and helps the smooth running of their doctor's office, hospitals, and other offices;
- Pay their plan premiums and any co-payments or coinsurance they owe for the covered services they get;
- Meet their other financial responsibilities as described in the Evidence of Coverage;
- Inform BCBSIL if they move; and
- Inform BCBSIL of any questions, concerns, problems, or suggestions by calling our Customer Service Department listed in their Evidence of Coverage.

BCBSIL is committed to ensuring that enrolled members are treated in a manner that respects their rights as individuals entitled to receive specific MA HMO Non-Delegated health care benefits. MA HMO Non-Delegated members are entitled to participate in decision-making regarding their treatment, to be confident that their PHI and PII is kept confidential, to be treated with dignity, courtesy, and respect, as well as to be free from inappropriate interference with the provider-patient relationship. BCBSIL members are also advised of their rights and responsibilities within the Evidence of Coverage.

Member Satisfaction

BCBSIL conducts a member satisfaction survey annually. Satisfaction with services, quality and access is evaluated by BCBSIL through the annual survey, as well as through the aggregation, trending, and analysis of member complaint and appeal data, which includes evaluation of quality of care, access, attitude and service, billing and financial issues and the quality of the provider, and provider's office site(s).BCBSIL uses the information obtained in the survey to address areas requiring improvement. If certain provider areas of responsibility require improvement, BCBSIL will notify provider of those areas and the action plan for improvement for provider.

Provider agrees to comply with the BCBSIL action plan, and to require its providers to comply with such plan.

The Centers for Medicare and Medicaid Services (CMS) collects information about Medicare beneficiaries' experiences with, and ratings of, Medicare Advantage (MA-only) plans, Medicare Advantage Prescription Drug (MA-PD) plans, and stand-alone Medicare Prescription Drug Plans (PDP) via surveys of beneficiaries who have been enrolled in their plans for six months or longer. The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey is administered annually to a sample of MA & PDP beneficiaries by mailings and telephone follow-up of non-respondents to the mailed questionnaire. Questions ask about ease of getting needed care and seeing specialists, getting appointments and care quickly, doctors who communicate well, coordination of Members' health care services, health and/or drug plan provides information or help when Members need it, ease of getting prescriptions filled, rating of health and/or drug plan, rating of health care quality, annual flu vaccine, and pneumonia vaccine. CAHPS ratings account for a fifth of the overall CMS Star Ratings.

Cultural Competency

The MA HMO Non-Delegated plan and provider, are obligated to ensure that services that services are provided in a culturally competent manner (42 C.F.R. § 422.112 (a)(8)) to all members, including those with limited English proficiency or reading skills or who are from diverse cultural and ethnic backgrounds.

The MA HMO Non-Delegated plan Customer Service Department (phone number appears on the back of member's ID card) has the following services available for MA HMO Non-Delegated plan members: a) teletypewriter (TTY) services; and b) translation services.

Provider, their employees, subcontractors and delegees, must have an awareness and recognition of customs, values, and beliefs of members and the ability to incorporate those attributes into the assessment, treatment, and interaction with any individual. Since culture is an integrated pattern of human behavior that includes thought communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group, provider must be sensitive to culturally preferred ways of meeting member needs which may be influenced by factors such as geographic location, lifestyle, and age. If a member has limited

English proficiency and therefore cannot, or is unable to speak, read, write, or otherwise understand the English language at a level that permits the individual to interact effectively with Provider, translation assistance must be provided to the member. In addition, to comply with the requirements of 42 C.F.R.§ 422.112 (a)(8), Provider is strongly encouraged to:

a. Recognize cultural, racial, ethnic, geographic, social, and spiritual, and economic diversity and individuality within and across all members and their families and caretakers;
b. Implement practices and policies that support the needs of members and families, including medical, developmental, educational, emotional, cultural, environmental, and financial needs;
c. Provide training on cultural competence to employees, subcontractors and delegees;
d. Acknowledge that families are essential to members' health and well-being and are crucial allies for quality within the service delivery system; and
e. Appreciate and recognize the unique nature of each member and his or her family.

Preventive Services

Members may access certain preventive services from any provider in accordance with the member's Evidence of Coverage. BCBSIL does not require member cost-sharing for those covered preventive services provided in- network for which there is no cost sharing required under Original Medicare. If, during the provision of a preventive service, additional non-preventive covered services are rendered, cost-sharing under the member's Evidence of Coverage will apply.

Members may directly access (through self-referral to any participating provider) in-network screening mammography and influenza vaccine. For additional information, refer to the preventive services section on the CMS website.

Advance Directives

Provider must document in a prominent part of the member's current medical record whether the member has executed an advance directive. Advance directives are written instructions, such as living wills or durable powers of attorney for health care, recognized under the law of the State of Illinois and signed by a member, that explain the member's wishes concerning the provision of health care if the member becomes incapacitated or for any other reason is unable to make those wishes known. Provider is not required to provide care that conflicts with an advance directive. In addition, provider shall not, as a condition of treatment, require a member to execute or waive an advance directive.

As a courtesy, provider may inform members that the Department of Public Health is required to make available a uniform advance directive for a do-not-resuscitate order that maybe used in all settings, the statutory Living Will Declaration form, the Illinois Statutory Short Form Power of Attorney for Health Care, the statutory Declaration of Mental Health Treatment Form, and the summary of advance directives law in Illinois. (Section 2310-600 of the Department of Public Health Powers and Duties Law of the Civil Administrative Code of Illinois, 20 ILCS 2310-600). Provider should inform individuals that any complaints concerning noncompliance with advance directive requirements maybe filed with the Illinois Department of Public Health (42 C.F.R. § 422.128(b)(3)).

Additional Benefits

Some MA HMO Non-Delegated plans offer additional benefits to those traditionally covered by Original Medicare such as vision, hearing, dental, travel benefit services and health/fitness programs. Members are advised to review their Evidence of Coverage and to contact Customer Service for information regarding these services.

Section 6: Compliance Standards

Provider Standards
In accordance with generally accepted professional standards, provider must:

- Meet the requirements of all applicable state and federal laws, rules, and regulations, including applicable CMS managed care guidance in the form of manuals, transmittals or otherwise.
- Agree to cooperate with BCBSIL to monitor compliance with its MA plan contract(s) and/or MA rules and regulations, and assist BCBSIL in compliance with corrective action plans necessary to comply with such laws, rules and regulations;
- Retain all agreements, documents, papers, and medical records related to the provision of services to BCBSIL members as required by state and federal laws;
- Provide Covered Services in a manner consistent with professionally recognized standards of health care [42 C.F.R.§ 422.504(a)(3)(iii)];
- Use Physician Assistants (PA) and Advanced Registered Nurse Practitioners Advanced Registered Nurse Practitioners (ARNPs) appropriately. PAs and ARNPs should provide direct Member care within the scope or practice established by the rules and regulations of the state and applicable BCBSIL policies, procedures, or guidelines; Assume full responsibility to the extent of the law when supervising PAs and ARNPs, whose scope of practice should not extend beyond statutory limitations;
- Clearly identify their title (e.g. M.D., D.O., ARNP, PA) to members and to other providers;
- Honor any member request to be seen by a Physician rather than a PA or ARNP;
- Administer treatment for any member in need of healthcare services they provide;
- Respond within the identified timeframe to BCBSIL's requests for medical records for compliance with regulatory requirements;
- Maintain accurate medical records and adhere to all BCBSIL policies and procedures governing the content and confidentiality of medical records;
- Allow BCBSIL to use provider's performance data;
- Ensure that all providers, employed physicians and other health care practitioners comply with the terms and conditions of the agreement with BCBSIL and this provider manual;
- Ensure that to the extent a provider employed physician maintains written agreements with contracted physicians or other healthcare practitioners and providers, that the agreements mirror required and applicable provisions in the agreement with BCBSIL and this provider manual;
- Maintain an environmentally safe office with equipment in proper working order to comply with city, state and federal regulations concerning accessibility, safety, and public hygiene;
- Communicate timely clinical information between providers, which will be analyzed by BCBSIL during medical record review;
- Upon request, provide timely transfer of clinical information to BCBSIL, the member or the requesting party at no charge, unless otherwise agreed;
- Preserve member dignity and observe the rights of members to know and understand the diagnosis, prognosis and expected outcome of recommended medical, surgical and medication treatment;
- Not discriminate in any manner between MA HMO Non-Delegated Members and non-MA HMO Non-Delegated members or non- BCBSIL members;
- Ensure that the hours of operation offered to MA HMO Non-Delegated members is no less than those offered to commercial members;

- Not deny, limit, or condition treatment to any MA HMO Non-Delegated member on the basis of any of the following factors:
    - Health status;
    - medical condition (including both physical and mental illnesses);
    - claims experience;
    - receipt of health care;
    - medical history;
    - genetic information;
    - evidence of insurability (including conditions arising out of acts of domestic violence);
    - disability; and,
    - any other health status-related factor determined appropriate by the Secretary of the Department of Health and Human Services.
- Communicate with and advise members regarding the member's condition, including, but not limited to diagnosis and available treatments;
- Advocate on the member's behalf for the member's health status, medical care and available treatment or non-treatment options including any alternative treatments, regardless of whether any treatments are covered services;
- Identify members who need services related to domestic violence, smoking cessation, or substance abuse. If indicated, provider agrees to refer members to available BCBSIL-sponsored or community-based programs;
- Document referrals to available BCBSIL-sponsored or community-based programs in the member's medical record and provide appropriate follow-up to ensure and document that the member actually accessed the services; and,
- Adhere to all BCBSIL policies and procedures, including, but not limited to, preauthorization requirements and timeframes, medical policies, credentialing requirements, care management and disease management program referrals, appropriate release of inpatient and outpatient utilization and outcomes information and providing treatment to members at appropriate levels of care.

Providers acting within the lawful scope of practice are encouraged to advise patients who are members of a MA HMO Non-Delegated plan about:

a. The patient's health status, medical care, or treatment options (including any alternative treatments that self-administered), including the provision of sufficient information to provide an opportunity for the patient to make an informed treatment decision from all relevant treatment options;
b. The risks, benefits and consequences of treatment or non-treatment; and
c. The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

These member advisements set forth above are considered supportive of MA HMO Non-Delegated plan members.

MA plan marketing is regulated by CMS. Provider should familiarize themselves with CMS regulations at 42 CFR Part 422, Subpart V, and the CMS Managed Care Manual, Chapter 3, Medicare Marketing Guidelines for MA Plans, MA-PDs, PDPs and 1876 Cost Plans (Marketing Guidelines), including, without limitation, materials governing "Provider Based Activities" in Section 70.8.3.

Provider must adhere to all applicable laws, regulations, and CMS guidelines regarding MA plan marketing, including without limitation 42 CFR Part 422, Subpart V, and the Marketing Guidelines. CMS holds MA Organizations such as BCBSIL responsible for any comparative/descriptive material developed and distributed on their behalf by their provider. Provider is not authorized to engage in any marketing activity on behalf of BCBSIL without the prior express written consent of an authorized BCBSIL representative, and then, only in strict accordance with such consent.

Sanctions

Provider must disclose to BCBSIL whether the provider, or any of their employees, independent employees, independent contractors, subcontractors or delegees, have any prior violation prior violation, fine, suspension fine, suspension, termination or other administrative action taken under Medicare or Medicaid laws, the rules, or regulations of the State of Illinois, the state or federal government, or any public insurer.

No provider, or provider, or its employees, independent contractors, subcontractors or delegees, shall have been convicted of any criminal offense related to involvement with Medicaid, Medicare or other state or federal health care programs. Provider agrees to immediately notify BCBSIL of any charge of criminal wrongdoing, or any similar charge, allegation or penalty, state or federal sanction connected to its, or its Providers, employees, independent employees, independent contractors, subcontractors, or sub-contractors or its delegees, involvement in Medicaid, Medicare or other state or federal health care programs.

Accordingly, and as specifically described and set forth in the agreement, provider shall immediately notify BCBSIL within five (5) business days of any of the following occurrences related to any provider:

a. loss, suspension or limitation of license or certification.
b. any lapse or material change in the liability insurance coverage required under the Agreement.
c. any judgment or finding against any provider which might materially impair his/her ability to perform under the Agreement.
d. any indictment or conviction of a felony or any criminal charge related to the practice of any Provider.
e. loss, suspension, or limitation of medical staff or admitting privileges at any BCBSIL credentialed hospital.
f. a professional review action based on the professional competence or professional conduct that reduces, restricts, suspends, revokes, denies, fails to renew, or otherwise adversely affects clinical privileges of a provider for a period of more than thirty (30) days.
g. failure to renew, or acceptance of the surrender, restriction, suspension, revocation, or denial of or other adverse action affecting clinical privileges of a provider while under investigation or in return for not conducting an investigation by a health care entity relating to possible professional incompetence or improper professional conduct.
h. entry of a civil judgment by a federal or state court relating to the delivery of a health care item or service, except as may relate to claims of malpractice.
i. Federal or state criminal conviction relating to the delivery of a health care item or service, except as may relate to claims of malpractice;
j. action by a federal or state agency responsible for licensing or certification resulting (i) in reprimand, censure, or probation, (ii) in revocation, suspension or loss of license, or loss of right to apply for or to renew license, whether by operation of law, voluntary surrender, non-renewal or otherwise, or (iii) in other publicly available negative action or finding; or
k. exclusion from participation in any federal or state health care program.

BCBSIL reserves the right to take appropriate action, including termination of provider for failure to make any required disclosure under this Section, or for any violation related to provider, its providers, employees,' independent contractors,' subcontractors' or its delegees,' involvement in Medicaid, Medicare or other state or federal health care programs.

Reporting Obligations

Cooperation and Meeting CMS Service Requirements
BCBSIL must provide CMS with information that is necessary for CMS to administer and evaluate the MAHMO Non-Delegated program and to establish and facilitate a process for current and prospective members to exercise choice in obtaining services. The information includes MA HMO Non- Delegated plan quality and performance indicators including but not limited to disenrollment rates, information on Member satisfaction, and information on health outcomes. Provider must cooperate with BCBSIL in its data reporting obligations by providing to BCBSIL any information, including Provider information that BCBSIL requires to meet its obligations.

Certification of Diagnostic Data
BCBSIL is specifically required to submit to CMS data necessary to characterize the context and purposes of each encounter between a member and a provider, supplier, or other practitioner (encounter data). As set forth in the Agreement, providers that furnish diagnostic data to assist BCBSIL in meeting BCBSIL's reporting obligations to CMS must attest by sworn statement, based upon the Provider's knowledge, information, and belief, that the data provided is accurate, complete, and truthful.

Compliance, Fraud, Waste and Abuse Program and Reporting
Provider will implement and maintain a compliance program that, at a minimum, meets the standards for an effective compliance program set forth in Laws, including, without limitation, the Federal Sentencing Guidelines, and that addresses the scope of services of services under the Agreement. Such compliance program will require cooperation with BCBSIL's compliance plan and policies and shall include, without limitation, the following:

1. A code of conduct particular to provider that reflects a commitment to preventing, detecting, and correcting fraud, waste, and abuse in the administration or delivery of Covered Services to Member.
2. Policies and procedures that promote communication and disclosure of potential incidents of non-compliance or other questions or comments relating to compliance with Laws and Provider's compliance and anti-fraud, anti-waste, and anti-abuse initiatives. Such program will include implementation and publication to provider's directors, officers, employees, agents, and contractors of a compliance hotline and/or other method(s) of communication, which provides for anonymous reporting of issues of non-compliance with Laws or other questions or comments relating to compliance with Laws and provider's anti-fraud, anti- waste, and anti-abuse initiatives.
3. Annual compliance risk assessments performed at provider's sole expense. Provider will, upon request, share the results of such assessments with BCBSIL to the extent any part of the assessment directly or indirectly relates to the Agreement.
4. Routine monitoring and auditing of provider's responsibilities and activities with respect to the administration or delivery of Covered Services to member and the Agreement. Provider hereby represents and warrants to BCBSIL that provider has an adequate work plan in place to perform such monitoring and audit activities. Provider will take corrective action to remedy any deficiencies found as appropriate.

5. Upon request, provision of a report to BCBSIL of the activities of provider's compliance program required by the Agreement including, without limitation, reports, and investigations, if any, of alleged failures to comply with laws, regulations, the terms and conditions of the CMS Contract, or the Agreement so that BCBS can fulfill its reporting obligations under Laws, the CMS Contract and/or the Agreement. Upon request, provider will provide to BCBSIL the results of any audits related to the administration or delivery of Covered Services to member. Provider will make appropriate personnel available for interviews related to any audit or monitoring activity.

Incidents of Suspected Non-Compliance, Fraud, Waste, or Abuse
Provider shall promptly investigate any potential and/or suspected incidents of non-compliance with Laws, fraud, waste, or abuse in connection with the Agreement and/or the administration or delivery of Covered Services to members ("Incident") and report any such Incident to BCBSIL as soon as reasonably possible, but in no instance later than thirty (30) calendar days after provider becomes aware of such Incident. Such, Notice to BCBSIL will include a statement regarding provider's efforts to conduct a timely, reasonable inquiry into the Incident, proposed or implemented corrective actions in response to the Incident, and any other information that may be relevant to BCBSIL in making its decision regarding self-reporting of such Incident.

Provider must cooperate with any investigation by BCBSIL, CMS, HHS or their authorized designees relating to such Incident, and provider acknowledges that its failure to cooperate with any such investigation may result in a referral to law enforcement and/or other implementation of corrective actions permitted under Laws.

Provider must cause its downstream entities to promptly report to provider, who must report to BCBSIL, any Incidents in accordance with this section.

Compliance Reviews
In addition to any other audits or reviews agreed to pursuant to the Agreement, provider will provide BCBSIL with access to provider's records, physical premises and facilities, equipment, and personnel in order for BCBSIL, in its sole discretion and at its sole cost and expense, to conduct compliance reviews in connection with the terms of the Agreement.

Conflicts of Interest
Provider will require any manager, officer, director, or employee associated with the administration or delivery of Covered Services to members to sign a conflict-of-interest statement, attestation, or certification at the time of hire and annually thereafter certifying that such individual is free from any conflict of interest in administering or delivering Covered Services to Members. Provider will supply the form of such statement, attestation, or certification to BCBSIL upon request.

Exclusion of Certain Individuals
Provider will certify that neither provider, provider employees, any subcontractor, any affiliate or any downstream entity involved in the provision of a delegated activity under the Agreement has been: (i) charged with a criminal offense in connection with obtaining, attempting to obtain, or performing of a public (Federal, State or local) contract or subcontract, (ii) listed by a federal governmental agency as debarred, (iii) proposed for Debarment or suspension or otherwise excluded from federal program participation or listed on the CMS preclusion list described in 42 C.F.R. § 422.222 ("CMS Preclusion List"), (iv) been convicted of or had a civil judgment rendered against them regarding dishonesty or breach of trust, including but not limited to, the commission of a fraud including mail fraud or false representations, violation of a fiduciary

relationship, violation of Federal or State antitrust statutes, securities offenses, embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, or receiving stolen property; or (v) within a three (3) year period preceding the date of the Agreement had one or more public transactions (Federal, State, or local) terminated for cause or default.

Provider will check appropriate databases monthly to determine whether any of provider's employees, subcontractors, affiliated parties, or downstream entities involved in the provision of a delegated activity under the Agreement have been suspended or excluded from participation in the Medicare Program, any other Federal health care program, State contracts or State medical assistance programs. Databases include the CMS Preclusion List, the OIG List of Excluded Individuals/Entities ("LEIE"), the System for Award Management ("SAM") exclusion lists, and any other federal or State governmental agency exclusion list of persons who are sanctioned, debarred, or voluntarily withdrawn as a result of a settlement agreement. Provider shall provide to BCBS upon request within the timeframe requested, but no later than within forty-eight (48) hours, documentation showing such databases/exclusion lists were reviewed for all individuals involved in the provision of a delegated activity under the Agreement.

Provider acknowledges and agrees that it has a continuing obligation to notify BCBSIL in writing within seven (7) business days if any of the above-referenced representations change. Provider further acknowledges and agrees that any misrepresentation of its status or any change in its status at any time during the term of the Agreement may be grounds for immediate termination of the Agreement, at the sole discretion of BCBSIL.

Lobbying Prohibitions
Provider certifies to the best of his knowledge and belief, that:

No federal appropriated funds have been paid or will be paid by or on behalf of the provider, to any Person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal loan or grant, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

If any funds other than Federally appropriated funds have been paid or will be paid to any Person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the provider shall complete and submit a Federal Standard Form LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions. Such Disclosure Form may be obtained by request from the Illinois Department of Healthcare and Family Services, Bureau of Fiscal Operations.

Section 7: Organization Determinations

Overview
BCBSIL can receive organization determination requests by mail, phone, portal, or fax. BCBSIL requires prior authorization or precertification for:

- All non-emergent and non-urgent inpatient admissions except for normal newborn deliveries.
- All non-emergent or non-urgent out-of-network services (except out-of-area renal dialysis);
- All other services requiring pre-authorization or pre-certification as further described in the Prior Authorization Requirements section of this manual or on the Prior Authorization Required List in the Standards and Requirements/Provider Manual section of our Provider website. BCBSIL requires contracted providers to obtain prior authorization on behalf of members for in-network services. HMO Non-Delegated Members are allowed to receive services outside the network, and providers may assist them with requesting prior authorization.

For initial and continuation and continuation of services, BCBSIL services, BCBSIL has appropriate processes to ensure consistent application of review criteria for authorization reviews and organization determinations, which include, but are not limited to:

- Medical necessity- approved medical review criteria will be referenced and applied.
- Where appropriate, involvement of a BCBSIL medical director;
- The member's medical history (e.g., diagnoses, conditions diagnoses, conditions, functional status), treating physician recommendations and clinical notes; and
- Consultation with the requesting Provider when appropriate.

If BCBSIL expects to issue a partial or full adverse medical necessity (or any substantively equivalent term used to describe the concept of medical necessity) decision based on the initial review of the request, the organization determination will be reviewed by a physician or other appropriate health care professional with sufficient medical and other expertise, including knowledge of Medicare coverage criteria, before BCBSIL issues the adverse medical necessity decision. The Physician or other health care professional must have a current and unrestricted license to practice within the scope of his or her profession in the State. Appropriate professionals can be, for example, physicians, certified nurse practitioners, doctoral-level clinical psychologists or certified addiction- medicine specialists, doctoral-level behavioral analysts, pharmacists, dentists, chiropractors, and physical therapists.

BCBSIL's determination process provides authorization numbers, effective dates for the authorization and specifies the services being authorized. The requesting provider will be notified verbally via telephone or via fax, mail or online, of the authorization.

In the event of an adverse medical necessity decision, BCBSIL will notify the member and the member's representative or provider, as appropriate. Provider may request copies of the criteria used for any specific determination of medical necessity by contacting our Utilization Management Department. The member may receive copies of the criteria by contacting the Customer Service Department.

Standard Organization Determinations
Standard organization determinations are made as expeditiously as the member's health condition requires, but no later than 14 calendar days after BCBSIL receives the request for service. An extension may be granted for 14 additional calendar days if the member requests an extension, or if BCBSIL justifies the need for additional information and documents that the delay is in the interest of the member. Standard pre-service organization determinations and notifications for Part B drug requests are made within 72 hours of the request.

Expedited Organization Determinations
Expedited organization determinations are requests to BCBSIL for expediting an organization determination when the member or his or her provider believes that waiting for a decision under the standard timeframe could place the member's life, health, or ability to regain maximum function in serious jeopardy. The request will be made as expeditiously as the Member's health condition requires, but no later than 72 hours after receiving the member's or Provider's request. The 72-hour period begins when the request is received by the appropriate office or department designated by BCBSIL. An extension may be granted for 14 additional calendar days if the member requests an extension, or if BCBSIL justifies a need for additional information and documents how the delay is in the interest of the member. Expedited organization determination may not be requested for cases in which the only issue involves a claim for payment for services that the member has already received. Expedited pre-service organization determinations and notifications for Part B drug requests are made within 24 hours of the request.

Section 8: Utilization Management

Overview
Provider should refer directly to Medicare coverage policies for information on Medicare coverage policies and determinations. There are two types of Medicare coverage policies: 1) National Coverage Determinations (NCDs) and 2) Local Coverage Determinations (LCDs). As an MA plan, BCBSIL must cover all services and benefits covered by Original Medicare.

National Coverage Determinations (NCDs)
The Centers for Medicare and Medicaid Services (CMS) explains NCDs through program manuals, which are located on the CMS website under Regulations & Guidance/Guidance/Manuals. Key manuals for coverage include the: a) Medicare National Coverage Determinations Manual; b) Medicare Program Integrity Manual; and c) Medicare Benefit Policy Manual.

CMS updates program manuals through program transmittals and sends updated information via articles through the Medicare Learning Network located in the Outreach & Education section of the CMS website.

Local Coverage Determinations (LCDs)
CMS contractors (e.g., Medicare Administrative Contractors or MACs) develop and issue LCDs to provide guidance to the public and Provider community within a specific geographical area. LCDs supplement an NCD or explain when an item or service will be considered covered if there is no NCD. An LCD cannot contradict an NCD. Provider may access LCDs online with the appropriate local contractor website for the region at issue.

Medicare Coverage Database
CMS launched the Medicare Coverage Database in 2002. To access, go to CMS/Medicare/Medicare Coverage – General Information and select the Medicare Coverage Database. The following areas may be searched:

- National Coverage Determinations (NCDs)
- National Coverage Analyses (NCAs) – These documents support the NCD process.
- Local Coverage Determinations (LCDs) – This section of the Medicare Coverage Database is updated monthly. Therefore, the most current information should be accessed through the local contractor websites listed in the preceding box.

In coverage situations where there is no NCD, LCD or guidance on coverage in original Medicare manuals, BCBSIL may adopt the coverage policies of other MA Organizations in its Service Area. BCBSIL may also make its own coverage determination(s) and provide a rationale using an objective evidence-based process.

Prior Authorization Requirements
Prior authorization is intended to facilitate the most appropriate level of care, in the most appropriate setting, at the right time. Prior authorization may be obtained by the member's PCP, treating specialist or facility. BCBSIL conducts the prior authorization process, including medical necessity and benefit determinations, prior to services being rendered.

Prior authorization requirements apply to pre-service coverage determinations.
Prior Authorizations are granted by either BCBSIL or eviCore healthcare (eviCore). For additional information, refer to the MA HMO Non-Delegated Prior Authorization Required List located on our website at https://www.bcbsil.com/provider/claims/um_gov.html.

Services that require preauthorization (as identified in the Prior Authorization List) but that are performed without preauthorization or that do not meet medical necessity criteria may be denied for payment, and the rendering provider may not seek reimbursement from the Member.

Please note that the fact that a service has been preauthorized/pre-certified is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility, and the terms of the member's evidence of coverage applicable on the date services were rendered.

Providers may submit requests for prior authorization via Availity Essentials, by utilizing the prior authorization form available in the Standards and Requirements/Provider Manual section of our Provider website, or by calling 877-774- 8592. In the event there is a need to request an expedited review for an urgent service after hours (to include weekends and holidays) BCBSIL recommends that providers call 877-774-8592.When requesting prior authorization for coverage, please include the following items:

- Member name and identification number.
- Services being requested.
- Pertinent medical information related to the request, including current plan of treatment, progress treatment, progress notes describing medical necessity, effectiveness of the treatment and goal of treatment.
- Applicable medical history.
- Diagnosis code(s) and place of service.
- Physician's Current Procedural Terminology; and
- Requesting Provider's TIN and demographics

Additional information for providers pertaining to requests for prior authorization, including service category codes, may be found on our website at https://www.bcbsil.com/provider/claims/um_gov.html..
Prior authorization for benefits is not required for Emergency Medical Conditions.

The Member's PCP, treating specialist, or facility must obtain preauthorization for the services on the Prior Authorization List except in an emergency. This list is subject to change and is provided at the CPT code level. Service category codes may be in the Prior Authorization Required List available on our website at https://www.bcbsil.com/provider/claims/um_gov.html.

All inpatient admissions require prior authorization from BCBSIL's Utilization Management (UM) Department. The prior authorization process for admissions is requested by the member's PCP, treating specialist, or facility.

Notification of admission and extension requests for an inpatient level of care must be received within 1 business day of admission.

Admitting providers are responsible for contacting the UM department through Availity Essentials at https://www.bcbsil.com/pdf/claims/um_process_gov.pdf or by phone at 877-774-8592 to request authorization for additional days of coverage if an extension of the approved length of stay is required. The admitting provider will provide appropriate referrals for extended care. UM personnel will assist in coordinating all necessary services identified by the facility during the discharge planning process.

Emergency Care

Emergency services are health care services provided in a hospital or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness or injury is of such a nature that failure to receive immediate medical care could result in:

- Serious jeopardy of the patient's health.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Section 9: Case Management

Care Coordination
BCBSIL assists Providers with continuity of services through arrangements that include, but are not limited to, the following:

- Offering each MA HMO Non-Delegated plan member access to an ongoing source of primary care and providing access to a primary care source to each member who accepts the offer.
- Establishing coordination of plan services that integrate arrangements with community and social service programs.
- Informing members of specific health care needs that may require follow-up and receive, as appropriate, training from Providers in self-care and other measures they may take to promote their own health; and
- Employing systems to identify and address barriers to member compliance with a provider's prescribed treatments or regimens.

To support the above requirements, BCBSIL has a comprehensive case management program. Our suite of programs includes care transition support, condition management, and complex case management programs. Where appropriate and possible, case managers identify members with complex needs so that interventions may be suggested by providers to increase positive health outcomes and facilitate appropriate utilization and level of care. Case managers, who are telephonically based, coordinate, and evaluate the options and services available to meet the member's needs.

Health Assessment / Annual Wellness Visits
CMS requires that a good faith effort is made to conduct an initial health assessment of all new members within 90 days of the effective date of enrollment. You can do this by performing the once-in- a-lifetime wellness visit known as the Initial Preventive Physical Examination (IPPE). Members are eligible for the IPPE during the first 12 months of enrollment in Medicare. After 12 months, Members may receive either the initial once-in-a-lifetime Annual Wellness Visit (AWV) or if already performed, the subsequent AWV. The subsequent AWV can be used the following calendar year after any wellness visit (IPPE, initial AWV, or subsequent AWV).

The Annual Health Assessment (AHA) is the name utilized for the AWVs at Blue Cross Blue Shield. The Blue Cross Medicare Advantage AHA serves as a platform to identify essential clinical, quality, and care management needs and meets the requirements of the Medicare initial preventive and annual visits. The components of the AHA include the Member's past medical history, social and family history, physical exam (including BMI), vital signs, functional ability and level of safety review, psychosocial and behavioral risks, medication review, preventive screenings, chronic disease monitoring and assessment of current conditions (management and/or treatment plan). These assessments can occur in-person or through telehealth, in the provider's office, or member's home to remove barriers to completion.

For reference purposes, the BlueCross BlueShield of IL Medicare Advantage AWV Guide and Form can be located at the following link: [Preventive Care Guidelines (bcbsil.com)]

Process for Submitting AHA – Paper Submission Procedure

1. The provider conducts a face-to-face annual visit (telehealth guidelines below) with the member and completes the required elements in the appropriate electronic medical record (EMR) or completes the Annual Health Assessment form according to the instructions provided. See previous section or section 10.2.3 below for the locations of this form on our website.
2. The Provider completes the encounter claim documenting the appropriate diagnosis codes and submits via normal claims submission to Provider.
    - Provider shall document on the encounter claim the appropriate HCPCS codes for well visits for medical billing purposes:
        a. G0402 – Initial Preventive Physical Examination
        b. Code is limited to new beneficiary during the first 12 months of Medicare Enrollment.
        c. G0438 – Annual Wellness Visit (AWV), Initial
        d. The initial AWV, G0438, is performed on patients who have been enrolled with Medicare for more than one year, including new or established patients.
        e. G0439 – Annual Wellness Visit (AWV), Subsequent
        f. The subsequent AWV occurs the following calendar year after any wellness visit (IPPE, initial AWV or subsequent AWV).

The provider ensures all required fields are completed in the EMR or on the AHA form. Upon completion, the member's medical record should be retained as required. The completed EMR or AHA form should be made available to BCBSIL upon request. Send any questions about this form to: RiskAdjustment@bcbsil.com.The codes G0402, G0438, and G0439 are preventive services and members receiving an Annual Wellness Visit are not responsible for a copayment or deductible. If rendering a significant, separately identifiable, medically necessary Evaluation and Management (E/M) service (e.g., 99213) in addition to the AHA, the Current Procedural Terminology (CPT) code with modifier -25 can be reported.

Both the evaluation and management (E/M) code and the HCPC "G" code should be submitted to Blue Cross Medicare Advantage as part of the normal MA HMO Non-Delegated claim process on standardized billing format and preferred submission via EDI or if necessary, paper claims. The wellness visits and most of the recommended preventive tests have both the copay and deductible waived.

AHA Telehealth Visits
AHAs can be done via telehealth for G0438 and G0439 and are advising the provider to bill with POS 11 and Modifier 95. G0402 - Initial Preventive Physical Examination is NOT approved for Telehealth by CMS.

If the Provider is billing G0438 or G0439, it will be calculated for their AHA performance since they are the same codes we use today. All telehealth services must have both audio and visual to meet the 'face to face' requirement for risk adjustment purposes. Telephone or audio only encounters do not count for risk adjustment purposes.

Telehealth must be billed: POS 11 and modifier 95 or POS 02 no modifier. The Member will not be responsible for copays, coinsurance, or deductibles as it will be considered part of the preventive visit.

New Annual Wellness Visit Resources for Medicare Providers

- Annual Wellness Visit Guide: includes a wellness visit checklist
- Annual Wellness Visit Form: new form includes sections for member's medical history, risk factors, conditions, treatment options, coordination of care, and advance care planning.
- More information posted on BCBSIL Website under News & Updates: https://www.bcbsil.com/provider/education/2020/2020_05_01.html

Section 10: Member Appeals and Grievances

Overview
Members have the right to make a complaint in the form of an appeal or grievance if they have concerns or problems related to their coverage or care. Provider must cooperate in the BCBSIL MA appeals and grievances process for members.

- An appeal is the type of request when the member wants BCBSIL to reconsider a decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs the Member has already received.
- A grievance is the type of complaint regarding any other type of problem with BCBSIL or a provider. For example, complaints concerning quality of care, waiting times in the waiting room or the cleanliness of the facilities are grievances. Provider, on behalf of its Providers, agrees to address any Member grievance concerns with its BCBSIL Provider Network Consultant.

Standard grievances requests regarding authorization of benefits, or termination of benefits, for a health care service should be mailed or faxed to:

Blue Cross Medicare Advantage
Attn: Grievances Department
P.O. Box 4288
Scranton, PA 18505
Fax: 855-674-9189

Standard appeal requests should be mailed or faxed to:

Blue Cross Medicare Advantage
Attn: Appeals Department
P.O. Box 663099
Dallas, TX 75266
Fax: 800-419-2009

Expedited appeals requests regarding authorization of benefits, or termination of benefits, for a health care service should be faxed or directed to the MA Provider Customer Service line:

Blue Cross Medicare Advantage
Attn: Expedited Appeals Department
877-774-8592
Fax: 800-338-2227

Note: For claims submission errors contact the MA Provider Customer Service at 877-774-8592.

Resolving Grievances
If a member has a grievance about BCBSIL, provider, its providers, or any other issue, provider should instruct the member to contact the Customer Service Department at the number listed on the back of the member's ID card.

Resolving Appeals
A member or the member's authorized Representative as denoted by an appropriately executed authorization form called the AOR or its equivalent, may appeal an adverse initial decision by BCBSIL concerning benefits for a health care service. A member's appeal of the denial for authorization of benefits or termination of benefits must generally be resolved by BCBSIL within 30 days, or sooner, if the member's health condition requires. An appeal concerning payment must generally be resolved within 60 days.

If the normal time-period for an Appeal could jeopardize the life or health of the member or the member's ability to regain maximum function, the member can request an expedited Appeal. Such Appeals are generally resolved within 72 hours unless it is in the member's interest to extend this time-period. When a member requests an expedited Appeal, BCBSIL will automatically expedite the Appeal. An Appeal concerning payment cannot be expedited.

BCBSIL will comply with all CMS-required appeal timeframes for MA plans. Members should be directed by Provider to refer to their Evidence of Coverage for specific Appeal information.

Further Appeal Rights
If BCBSIL denies the member's Appeal in whole or part, BCBSIL will forward the Appeal to an independent review entity (IRE) that has a contract with the federal government and is not part of BCBSIL. BCBSIL must forward the member's casefile to the IRE within applicable regulatory timeframes.

The IRE will review the Appeal and, if the Appeal involves authorization for benefits, decide as expeditiously as the member's health condition requires, but no later than within 30 days of receipt of the member's casefile. If the Appeal involves payment determination, the IRE will generally make the decision within 60 days of receipt of the member's casefile. If the Appeal involves an expedited Reconsideration decision, the IRE will make the decision as expeditiously as the member's health condition requires, but no later than within 72 hours of receipt of the member's casefile.

If the IRE issues an adverse decision and the amount at issue meets a specified dollar threshold, the member may appeal to an Administrative Law Judge (ALJ). If the Member is not satisfied with the ALJ's decision, the member may request review by the Medicare Appeals Council (MAC). If the MAC refuses to hear the case or issues an adverse decision, the Member may be able to request Judicial Review.

BCBSIL will comply with all CMS-required Appeal timeframes for MA plans. Members should be directed by provider to refer to their Evidence of Coverage for specific Appeal information.

Detailed Notice of Discharge
Hospitals are required to deliver the Important Message from Medicare (IM), CMS-R-193, to all MA HMO Non- Delegated Plan Members who are Hospital inpatients. The IM informs Hospitalized inpatient beneficiaries of their hospital discharge Appeal rights. Members who choose to Appeal a discharge decision must receive the receive the Detailed Notice of Discharge (DND) from the Hospital or their MA Plan, if applicable. These requirements were published in a final rule, CMS- 4105-F: Notification of Hospital Discharge Appeal Rights, which became effective on July 2, 2007.

SNF, HHA, and CORF Discharge Notification Requirements
All health care Providers providing services to MA HMO Non-Delegated plan members, must give an advance, completed copy of the Notice of Medicare Non-Coverage (NOMNC) to members receiving skilled nursing (SNF), home health agency (including psychiatric home health) (HHA), or comprehensive outpatient rehabilitation facility services (CORF), no later than two days before the termination of services, and a copy must be provided to:

Fax: 855-874-4711
Mail: BCBSIL P.O. Box 4288
Scranton, PA 18505

If the member's services are expected to be fewer than 2 days in duration, the provider should notify the member at the time of admission. If, in a non-institutional setting, the span of time between services exceeds two days, the notice should be given no later than the next to last time that services are furnished. This notice fulfills the requirement at 42 C.F.R. 422.624(b)(1) and (2). Providers are expected to comply with all applicable provisions of 42 C.F.R. 422.624.

The notice must be validly delivered. Valid delivery means that the member must be able to understand the purpose and contents of the notice to sign for receipt of it. The Member must be able to understand that he or she may Appeal the termination decision. If the member is not able to comprehend the contents of the notice, it must be delivered to and signed by a Representative.

Valid delivery does not preclude the use of assistive devices, witnesses, or interpreters for notice delivery. Thus delivery. Thus, if a member is not able to physically sign the notice to indicate receipt, then receipt, then delivery may be proven valid by other means.

Do not use the NOMNC if coverage is being terminated for any of the following reasons:
- Because the MA benefit is exhausted.
- For denial of MA admission.
- For denial of non-MA Covered Services; or
- Due to a reduction or termination of an MA service, that does not end the skilled MA stay.

In these cases, BCBSIL will issue the CMS form 10003 - Notice of Denial of Medical Coverage (NDMC).

The NOMNC is a standardized notice. Therefore, MA plans, provider, and provider, and its providers its providers may not re- write, re- interpret or insert non-OMB-approved language into the body of the notice except where indicated.

The Member must be able to understand that he or she may Appeal the termination decision. If the member thinks his or her coverage is ending too soon, the member can Appeal directly and immediately to the Quality Improvement Organization (QIO). The Member must request an Appeal to the QIO no later than noon of the day before the date services are to end. If the Member misses the deadline, for Appealing to the QIO, the member should still reach out to the QIO for assistance.

Detailed Explanation of Non-Coverage

BCBSIL will provide a completed copy of the Detailed Explanation of Non-Coverage (DENC) to members receiving SNF, HHA or CORF services upon notice from the QIO that the Member has appealed the termination of services in these settings. This notice fulfills the requirement at 42 CFR 422.626(e)(1) and will be provided to the member no later than close of business of the day of the QIO's notification. The DENC is a standardized notice. BCBSIL may not deviate from the wording or content of the form except where authorized to do so. BCBSIL will also send a copy of the DENC to the QIO. The DENC will include the following:

- A specific and detailed explanation why services are either no longer reasonable and necessary or otherwise no longer covered;
- A description of any applicable Medicare coverage rule, instruction or other Medicare policy, including citations to the applicable Medicare policy rules or information about how the Member may obtain a copy of the Medicare policy from BCBSIL;
- Any applicable BCBSIL MA plan policy, contract policy, contract provision, or rationale upon which the termination decision was based; and
- Facts specific to the member and relevant to the termination decision that decision that is sufficient to advise the Member of the applicability of the coverage rule or policy to the member's case

Section 11: Quality Improvement

Quality Improvement Project
Quality improvement is an essential element in the delivery of care and services by Blue Cross Medicare Advantage (Non- Delegated HMO/PPO). To define and assist in monitoring quality improvement, the Blue Cross Medicare Advantage (Non- Delegated HMO/PPO) Quality Improvement Program focuses on measurement of clinical care and service delivered by physician, professional Provider, facility, or ancillary Providers against established goals. Key components of the program described below include the Chronic Care Improvement Program (CCIP), Quality Improvement Projects (QIPs) and performance monitoring (HEDIS, CAHPS, HOS). Formal evaluation of the program occurs annually to assess the impact and effectiveness of the program.

Chronic Care Improvement Program (CCIP)
A set of interventions designed to improve the health of individuals who live with multiple or sufficiently severe chronic conditions and include patient identification and monitoring.
Other programmatic elements may include the use of evidence- based practice guidelines, collaborative practice models involving physicians as well as support-services providers, and patient self-management techniques.

Quality Improvement Project (QIP)
An organization's initiative that focuses on specified clinical and non-clinical areas.

Healthcare Effectiveness Data and Information Set (HEDIS®)
A widely used set of health plan performance measures utilized by both private and public health care purchasers to promote accountability and assess the quality of care provided by managed care organizations.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
A patient's perspective of care survey, administered annually, in which a sample of Members from Provider organizations (e.g., MAOs, PDPs, PFFS) are asked for their perspectives of care that allow meaningful and objective comparisons between Providers on domains that are important to consumers; create incentives for Providers to improve their quality of care through public reporting of survey results; and enhance public accountability in health care by increasing the transparency of the quality of the care provided in return for the public investment status.

Health Outcomes Survey (HOS)
This survey is the first outcomes measure used in the Medicare program. It is a longitudinal, self-administered survey that uses a health status measure, the VR-12, to assess both physical and mental functioning. A sample of Members from each MA organization health plan is surveyed. Two years later, these same Members are surveyed again to evaluate changes in health status.

Quality of Care Issues

The Quality Improvement Program includes aggregation and analysis of trend for quality-of-care issues. A quality- of-care complaint may be filed through the Medicare health plan's grievance process and/or the Beneficiary and Family Centered Quality Improvement Organization (BFCC-QIO). A BFCC-QIO must determine whether if the quality of services (including both inpatient and outpatient services) provided by a Medicare health plan meets professionally recognized standards of health care a grievance related to whether the quality of covered services provided by a plan or provider meets professionally recognized standards of health care, including whether appropriate health care services have been provided or have been provided in appropriate settings, including whether appropriate health care settings were provided and whether services were provided in appropriate settings.

The BFCC- QIO is comprised of practicing doctors and other health care experts under contract with the Federal government to monitor and improve the care given to Medicare enrollees. The BFCC-QIOs review complaints raised by Medicare enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare managed health plans, and ambulatory surgical centers. The QIOs also review continued stay denials for Medicare enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs, and CORFs.

CMS Star Ratings

The Centers for Medicare & Medicaid Services (CMS) posts quality ratings of Medicare Advantage plans to provide Medicare beneficiaries with additional information about the various Medicare Advantage plans offered in their area. CMS rates Medicare Advantage plans on a scale of one to five stars and defines the star ratings in the following manner:

- 5 Stars = Excellent performance.
- 4 Stars = Above average performance.
- 3 Stars = Average performance.
- 2 Stars = Below average performance; and,
- 1 Star = Poor performance.

The quality scores for Medicare Advantage plans are based upon performance measures from the following that are derived from four sources:

- Healthcare Effectiveness Data and Information Set (HEDIS®);
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®);
- Health Outcomes Survey (HOS); and,
- CMS Administrative data, including information about member satisfaction, plans' appeals processes, audit results, and customer service.
- Prescription Drug Event (Part D)
- Improvement of Plans Performance
- CMS groups the quality measure into five nine domains, including:
- Staying healthy: screenings, tests, and vaccines;
- Managing chronic (long-term) conditions;
- Member experience with health plan or drug plan
- Ratings of health plan responsiveness and care;
- Member complaints and changes in the health plan's performance or drug plan's performance, problems getting services and choosing to leave the plan; and,
- Health plan or drug plan customer service.
- Drug safety and accuracy of drug pricing

Part C measures are grouped to calculate a Part C rating. Part D measures are grouped to calculate a Part D rating. For MA-PDs, all unique Part C and Part D measures are grouped to create an overall rating. All rated plans receive both summary scores and overall scores. The summary score is used to provide quality- based payments and an overall measure of a plan's quality based on indicators specific to quality and access to care. The overall score differs from the summary score because it combines a plan's summary score with its Part D plan rating.

Cooperation with BCBSIL and Quality Improvement Organizations

Participating physician, professional Provider, facility, or ancillary Providers must comply and cooperate with all Blue Cross Medicare Advantage (Non-Delegated HMO/PPO) Medical Management policies and procedures and in the Blue Cross Medicare Advantage (Non-Delegated HMO/PPO) Quality Assurance and Performance Improvement Programs. In addition, participating physician, professional Provider, facility, or ancillary Providers must cooperate with the independent quality review and improvement organization, [Quality Improvement Organization (QIO)], approved by CMS in its review of quality of care and investigation of quality complaints on behalf of the Medicare program. KEPRO Livanta is the QIO for Blue Cross Medicare Advantage (Non-Delegated HMO/PPO).

Section 12: MA HMO Non-Delegated Plan Contact Information

Contact	Phone/Fax/URL
Appeals and Grievances (members)	**Appeals:** Blue Cross Medicare Advantage Attn: Appeals Department P.O. Box 663099 Dallas, TX 75266 **Grievances:** Blue Cross Medicare Advantage Attn: Grievances Department P.O. Box 4288 Scranton, PA 18505 **Customer Service Phone:** 877-774-8592 **Appeals Fax:** 800-419-2009 **Expedited Appeals Fax (Pre-**Service Only) 800-338-2227 **Grievances Fax:** 855-674-9189
The Availity® Essentials *(For electronic claim questions)*	Availity Client Services – 800-282-4548 Availity® Essentials
Blue Medicare Rx *MAPD Pharmacy Help Desk*	**(800)-693-6704**
Care Management Programs *(Medical & Behavioral Health)*	**(855)-390-6567** **(855) 390-6573**
Claims Address *(For submission of paper claims)*	Blue Cross Medicare Advantage c/o Provider Services P.O. Box 3686 Scranton, PA 18505
CMS Website Address	www.cms.gov
EDI Claim Submission- PAYER ID	**66006**
Member/Provider Customer Service *(To obtain benefits, eligibility or claims status)*	**(877)-774-8592 (TTY: 711)** Hours of operation: 8 a.m. to 8 p.m., MT, 7 days a week. alternate technologies (for example, voicemail) will be used on the weekends and holidays.

Provider Claim Dispute *(Post Service - Claim Only)*	Blue Cross Medicare Advantage c/o Provider Services P.O. Box 4555 Scranton, PA 18505 **Dispute Fax: (855)-674-9185** **Phone: (877)-774-8592**
Provider Network Consultants (PNC): Please refer to BCBSIL website for PNC list.	https://www.bcbsil.com/provider/network/provider_network_consultant.html
Provider Pre-Service Appeal	**Appeals:** Blue Cross Medicare Advantage Attn: Appeals Department PO Box 663099 Dallas, TX 75266 **Customer Service Phone:** (877)-774-8592 **Appeals Fax:** 800-419-2009 **Expedited Appeals Fax (Pre-**Service Only) 800-338-2227
Utilization Management (UM) *(For Medical and Behavioral Health)* Availity Essentials Portal Preauthorization & Out-of-Network Authorizations Preauthorization Fax eviCore Website	https://www.Availity Essentials.com/healthplans **877-774-8592 (P)** **855-874-4711 (F)** https://www.evicore.com/healthplan/bcbsil For a detailed listing of CPT codes that require authorization, please see the document titled "*Prior Authorization Procedure Code List*" *under the* Blue Cross Medicare Advantage HMO Manual/Resources section on the www.bcbcsil.com website.

Glossary of Terms

Term	Description
Agreement	The operative and controlling MA HMO Non-Delegated contract between a provider and Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation ("HCSC"), a Mutual Legal Reserve Company and an Independent Licensee of the Blue Cross and Blue Shield Association.
Annual Health Assessment	An Annual Health Assessment (AHA) may be completed with a health professional who may be a physician, physician assistant, nurse practitioner or clinical nurse specialist.
Appeal	Any of the actions or procedures that involve a request for review of adverse organization determinations pertaining to health care services received, or any amounts that the member must pay for a covered service (including prescription drugs).
Covered Services	Those health care benefits which are available to the member enrolled in the MA HMO Non-Delegated plan and described in the member's Evidence of Coverage.
Emergency Medical Condition	Medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injuries of such a nature that failure to receive immediate medical care could result in: • Serious jeopardy of the patient's health; • Serious impairment of bodily functions; • Serious dysfunction of any bodily organ or part; • Serious disfigurement; or • Serious jeopardy to the health of the fetus, in the case of a pregnant patient.
Emergency Services	These are covered services that are needed to evaluate or stabilize an emergency medical condition, and which are furnished by a provider qualified to furnish services to individuals experiencing an emergency medical condition.
Evidence of Coverage	The document(s) which describe the describe the health benefits coverage available to members enrolled in a MA HMO Non-Delegated plan.
Hospital	A Medicare-certified institution licensed in a state, which provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term "hospital" does not include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily custodial care, including training in routines of daily living.

Laws	Means all applicable laws, rules, regulations, statutes, orders, and standards of the United States of America, the states or any department or agency thereof with jurisdiction over any or all the parties, as such laws, rules, regulations, statutes, orders, and standards are adopted, amended, or issued from time to time. Laws include, without limitation, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations, including the HIPAA Privacy Rule and HIPAA Security Rule; Parts C and D of Title XVIII of the Social Security Act and its implementing regulations, including Parts 422 and 423 of Title 42 of the Code of Federal Regulations; all CMS guidance and instructions relating to the Medicare Advantage and Medicare Prescription Drug Programs; Title VI of the Civil Rights Act of 1964; the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act; the requirements applicable to individuals and entities receiving federal funds; the federal False Claims Act; any applicable state false claims statute, the federal anti-kickback statute; and the federal regulations prohibiting the offering of beneficiary inducements.
Medicare	The Federal Government health insurance program established by Title XVIII of the Social Security Act.
Medicare Part A	Part A includes benefits for hospital insurance benefits including inpatient hospital care, skilled nursing facility care, home health agency care and hospice care offered through Medicare.
Medicare Part B	Part B includes benefits for physician services (in both Hospital and non- Hospital settings) and services furnished by certain non-physician practitioners. Other Part B services include lab testing, durable medical equipment, diagnostic tests, ambulance services, prescription drugs that cannot be self-administered, certain self- administered anti-cancer drugs, some other therapy services, certain other health services, and blood not covered under Part A.
Medicare Advantage (MA) Plan	A policy or benefit package offered by an MA organization under which a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area covered by the MA organization. An MA organization may offer more than one benefit plan in the same Service Area. In many cases, MA Plans also offer Medicare Part D (prescription coverage). These plans are called MA plans with prescription drug coverage (MAPD).
Member	A Medicare beneficiary entitled to receive Covered Services who has voluntarily elected to enroll in a MA HMO Non-Delegated plan and whose enrollment has been confirmed by CMS.

Participating IPA	Any duly organized Individual practice association (IPA), Independent Physician Association, organized medical group, physician Hospital organization or other legal entity organized to arrange for the provision of professional medical service which has in force a contract or agreement with BCBSIL to provide professional and ancillary services to members enrolled in BCBSIL as outlined in provider manual and according to the member's plan of benefits outlined in his or her evidence of coverage.
Participating Provider	A hospital facility, health care facility, laboratory, physician, person, or other provider of medical services which has a written agreement with BCBSIL at the time covered services are provided to members and that is duly licensed by the appropriate state and local authority to provide such services.
Physician	Any person currently licensed to practice medicine or osteopathy in the state in which the person maintains their office.
Primary Care Physician (PCP)	Any IPA Physician who has been selected by the member to be primarily responsible for treating and coordinating the member's health care needs. A PCP may be a physician who is board certified or board eligible in internal medicine, family practice, general practice or geriatric medicine.
Provider	Any physician or health care practitioner, to include, but not limited to, a physician, physical therapist, psychologist therapist, psychologist, hospital facility, health care facility, laboratory facility, laboratory, and any other provider of medical services, licensed in accordance with all applicable Laws. A provider may be independently contracted or a participating provider within a participating IPA.
Provider Manual	This booklet which describes the requirements and responsibilities of participating IPAs and its Providers or an Individually contracted provider who have agreed to participate in the MA HMO Non-Delegated network.
Quality Improvement Organization (QIO)	Organizations comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to MA members and Medicare enrollees. QIOs review complaints raised by MA members about the quality of care provided by Physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled rooms, skilled nursing facilities, home health agencies, Medicare health plans and ambulatory surgical centers. The QIOs also review continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs and CORFs. KEPRO in Area 4 located at 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609 is the QIO for BCBSIL. Toll-free Phone Number: 855-408-8557 Fax: 844-834-7130 Local Phone Number: 813-280-8256

Reconsideration	A BCBSIL MA member's first step in the Appeal process after an adverse organization determination. BCBSIL or an independent review entity may re-evaluate an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.
Representative	An individual appointed by a MA HMO Non-Delegated plan member or other party, or authorized under state or other applicable law, to act on behalf of the member or other party involved in an appeal or grievance. Unless otherwise stated, the representative will have all the rights and responsibilities of the member or party in obtaining an organization determination, filing a grievance, or in dealing with any of the levels of the appeals process, subject to the applicable rules described at 42 CFR Part 405.

Checking eligibility and/or benefit information and/or obtaining prior authorization is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage, including, but not limited to, exclusions and limitations applicable on the date services were rendered. If you have any questions, call the number on the member's ID card.

Availity is a trademark of Availity, LLC., a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSIL. eviCore healthcare (eviCore) is an independent company that has contracted with BCBSIL to provide prior authorization for expanded outpatient and specialty utilization management for members with coverage through BCBSIL. BCBSIL makes no endorsement, representations or warranties regarding third party vendors and the products or services they offer.