Capital BlueCross

Schedule of Preventive Care Services

The greatest advantage of preventive care services is detecting potential problems early. To help members avoid serious illness, our group health plans include coverage for the pediatric and adult preventive care services listed below.

PEDIATRIC CARE (Birth through age 18)*

Service	Preventive Benefit Coverage
Routine History and Physical Exam Exams may include: newborn screening; height, weight and blood pressure measurements; body mass index (BMI); developmental milestones; sensory screening for vision and hearing.	21 exams between the ages of 0-10, which typically occur as follows: – As a newborn and at 2 to 4 weeks; – At months 1, 2, 4, 6, 9, 12, 15, 18, 24 and 30; and – At 3, 4, 5, 6, 7, 8, 9 and 10 years of age. – One exam annually, between 11 and 18 years of age
Screenings Includes, but is not limited to: newborn screenings for PKU; sickle cell; hemoglobinopathies and hypothyroidism; lead screening; hemoglobin and hematocrit; urinalysis; lipid screening; tuberculin test; Pap test and screening for sexually transmitted disease (when indicated).	Administered in accordance with age and frequency guidelines recommended by the American Academy of Pediatrics, U.S. Preventive Services Task Force, and the Centers for Disease Control and Prevention.
Immunizations Includes: Rotavirus; Polio; Diphtheria-Tetanus-Pertussis (DTaP); Tetanus-reduced Diphtheria/Pertussis (Tdap); Measles-Mumps-Rubella (MMR); Haemophilus influenzae type b (Hib); Hepatitis B; Chickenpox (VZV); Hepatitis A; Influenza*; Pneumococcal (PCV); Meningococcal (MCV4); Human Papillomavirus (HPV) for males and females.	Administered in accordance with age and frequency guidelines as required by state law and/or as recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention. Mandated childhood immunizations are covered through age 20, in accordance with state law.
Nutritional Counseling for Children Diagnosed With Obesity Includes two sessions for anticipatory guidance for age-appropriate issues such as growth and development, breastfeeding/nutrition and obesity prevention.	Administered in accordance with guidelines recommended by the American Academy of Pediatrics and the U.S. Preventive Services Task Force.

ADULT CARE (Ages 19 and over)

Service	Preventive Benefit Coverage
Routine History and Physical Exam Includes pertinent patient education and counseling.	Nine exams between the ages of 19-49, which typically occur as follows: – Ages 19-29, once; – Ages 30-49, every four years; and – Age 50+, annually.
Screenings Includes, but may not be limited to: Pap smear/pelvic exam; chlamydia/gonorrhea tests (women); HIV tests (men/women); fasting lipid profile; fasting glucose; fecal occult blood test; flexible sigmoidoscopy; colonoscopy; barium enema; prostate specific antigen (PSA); bone mineral density (women); mammogram; abdominal ultrasound (men; screen for abdominal aortic aneurysm). Prenatal screenings include, but may not be limited to: Bacteriuria; Hepatitis; Iron Deficiency Anemia; Rh (D) blood typing and antibody testing; and sexually transmitted diseases.	Administered in accordance with age and frequency guidelines as required by state law and/or as recommended by the U.S. Preventive Services Task Force, National Institutes of Health, Centers for Disease Control and Prevention, American Diabetes Association, and the American Cancer Society.
Immunizations Includes: Tetanus/Diphtheria (Td); Hepatitis A; Hepatitis B; Meningococcal (MCV4/MPSV4); Measles/Mumps/Rubella (MMR); Chickenpox (VZV); Influenza*; Pneumococcal (PPV); Human Papillomavirus (HPV), Zoster	Administered in accordance with age and frequency guidelines as required by state law and/or as recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention.
Women's Services Includes well-women visits, screening and counseling (i.e., interpersonal and domestic violence, sexually transmitted infections, gestational diabetes, HIV).	Administered in accordance with guidelines as required by federal law and as recommended by the U.S. Department of Health and Human Services (HHS).
Nutritional Counseling for Adults Diagnosed With Obesity Includes two sessions for obesity screening and health diet counseling.	Administered in accordance with guidelines as required by state law and/or as recommended by the U.S. Preventive Services Task Force.

* Capital BlueCross has extended coverage of influenza immunization to all individuals with the preventive benefit regardless of risk.

This information highlights the preventive care services available under this *coverage*. It is not intended to be a complete list or complete description of available services. Services may be subject to *copayment*, *deductible* and/or *coinsurance*. Additional diagnostic studies may be covered if *medically necessary* for a particular diagnosis or procedure. Refer to the *Certificate of Coverage* for specific information on available *benefits*. This schedule is periodically updated to reflect current recommendations from the American Academy of Pediatrics, National Institutes of Health, U.S. Preventive Services Task Force, American Cancer Society, Advisory Committee on Immunization Practices and Centers for Disease Control and Prevention.

This preventive schedule includes the services deemed to be mandated under the federal Patient Protection and Affordable Care Act (PPACA). As changes are communicated, Capital BlueCross will adjust the preventive schedule as required.

Capital BlueCross

Preauthorization Program

Traditional, Comprehensive, PPO

To receive the highest level of benefits it is sometimes necessary to obtain preauthorization for services.

SERVICES REQUIRING PREAUTHORIZATION

The following services, regardless of whether they are performed as an inpatient or outpatient, require preauthorization:

- All non-emergency inpatient admissions including acute care, long-term acute care, skilled nursing facilities, rehabilitation hospitals and mental health care and substance abuse treatment facilities, including partial hospitalization. Emergent admissions require notification within 48 hours;
- Non-emergent air and ground ambulance transports;
- Behavioral health (mental health care/substance abuse) - intensive outpatient programs (Behavioral health phone numbers are listed on the member's ID card);
- Diagnostic assessment and treatment for autism spectrum disorder;
- Bio-engineered or biological wound care products.
- Category IDE Trials;
- Clinical Trials (including cancer related trials);
- Durable medical equipment (DME), orthotic devices and prosthetic appliances for all purchases and repairs greater than or equal to $500 dollars. All DME rental items that are on the preauthorization list, regardless of price per unit, require preauthorization;
- Enhanced external counterpulsation (EECP)
- All testing for genetic disorders except; standard chromosomal tests, such as Down Syndrome, Trisomy, and Fragile X, and state mandated newborn genetic testing;
- Home health care;
- Home infusion therapy;
- Hyperbaric Oxygen Therapy (non-emergent);
- Intraocular injection for retinal pathology when performed in a facility;
- All potentially investigational and reconstructive/cosmetic therapies and procedures;
- Laser treatment of skin lesions
- Office surgical procedures that are performed in a facility, including, but not limited to:
  - Arthrocentesis;
  - Aspiration of a joint;
  - Colposcopy;
  - Electrodessication condylomata (complex);
  - Excision of a chalazion;
  - Excision of a nail (partial or complete);
  - Enucleation or excision of external thrombosed hemorrhoids
  - Injection of a ligament or tendon;
  - Oral surgery;
  - Pain management (including facet joint injections, trigger point injections, stellate ganglion blocks, peripheral nerve blocks, SI joint injections, and intercostals nerve blocks);
  - Proctosigmoidoscopy/flexible Sigmoidoscopy;
  - Removal of partial or complete bony impacted teeth (if a benefit);
  - Repair of lacerations, including suturing (2.5 cm or less);
  - Vasectomy;
  - Wound care and dressings (including outpatient burn care)
- Outpatient surgeries - All potentially reconstructive/cosmetic and investigational surgeries/procedures;
- Outpatient rehabilitation therapies including physical medicine, occupational therapy, respiratory therapy and manipulation therapy. Pulmonary rehabilitation programs;
- Sleep Studies for the diagnosis and medical management of obstructive sleep apnea syndrome
- Specialty Medical Injectable Medications
- Transplant evaluation and services. Preauthorization will include referral assistance to the Blue Quality Centers for Transplant network if appropriate.

Preauthorization requirements do not apply to services provided by a hospital emergency room provider. If an inpatient admission results from an emergency room visit, notification must occur within forty-eight (48) hours or two (2) business days of the admission. If the hospital is a participating provider, the hospital is responsible for performing the notification. If the hospital is a non-participating provider, the member or the member's responsible party acting on the member's behalf is responsible for the notification.

HOW TO OBTAIN REQUIRED PREAUTHORIZATION

The member's identification card will show if preauthorization is required before receiving the listed services or supplies.

If preauthorization is required, members should present their identification card to their health care provider when medical services or supplies are requested. The member's participating provider will be asked to provide medical information on the proposed treatment to Capital's Clinical Management Department by calling **1-800-471-2242**.

If members use a non-participating provider or a BlueCard participating provider, it is their responsibility to obtain preauthorization. Members should call Capital's Clinical Management Department toll-free at **1-800-471-2242** to obtain the necessary preauthorization. A non-participating provider may call on the member's behalf. However, it is ultimately the member's responsibility to obtain preauthorization.

Capital's Clinical Management Department will notify the member's health care provider and the member of the authorization or denial of the requested procedures, services, and/or supplies within fifteen (15) days after Capital receives the request for preauthorization. Capital may extend the fifteen (15)-day time period one (1) time for up to fifteen (15) days for circumstances beyond Capital's control. Capital will notify the member prior to the expiration of the original time period if an extension is needed. The member and Capital may also agree to an extension if the member or Capital requires additional time to obtain information needed to process the member's preauthorization.

Preauthorization of elective admissions and selected services should be obtained at least seven (7) days prior to the date of service. Maternity admissions require notification within two (2) business days of the date of admission.

PREAUTHORIZATION OF MEDICAL SERVICES INVOLVING URGENT CARE

Special rules apply to preauthorization of urgent care medical services.

If the member's request for preauthorization involves urgent care, the member or the member's provider should advise Capital of the urgent medical circumstances when the member or the member's provider submit the request to Capital's Clinical Management Department. Capital will respond to the member and the member's provider no later than seventy-two (72) hours after Capital's Clinical Management Department receives the preauthorization request.

Members who are dissatisfied with an adverse preauthorization determination regarding an urgent care claim may submit an appeal. Urgent care appeals may be submitted orally by contacting Capital's Customer Service Department, toll-free, at **1-800-962-2242**. Capital will notify the member's health care provider and the member of the outcome of the appeal via telephone or facsimile no later than seventy-two (72) hours after Capital receives the appeal.

PREAUTHORIZATION PENALTY

When a procedure is not preauthorized when required, there may be a preauthorization penalty.

If the member presents his/her ID card to a participating provider in the 21-county area and the participating provider fails to obtain or follow preauthorization requirements, the allowable amount will not be subject to reduction.

When members undergo a procedure requiring preauthorization and fail to obtain preauthorization (when responsible to do so), benefits will be provided for medically necessary covered services. However, in this instance, the allowable amount may be reduced by the dollar amount or the percentage established in the Certificate of Coverage.

PLEASE NOTE: This listing identifies those services that require preauthorization only as of the date it was printed. This listing is subject to change. Members should call Capital at **1-800-962-2242** (TDD number at **1-800-242-4816**) with questions regarding the preauthorization of a particular service.

This information highlights the standard Preauthorization Program. *Members* should refer to their *Certificate of Coverage* for the specific terms, conditions, exclusions and limitations relating to their *coverage*.

Keystone HEALTH PLAN® CENTRAL
A Capital BlueCross Company

Preauthorization Program
HMO

SERVICES REQUIRING PREAUTHORIZATION

The following services require preauthorization:

- All non-emergency inpatient admissions including acute care, long-term acute care, skilled nursing facilities, and rehabilitation hospitals;
- Non-emergent air and ground ambulance transports;
- Behavioral health (mental health care/substance abuse) – all inpatient admissions, partial hospitalization, outpatient services, and intensive outpatient programs (Behavioral health phone numbers are listed on the member's ID card);
- Diagnostic assessment and treatment for autism spectrum disorder;
- Bio-engineered or biological wound care products;
- Category IDE Trials;
- Clinical Trials (including cancer related trials);
- Durable medical equipment (DME), orthotic devices and prosthetic appliances for all purchases and repairs greater than or equal to $500 dollars. All DME rental items that are on the preauthorization list, regardless of price per unit, require preauthorization;
- Enhanced external counterpulsation (EECP);
- All testing for genetic disorders except: standard chromosomal tests, such as Down Syndrome, Trisomy, and Fragile X, and state mandated newborn genetic testing;
- Home health care;
- Home infusion therapy;
- Hyperbaric Oxygen Therapy (non-emergent);
- All high-tech, non-emergency imaging procedures including: MRIs (magnetic resonance imaging), MRAs (magnetic resonance angiography), CT (computerized tomography) scans, PET (positron emission tomography) scans, SPECT (single proton emission computerized tomography) scans, and all cardiac nuclear medicine studies, including nuclear cardiac stress tests;
- Intraocular injection for retinal pathology when performed in a facility;
- All potentially investigational and reconstructive/cosmetic therapies and procedures;
- Laser treatment of skin lesions;
- Manipulation therapy (chiropractic and osteopathic);
- All care performed by a non-participating provider.
- Office surgical procedures that are performed in a facility, including, but not limited to:
  - Arthrocentesis;
  - Aspiration of a joint;
  - Colposcopy;
  - Electrodessication condylomata (complex);
  - Excision of a chalazion;
  - Excision of a nail (partial or complete);
  - Enucleation or excision of external thrombosed hemorrhoids
  - Injection of a ligament or tendon;
  - Oral surgery;
  - Pain management (including facet joint injections, trigger point injections, stellate ganglion blocks, peripheral nerve blocks, SI joint injections, and intercostals nerve blocks);
  - Proctosigmoidoscopy/flexible Sigmoidoscopy;
  - Removal of partial or complete bony impacted teeth (if a benefit);
  - Repair of lacerations, including suturing (2.5 cm or less);
  - Vasectomy;
  - Wound care and dressings (including outpatient burn care)
- Outpatient surgeries - All potentially reconstructive/cosmetic or investigational surgeries;
- Pulmonary rehabilitation programs;
- Rehabilitation therapies including physical medicine, occupational therapy, and respiratory therapy;
- Sleep Studies for the diagnosis and medical management of obstructive sleep apnea syndrome
- Specialty Medical Injectable Pharmaceuticals.
- Transplant evaluation and services. Preauthorization will include referral assistance to the Blue Quality Centers for Transplant network if appropriate;

Preauthorization requirements do not apply to services provided by a hospital emergency room provider. If an inpatient admission results from an emergency room visit, notification to Keystone Health Plan® Central must occur within forty-eight (48) hours or two (2) business days of the admission. If the hospital is a participating provider, the hospital is responsible for performing the notification. If the hospital is a non-participating provider, the member or the member's responsible party acting on the member's behalf is responsible for the notification.

HOW TO OBTAIN REQUIRED PREAUTHORIZATION

Members should present their identification card to their health care provider when services or supplies are requested. The member's provider will need to provide medical information on the proposed treatment to Keystone Health Plan Central's Clinical Management Department by calling **1-800-471-2242**. Keystone Health Plan Central will verify the member's eligibility for benefit coverage, and the medical necessity of the service being requested. The member's participating provider is responsible for obtaining preauthorization. However, we recommend that members check with their provider to be sure that the necessary approvals were obtained before receiving services. Preauthorization of elective admissions and selected services should be obtained at least two (2) weeks prior to the date of service. Maternity admissions require notification within two (2) business days of the date of admission.

PLEASE NOTE: This listing identifies those services that require preauthorization only as of the date it was printed. This listing is subject to change. Members should call Keystone Health Plan Central at **1-800-669-7061** (TDD number at **1-800-669-7075**) with questions regarding the preauthorization of a particular service.

This information highlights Keystone Health Plan Central's Preauthorization Program. Members should refer to their Certificate of Coverage for the specific terms, conditions, exclusions and limitations relating to their *coverage*.