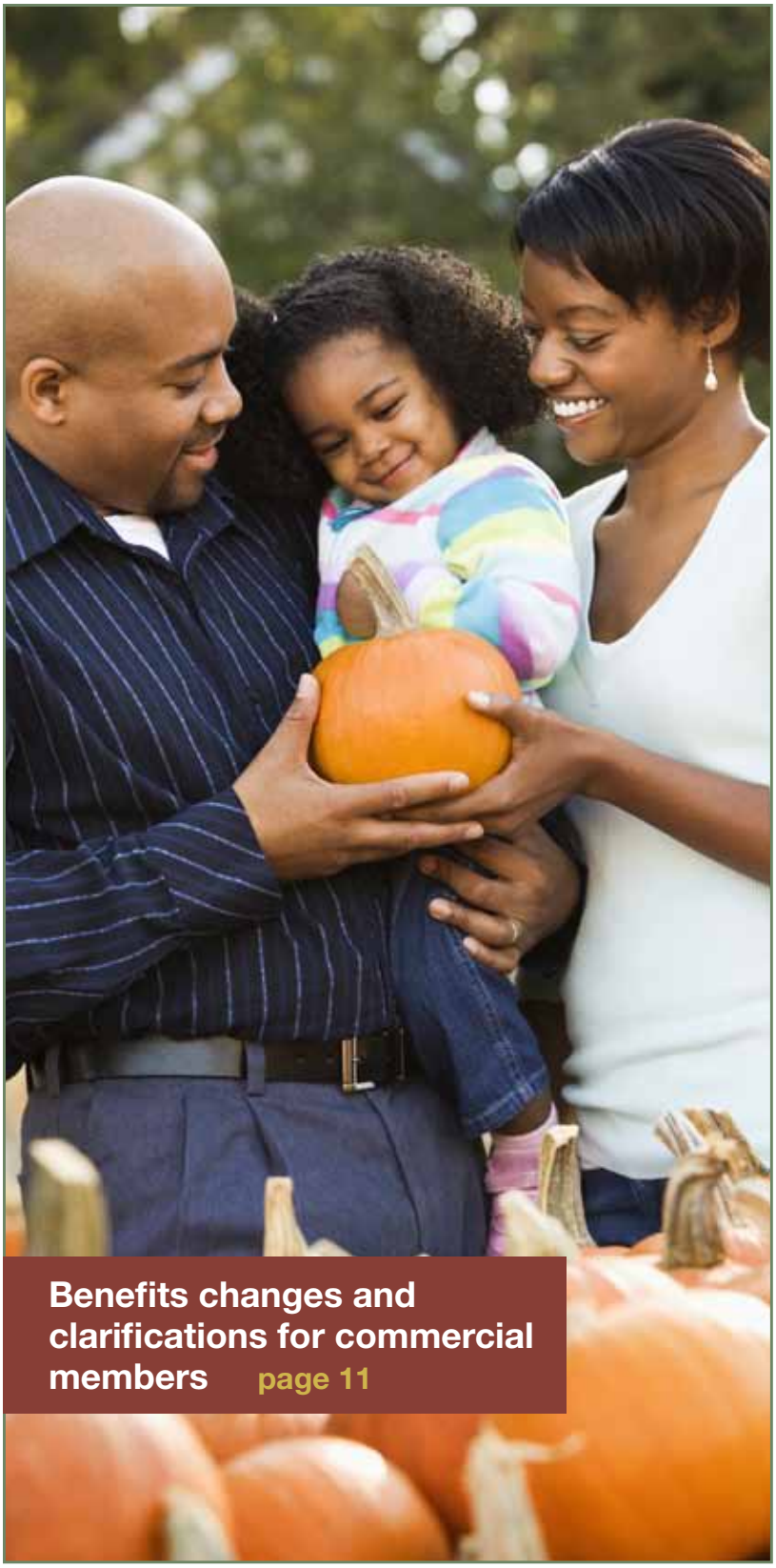
Independence Partners in Health
UPDATE℠



Benefits changes and clarifications for commercial members page 11

Inside this edition

▶ Articles designated with an orange arrow include notice of changes or clarifications to administrative policies and procedures.

Reminder...

P F A

Update your provider information with us

Have you made any changes to your key practice information, such as your mailing address or the name of your practice? If so, please be sure to notify us.

We value your help in keeping our data files current. Accurate data files allow us to continue to provide you with important information on billing, claims, changes or additions to policies, and announcements of administrative processes.

Professional providers

Please send any changes to your information by submitting the *Provider Change Form*, which is available on the NaviNet® web portal or on our website at *www.ibx.com/providerforms*. You may also call your Network Coordinator to report changes.

Facility and ancillary providers

You are required to submit any changes to your information in writing. This request should be sent directly to the senior vice president of contracting and the legal department at the addresses below:

Independence Blue Cross
Attn: Senior Vice President, Contracting and Provider Networks
1901 Market Street, 29th Floor
Philadelphia, PA 19103

Independence Blue Cross
Attn: Legal Department
1901 Market Street, 36th Floor
Philadelphia, PA 19103

Note: Thirty days' advance notice is required for processing.

Personal Choice®, Keystone 65 HMO, and Personal Choice 65℠ PPO have an accreditation status of *Excellent* from the National Committee for Quality Assurance (NCQA).

Keystone Health Plan East has an accreditation status of *Commendable* from NCQA.

Partners in Health Update℠ is a publication of Independence Blue Cross and its affiliates (IBC), created to provide valuable information to the IBC-participating provider community. This publication may include notice of changes or clarifications to administrative policies and procedures that are related to the covered services you provide in accordance with your participating professional provider, hospital, or ancillary provider/ancillary facility contract with IBC. This publication is the primary method for communicating such general changes. Suggestions are welcome.

Contact information:

Provider Communications
Independence Blue Cross
1901 Market Street
29th Floor
Philadelphia, PA 19103
provider_communications@ibx.com

John Shermer
Managing Editor

Charleen Baselice
Production Coordinator

Changing the way we do business with you

Earlier this year, we advised you of an upcoming transition to a new operating platform for our core processing activities to help us gain efficiencies and lower operating costs. This transition will also help us to add new capabilities that enhance the overall customer experience.

IBC will be using Highmark's operating platforms to handle core processing functions such as enrollment, claims, and billing. IBC employees will continue to process claims but will be using Highmark's systems instead of IBC systems. IBC and Highmark remain separate and independent companies.

We are committed to working closely with our network physicians and hospitals to provide continued information, support, and necessary training. In order to keep you informed of the upcoming changes, we will be sending an increased volume of communications. We have also created this new section within *Partners in Health Update* – Business Transformation – which will be dedicated to news related to this transition. We ask that you read each edition carefully as we will outline any changes that may affect your day-to-day operations. Additional communication channels will include direct mail, the NaviNet® web portal, our website, emails, and face-to-face provider education.

As noted earlier this year, we have already begun to engage and educate trading partners and clearinghouses on the upcoming EDI changes. Please be sure to check with your third-party vendors to see if changes to your current processes are necessary.

We will provide comprehensive communications and tools to support our members and providers before, during, and after the migration to the Highmark operating platform. If you have questions related to the transition, please email us at *provider_communications@ibx.com*.

ICD-10 Spotlight:
Know the codes

Each month, IBC will feature an example of how ICD-9 codes will translate to ICD-10 codes. We will present coding examples from different specialties and popular disease categories to demonstrate the granularity that the new ICD-10 code set will provide.

CODING CONVENTION/GUIDELINE: EXCLUDES1 AND EXCLUDES2, AND BORDERLINE DIAGNOSIS CODES

Similar to ICD-9, there are coding conventions, general guidelines, and chapter-specific guidelines in ICD-10. These conventions and guidelines are rules and instructions that must be followed to classify and assign the most appropriate code. As with ICD-9, adherence to these guidelines is required under the Health Insurance Portability and Accountability Act (HIPAA). Many of the conventions and guidelines in ICD-9 are the same in ICD-10. This article will focus on a new Coding Convention: Excludes1 and Excludes2, and a new General Coding Guideline: Borderline Diagnosis Codes.

Excludes1 and Excludes2

As in ICD-9, a variety of notes appear in both the Alphabetic Index and Tabular List of ICD-10. These types of notes consist of inclusion notes, excludes notes, code first notes, use additional code notes, and cross reference notes. ICD-10 incorporates two types of excludes notes: Excludes1 and Excludes2. Each type of note has a different definition for use but are similar in that they indicate codes excluded from each other are independent of each other.

EXCLUDES1

A type 1 Excludes note is a pure excludes note. It means "NOT CODED HERE!" It corresponds with what the current ICD-9 Excludes note indicates. An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note. An Excludes1 note is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.

K51.4	**Inflammatory polyps of colon**
EXCLUDES1	adenomatous polyp of colon (D12.6) polyposis of colon (D12.6) polyps of colon NOS (K63.5)

EXCLUDES2

A type 2 Excludes note represents "Not included here." An Excludes2 note indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time. When an Excludes2 note appears under a code, it is acceptable to use both the code and the excluded code together, when appropriate.

J37.1	**Chronic laryngotracheitis**
EXCLUDES2	acute laryngotracheitis (J04.2) acute tracheitis (J04.1)

continued on next page

ICD-10 Spotlight:
Know the codes

ICD | 10
More codes • More detail • Improved accuracy℠

CODING CONVENTION/GUIDELINE: EXCLUDES1 AND EXCLUDES2, AND BORDERLINE DIAGNOSIS CODES (*continued)*

*Borderline Diagnosis**

If the provider documents a "borderline" diagnosis at the time of discharge, the diagnosis is coded as confirmed, unless the classification provides a specific entry. If a borderline condition has a specific index entry in ICD-10, it should be coded as such. Since borderline conditions are not uncertain diagnoses, no distinction is made between the care setting (inpatient versus outpatient).

Examples of Specific Borderline Entries:

F60.3	Borderline personality disorder
R41.83	Borderline intellectual functioning
H40.021	Open angle with borderline findings, high-risk, right eye

**Whenever the documentation is unclear regarding a borderline condition, coders are encouraged to query for clarification.*

For additional information related to the IBC transition to ICD-10, please visit *www.ibx.com/icd10*. On this site you will also find other examples of how ICD-9 codes will translate to ICD-10 codes in the *ICD-10 Spotlight: Know the codes* booklet.

Administrative

Cost-sharing for sleep disorder testing (sleep studies)

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Beginning with December 1, 2012, dates of service, cost-sharing (deductible, coinsurance, and/or copayments) will apply to sleep studies for all commercial HMO, POS, and PPO members. Members will be responsible for the same cost-sharing that is applied to their routine radiology benefit.

Cost-sharing varies based on the member's type of coverage and benefit plan. Providers can view a summary of member benefits on the NaviNet® web portal. Cost-sharing for sleep studies can be found under "Routine Radiology/Diagnostic" within the Benefit Snapshot when using the *Eligibility and Benefits Inquiry* transaction. Providers without NaviNet access must contact Customer Service at 1-800-ASK-BLUE to determine the appropriate member cost-share responsibility.

For detailed information on IBC's coverage of sleep disorder testing, please refer to our Medical Policy website at *www.ibx.com/medpolicy*.

Reminder: Elimination of capitated podiatry program

P

On January 1, 2013, IBC will be eliminating the capitated podiatry program design for our commercial and Medicare Advantage HMO/POS members. This change will allow members broader access to the podiatry network.

As a result of this change, primary care physicians (PCPs) will no longer need to select one designated podiatry provider. Commercial and Medicare Advantage HMO/POS members will have access to any podiatrist in the HMO network.

Commercial and Medicare Advantage HMO/POS members will still need to obtain a referral from their PCP for podiatry services. Direct POS members will not require a referral.

If you have any questions about this change, please contact your Network Coordinator.

BlueCard®

Fall 2012 edition of *Inside IPP* now available

F A

The Fall 2012 edition of *Inside IPP*, an inter-plan programs publication, is now available and features the following articles:

- *Identifying members of foreign Licensees and submitting their claims*
- *BlueCard claims clarification for DME, independent clinical laboratory, and specialty pharmacy providers*
- *HHS announces new ICD-10 compliance date of October 1, 2014*

Go to *www.ibx.com/insideipp* to read this edition. You can also find a complete archive of past editions there. Printed copies of *Inside IPP* are available by submitting an online request at *www.ibx.com/providersupplyline* or by calling the Provider Supply Line at 1-800-858-4728.

Inside IPP is a newsletter intended to increase awareness of and satisfaction with the BlueCard Program. It highlights BlueCard-specific initiatives and plans for improvement.

PFA

Reminder: IBX Mobile, our free smartphone application

Last fall, IBC released IBX Mobile, a free smartphone application that provides a streamlined version of ibxpress.com, our consumer website. IBX Mobile enables direct, convenient, and secure access to important health information and powerful online tools when and where it is needed most.

IBC members can use IBX Mobile to do the following:

- **Review their Personal Health Record (PHR).** Members who have completed their PHR can look up their family health history and recent health information, providing valuable information for their appointments.
- **View their member ID card.** If members forget their member ID card when they're at an office or facility to receive services, they can use IBX Mobile to show both the front and back sides of their member ID card.
- **Find a doctor.** If you refer one of our members to a specialist, he or she can see whether the specialist is in our provider network and view the address and phone number for the specialist's office.
- **Check their FSA/HRA account balance.** Members can check their account balance anytime, anywhere.
- **Estimate the cost of prescription drugs.** If you write a new prescription for an IBC patient and he or she wants to know how much it will cost them, that information can be found using IBX Mobile. In the event that a particular drug is not listed in our formulary, or has a cheaper generic version, we encourage you to work with the member to prescribe accordingly.
- **Record notes and instructions.** In the near future, patients will be able to use the 'Notes' feature to record provider's instructions, advice, and information.

While IBX Mobile provides a suite of helpful tools geared towards our members, the application can also serve as a platform for enhanced provider/patient interaction. Providers can use the application to help determine if members are getting their prescriptions filled, to verify that they are getting the correct prescriptions filled, and to help patients find alternate versions of drugs (in the event that a prescribed drug is not on the formulary, or has a less expensive, but equally effective, generic version).

IBX Mobile is a tool that our members are expected to download and use in increasing frequency, and we hope you'll encourage your IBC patients to use this tool to maximize the effectiveness of their care, and make good decisions about their health.

Enhancements, improvements, and new tools will be added over time, and we expect this still-evolving technology to continue to help enhance the doctor/patient interaction and empower members to improve their health.

Note: The IBX Mobile application is available at no cost. Apple users can download IBX Mobile through Apple's App Store (accessible via iTunes), while Android users can download the app through Google Play (formerly Android Market). Members can also type "ibxpress.com" into their mobile Internet browser to use IBX Mobile.

PFA

Introducing new cost and quality transparency tools and features

Due to the rapid growth in consumer-driven health plans and provider incentive programs, IBC must become more transparent by increasing the availability and accessibility of health information and data. With that, we are pleased to announce the launch of new provider cost and quality transparency tools and features for commercial and Medicare Advantage HMO and PPO members, including those who carry an Independence Administrators ID card, and participating providers.

Over the next few months and throughout 2013, new tools and features will be released to assist IBC members in becoming more informed consumers and managing their health benefits. In addition, these tools will assist providers as they strive to become more accountable for the cost and quality of care being delivered.

Member-facing tools

The following new tools and features will be released in December 2012:

- **Search for a Doctor, Hospital, or Other Medical Facility.** This new, easy-to-use tool will more efficiently assist members in their online search of the doctors, specialists, hospitals, and other health care professionals who participate in IBC's network.
- **Patient Review of Physicians.** This new feature will allow IBC members to read and write physician reviews regarding their experiences and care received from physicians. Members will be able to view patient reviews and comments when searching for an IBC-participating provider and use this information to assist in the process of selecting a physician. A comprehensive process will be in place to authenticate membership, verify a physician visit occurred within the past six months, and moderate reviews prior to them appearing on this tool. In addition, all reviews will be checked for appropriateness of language and content.
- **Cost Estimator.** This new feature will allow IBC members to review provider-specific cost range information for an assortment of inpatient and outpatient services to better enable them to estimate their out-of-pocket costs (i.e., coinsurance and deductible amounts) and manage their benefits. This information will be made available for a menu of treatment categories, which will be modified periodically. It is important to note that this cost information will be available only to IBC members who access our provider finder through our secure member website, ibxpress.com, or through MyIBXTPA.com for Independence Administrators' plan members.
- **Hospital Quality Measures.** Through the new search tool, IBC will continue to promote and encourage members to access publicly available hospital quality data, such as information published on *www.phcqa.org*, and other information made available via third-party data sources on IBC's websites.

Additional tools that will be introduced in 2013 include:

- **Quality Measurement & Recognition.** IBC members will be able to view primary care physician quality performance measurement scores and local benchmarks. Information provided will include screening rates and other process measures, such as those included in IBC's QIPS program. Additionally, IBC members will be able to easily identify provider recognitions, such as Patient-Centered Medical Home certification, and identify top-performing practices in QIPS. Recognition icons will highlight these types of providers in the new search tool results.

Provider-facing tools

To complement the Cost Estimator feature for members, a new tool, through the NaviNet® web portal, will be introduced in January 2013 for IBC-participating primary care physicians in the Pennsylvania 5-county service area:

- **Comparative Procedure Costs.** Through a new transaction in NaviNet called Population Management Tools, IBC-participating primary care physicians in the Pennsylvania 5-county service area will be able to access the new Comparative Procedure Costs tool to view network cost ranges and provider-specific relative cost rankings for a menu of treatment categories, which will be modified periodically. These provider-specific relative cost rankings, displayed at facility level, will be based on the historical total cost of each encounter based on the contracted facility and professional costs.

Look for more information regarding these new tools and features in future editions of *Partners in Health Update*.

PFA

Policy notifications posted as of October 26, 2012

All policies are posted prior to their effective date. Below is a listing of the policy notifications that we have posted to our website as of October 26, 2012.

Policy effective date	Policy No.	Notification title	Notification issue date
October 26, 2012	06.02.24f	Preimplantation Genetic testing	September 26, 2012
October 26, 2012	07.13.06g	Scanning Computerized Opthalmic Diagnostic Imaging (SCODI)	September 26, 2012
October 30, 2012	11.14.07i	Intra-articular Injection of Hyaluronan for the Treatment of Osteoarthritis	August 1, 2012
November 9, 2012	02.01.01b	Home Health Care Services	October 10, 2012
November 9, 2012	11.11.01d	Evaluation and Treatment of Erectile Dysfunction (ED)	October 10, 2012
November 9, 2012	06.02.31c	Genetic Testing for Congenital Long QT Syndrome	October 10, 2012
November 9, 2012	11.06.04g	Uterine Artery Embolization	October 10, 2012
November 9, 2012	07.02.10b	End-Diastolic Pneumatic Compression Therapy	October 10, 2012
November 15, 2012	06.02.14e	In Vitro Chemosensitivity and Chemoresistance Assays	October 16, 2012
November 26, 2012	08.00.95b	Personalized Vaccines (e.g., Provenge)	October 26, 2012
December 12, 2012	11.00.06d	Treatment of Obstructive Sleep Apnea (OSA) and Primary Snoring for Adults	September 13, 2012
January 1, 2013	00.03.01j	Podiatry Services Included in Capitation for Pennsylvania Based Health Maintenance Organization (HMO) or Health Maintenance Organization Point-of-Service (HMO-POS) Products	November 3, 2012
January 9, 2013	11.01.01g	Otoplasty	October 10, 2012

To view the policy notifications, go to *www.ibx.com/medpolicy*, select *Accept and Go to Medical Policy Online,* and click on the *Policy Notifications* box. You can also view policy notifications using the NaviNet® web portal by selecting *Reference Tools* from the Plan Transactions menu, then *Medical Policy.* Once these policies are in effect, they will be available by using the Search box on the Medical Policy homepage. Be sure to check back often, as the site is updated frequently.

Vaccination coverage for Medicare Advantage HMO and PPO members

Most vaccinations or inoculations are excluded under the Medicare Part B medical benefit. The only preventive vaccines covered under the member's Part B benefit are pneumococcal, influenza virus, and Hepatitis B (for those who are at high or intermediate risk of contracting Hepatitis B) unless they are directly related to the treatment of an injury or direct exposure to a disease or condition, such as anti-rabies treatment. In the absence of injury or direct exposure, preventive immunization (vaccination or inoculation) against diseases (e.g., shingles) is only covered under the Medicare Part D pharmacy benefit.

Medicare Advantage HMO and PPO members who purchase Part D coverage have the option to receive preventive Part D vaccines through a participating pharmacy that accepts Medicare Part D coverage. In addition, there may be instances when Medicare Advantage HMO and PPO members prefer to have the vaccine supplied and administered in their physician's office. If the member chooses this option, the physician will utilize his or her own stock of vaccine and administer it to the member. Since these vaccines are only covered through the Part D pharmacy benefit, and not the Medical Part B benefit, the member will have to pay the physician's office for the cost of the vaccine and administration out of his or her own pocket. However, if the member has Part D coverage, he or she can request reimbursement of his or her out-of-pocket expenses by submitting the *Medicare Part D Vaccine and Administration (Injection) Claim Form*, which can be found at *www.ibxmedicare.com*.

For a list of vaccinations covered under Medicare Part B and/or Medicare Part D, please refer to Claim Payment Policy #08.09.11p: Medicare Part B vs. Part D Crossover Drugs.

Policy reminder regarding utilization review decisions

In accordance with the benefits available under the member's health plan and our definition of medical necessity, it is our policy that all utilization review decisions are based on the appropriateness of health care services and supplies.

Only physicians may make denials of coverage of health care services and supplies based on lack of medical necessity. The nurses, medical directors, other professional providers, and independent medical consultants who perform utilization review services for us are not compensated or given incentives based on their coverage decisions. Medical directors and nurses are salaried employees, and contracted external physicians and other professional consultants are compensated on a per-case reviewed basis, regardless of the coverage determination. We do not reward or provide financial incentives to individuals performing utilization review services for issuing denials of coverage. There are no financial incentives for such individuals that would encourage utilization review decisions that result in underutilization.

PFA

Benefits changes and clarifications for commercial members

Effective January 1, 2013, unless otherwise noted, the following member benefits changes and clarifications will be implemented for several commercial programs for Pennsylvania members:

Type of service	Plans affected	Change/clarification
Group premium change	All HMO, All POS, All PPO	Language is being revised to allow Independence Blue Cross premium adjustment flexibility at any time during the course of the benefit year upon mutual consent, not just on the anniversary dates. *Note: This change applies only to fully insured contracts.*
Podiatry capitation removal	All HMO, All POS	Language is being revised to remove capitation from Podiatry. Members with HMO and POS products will have access to any podiatrist in the network with the required referral. DPOS products will not require a referral.
Amendments to termination provisions of contracts	All HMO, All POS, All PPO	Language is being revised to allow flexibility for termination of group contracts and migration to other plans. *Note: This change applies only to fully insured contracts.*
Timely filing for PPO claims	All PPO	To be consistent across all managed care products, the time frame for commercial PPO members to submit a claim is being reduced from 24 months to 12 months.
Urgent Care Centers	All HMO, All POS, All PPO	New definitions and descriptions of the terms Urgent Care Center and Retail Clinic are being added to member booklets and contracts.
Women's Preventive Health	All HMO, All POS, All PPO	As required by the Patient Protection and Affordable Care Act, language is being updated to state that preventive care services for women are now covered at 100 percent. The new language will include the following clarifications: • All FDA-approved contraceptive methods are covered at the in-network level with no cost-sharing under the medical component and at the generic level under the pharmacy component of coverage at retail and mail-order pharmacies. • Comprehensive lactation support and counseling during pregnancy and/or postpartum period with no in-network cost-sharing are covered. One hundred percent coverage for the in-network rentals of breast pumps is also provided (subject to precertification).
Appeals process	All HMO, All POS, All PPO, All Traditional	The appeals process is being updated to reflect the external review process as required by the Patient Protection and Affordable Care Act.

PFA

Upcoming Medicare Advantage HMO and PPO benefits changes

Effective January 1, 2013, there will be several changes to our current Medicare Advantage HMO and PPO plans in addition to the introduction of our $0 premium medical-only plan, Keystone 65 Select HMO. The following tables highlight some of these changes. Please note that this is a list of our significant benefits changes, not a comprehensive list of all benefits changes.

Keystone 65 Preferred HMO benefits changes

Benefit	Keystone 65 Preferred HMO	
	Current (2012)	Changes for 2013
Depression screening	Not covered	No copayment
Emergency care	$50 copayment for emergency care; emergency care is offered in the United States.	$65 copayment for emergency care; worldwide coverage for emergency and urgently needed care (not waived if admitted).
Inpatient hospital care	$190 copayment per day for days 1 – 8; $0 copayment for additional days per stay; $1,520 maximum per stay.	$215 copayment per day for days 1 – 7; $0 copayment for additional days per stay; $1,505 maximum per stay.
Obesity screening and therapy to promote sustained weight loss	Not covered	No copayment
Outpatient Hospital	$350 copayment for Outpatient Hospital (per date of service); $100 copayment for Ambulatory Surgical Centers (per date of service).	$350 copayment for Outpatient Hospital (per date of service); $100 copayment for Ambulatory Surgical Centers (per date of service).
Primary care physician	$10 copayment per visit	$5 copayment per visit
Screening and counseling to reduce alcohol misuse	Not covered	No copayment
Services to treat kidney disease and conditions	$25 copayment per visit for outpatient dialysis	20% per visit for outpatient dialysis
Urgently needed care	$10 – $40 copayment for urgently needed care. The copayment amount depends on the provider type: • $10: PCP • $40: Specialist	$5 – $40 copayment for urgently needed care. The copayment amount depends on the provider type: • $5: PCP • $20: Network Urgent Care Center • $40: Specialist Urgently needed care is covered worldwide. For urgently needed care received outside of the United States, the emergency room copayment will apply.

continued on the next page

Upcoming Medicare Advantage HMO and PPO benefits changes (continued)

Personal Choice 65℠ PPO benefits changes

Benefit	Personal Choice 65℠ PPO	
	Current (2012)	Changes for 2013
Annual physical exam	Not covered	No copayment
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)	Not covered	No copayment Out-of-network: 30% coinsurance
Cervical and vaginal cancer screening	Pap tests and pelvic exams are covered once every 12 months	Pap tests and pelvic exams are covered once every 24 months
Depression screening	Not covered	No copayment Out-of-network: 30% coinsurance
Dialysis	$25 copayment per dialysis visit	20% coinsurance per dialysis visit
Emergency care	$50 copayment	$65 copayment (not waived if admitted)
Obesity screening and therapy to promote sustained weight loss	Not covered	No copayment Out-of-network: 30% coinsurance
Primary care physician	$10 copayment per office visit	$5 copayment per office visit
Screening and counseling to reduce alcohol misuse	Not covered	No copayment Out-of-network: 30% coinsurance
Urgently needed care	$10 - $40 copayment	$5 - $40 copayment

Optional supplemental benefits package available to Keystone 65 Select HMO members

Our Keystone 65 Select HMO members will have the option to purchase the Choice Care program, an optional supplemental benefits package, for an additional $10 a month. The optional supplemental benefits package will cover vision, dental, and hearing. See the table below for details about the supplemental benefits package.

Covered Services	Member pays
Dental services — Preventive dental	
One exam and cleaning every six months	$15 copayment per visit
Hearing services	
Non-Medicare-covered routine hearing exams, including fitting and evaluation for two hearing aids, covered every three years	$45 copayment for non-Medicare-covered hearing exams and evaluation
Medicare-covered hearing exams	$45 copayment for Medicare-covered hearing exams and evaluations
Hearing aids, covered every three years	Covered up to $500 for two hearing aids
Vision care	
Non-Medicare-covered routine eye exams, every two years	$0 copayment for routine eye exams, once every two years
Eyewear not covered by Medicare, every two years	Covered up to $100 for eyewear

Note: Vision, dental, hearing, and SilverSneakers® are still included in the benefits packages for Keystone 65 Preferred HMO and Personal Choice 65 PPO members.

Please contact your Network Coordinator if you have any questions about these 2013 benefits changes for Medicare Advantage HMO and PPO members.

PFA

Reminder: Upcoming changes for Keystone 65 Select HMO

In 2013, the Keystone 65 Select HMO premium has been reduced to $0 for medical-only plans in all counties. In addition, the premiums for the Keystone 65 Select Rx HMO plans have been reduced to $31.50 for those in Philadelphia and Bucks Counties, and $46.50 for those in Chester, Delaware, and Montgomery Counties. Keystone 65 Select also includes a worldwide travel benefit for emergency care and urgently needed care.

The Choice Care program, which includes dental services, hearing services, and vision care, is an additional $10 monthly premium. Keystone 65 HMO has a $6,700 out-of-pocket maximum for 2013.

Last month, Medicare beneficiaries were mailed their 2013 *Annual Notification of Change (ANOC)/Evidence of Coverage (EOC)*, which outlines all of the changes for 2013. Members may enroll in a new plan for 2013 any time between October 15 and December 7, 2012.

Keystone 65 Select HMO benefit highlights

Service	Cost to member
Primary care physician visits	$15 copay per visit
Specialist visits	$45 copay per visit
Emergency department	$65 copay (not waived if admitted)
Urgently needed care	$15 – 45 copay per visit
Outpatient surgery	$350 copay (per date of service) for outpatient hospital; $100 copay for Ambulatory Surgical Centers (per date of service)
Inpatient hospital	$245 per day for days 1 – 7 ($1,715 per stay maximum). $0 copayment/day for 8+ days; unlimited days each benefit period.
Preventive dental, routine eye, hearing services	Benefits package available for additional $10 per month in plan premiums

Note: All Keystone 65 HMO and Personal Choice 65℠ PPO plans includes the SilverSneakers® fitness benefit in 2013.

Please contact your Network Coordinator if you have any questions.

SilverSneakers® is a registered mark of Healthways, Inc., an independent company.

HEALTH AND WELLNESS

Connections℠ Health Management Program: Supporting your patients, our members

P

Call the Provider Support Line at 1-866-866-4694 to refer a member to a Health Coach if the member has any of the following conditions:

- asthma
- coronary heart disease (CHD)
- chronic obstructive pulmonary disease (COPD)
- diabetes
- heart failure

Health Coaches also provide decision support for numerous health-related issues, including back pain, fall prevention, depression, cardiometabolic risk, weight loss surgery, breast or prostate cancer, and chronic pain.

Information about our Connections Health Management Program is available at *www.ibx.com/providerconnections*.

Important Resources

Anti-Fraud and Corporate Compliance Hotline	1-866-282-2707 www.ibx.com/antifraud
Care Management and Coordination	
Case Management	1-800-313-8628
Baby BluePrints®	215-241-2198 1-800-598-BABY (2229)*
Connections℠ Health Management Programs	
Connections℠ Health Management Program Provider Support Line	1-866-866-4694
Connections℠ Complex Care Management Program	1-800-313-8628
Connections℠ Provider Portal	www.hdproviderportal.com/ibc
Credentialing	215-988-1413
Credentialing Violation Hotline	www.ibx.com/credentials
Customer Service/Provider Services • Provider Automated System (eligibility/claims status/referrals) • Connections Health Management Programs • Precertification/maternity requests — Imaging services (CT, MRI/MRA, PET, and nuclear cardiology) — Authorizations	1-800-ASK-BLUE (275-2583)
Provider Services user guide	www.ibx.com/providerautomatedsystem
eBusiness Help Desk	215-241-2305
FutureScripts® (pharmacy benefits)	
Prescription drug prior authorization	1-888-678-7012
Fax	1-888-671-5285
Direct Ship Specialty Pharmacy Program	1-888-678-7012
Fax	1-888-671-5285
Mail order program toll-free fax	1-877-228-6162
Blood Glucose Meter Hotline	1-888-678-7012
Pharmacy website (formulary updates, prior authorization)	www.ibx.com/rx
FutureScripts® Secure (Medicare Part D)	1-888-678-7015
Formulary updates	www.ibxmedicare.com
Mail order program toll-free fax	1-877-344-1318
IBC Direct Ship Injectables Program (medical benefits)	www.ibx.com/directship
Medical Policy	www.ibx.com/medpolicy
NaviNet® portal registration	www.navinet.net
Provider Supply Line	1-800-858-4728 www.ibx.com/providersupplyline

* Outside 215 area code

Independence

Visit our website:
www.ibx.com/pnc