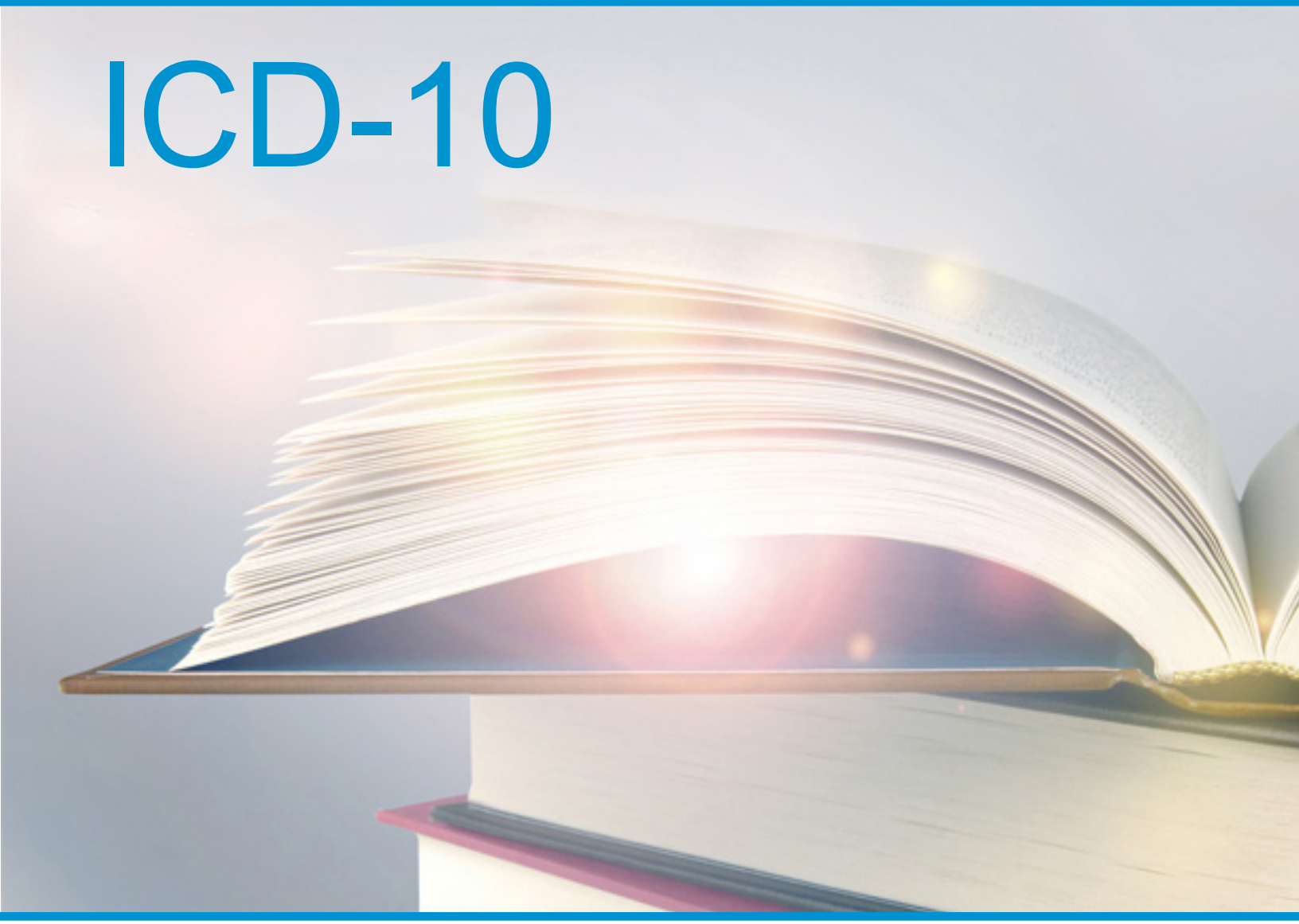
Partners in Health update℠

Working together for quality health care

October 2015

ICD-10



Independence

Inside this edition

For articles specific to your area of interest, look for the appropriate icon:

(P) Professional (F) Facility (A) Ancillary

- Articles designated with a blue arrow include notice of changes or clarifications to administrative policies and procedures.

*Partners in Health Update*SM is a publication of Independence Blue Cross and its affiliates (Independence), created to provide valuable information to the Independence-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 Independence. This publication is the primary method for communicating such general changes. Suggestions are welcome.

Contact information:

Provider Communications
Independence Blue Cross
1901 Market Street
27th Floor
Philadelphia, PA 19103

provider_communications@ibx.com

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This is not a statement of benefits. Benefits may vary based on state requirements, Benefits Program (HMO, PPO, etc.), and/or employer groups. Providers should call Provider Services for the member's applicable benefits information. Members should be instructed to call the Customer Service telephone number on their ID card.

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Keystone Health Plan East, Personal Choice®, Keystone 65 HMO, and Personal Choice 65SM PPO have an accreditation status of *Commendable* from NCQA.

PFA

ICD-10: FAQ highlights

The ICD-10 compliance date is October 1, 2015, Independence is now requiring ICD-10 codes on all authorizations, referrals, and claims. Below are some of the frequently asked questions (FAQ) we received from providers. The answers can assist you in the new ICD-10 landscape.

Authorizations and referrals

Q: How will Independence handle authorizations and referrals for services that occur on or after the ICD-10 compliance date of October 1, 2015?

A: Changes were recently made to the way authorizations and referrals are processed in regards to ICD-9/ICD-10 coding, as reflected in the recent enhancements to the NaviNet® web portal.

Please use the updated guidelines below when submitting an authorization and/or referral for services that occur on or around the October 1, 2015, ICD-10 compliance date:

- All authorization and referral requests submitted with an anticipated/proposed date of service prior to and including September 30, 2015, are required to use ICD-9 codes.
- All authorization and referral requests submitted with an anticipated/proposed date of service on or after October 1, 2015, are required to use ICD-10 codes.

Important: If you already have an authorization or referral that was submitted with an ICD-9 code and the actual date of service is on or after October 1, 2015, you do not need to resubmit a new request. Independence will take steps to ensure claims processing is not impacted.

If you already have an authorization that was submitted with an ICD-9 code with a beginning date of service on or before to September 30, 2015, and you need to request an extension (e.g., additional services or additional days) for dates of service on or after October 1, 2015, you do not need to update the diagnosis code to ICD-10.

Note: When submitting an authorization request through NaviNet, please do not include the decimal point when entering diagnosis codes. Use the ICD-9 code (for dates of service prior to October 1, 2015) or ICD-10 code (for dates of service on or after October 1, 2015).

Claims submission

Q: Will Independence accept ICD-9 codes after October 1, 2015, for dates of service that were *prior* to October 1, 2015?

A: Yes, ICD-9 codes should be submitted on claims with dates of service prior to October 1, 2015. Current regulations require the use of ICD-9 codes for dates of service prior to the mandated implementation date. Inpatient claims with discharge dates on or after the mandated implementation date must be coded in ICD-10. All outpatient and professional claims with dates of service on or after the mandated implementation date must contain ICD-10 diagnosis codes.

Q: Will both ICD-9 and ICD-10 codes be accepted on a single claim?

A: No, in accordance with the Centers for Medicare & Medicaid Services (CMS) billing guidelines, ICD-9 and ICD-10 codes cannot be submitted as part of a single claim.

Q: What happens if an incorrect code is submitted on a claim?

A: If your office submits an invalid code on a claim (i.e., an ICD-9 code is submitted for a date of service on or after October 1, 2015), your claim will be denied and sent back to you for compliant coding. Depending on your clearinghouse, these invalid claims may either be rejected directly by your clearinghouse or, if passed by the clearinghouse, may be rejected by Independence. Providers should closely monitor the front-end reports from their clearinghouses and Independence.

For a full listing of all provider FAQs related to ICD-10, please refer to the *Transition to ICD-10: Frequently Asked Questions* document at *www.ibx.com/icd10*. Additional information on ICD-10 can be found at the CMS ICD-10 dedicated website at *www.cms.gov/icd10.*

ADMINISTRATIVE

PFA

Coming soon: New Provider Automated System

The NaviNet® web portal, our secure, online provider portal, gives you and your office staff access to critical administrative and clinical data. We encourage you to use NaviNet to access benefits, claims, and eligibility information for Independence members.

However, on **December 1, 2015,** Independence is introducing a new Provider Automated System to help providers obtain critical information when they are unable to access NaviNet.

The Provider Automated System will enable providers to access the following information:

- **Benefits.** Verify copay, coinsurance, and deductible information.
- **Claims.** Obtain paid status, claim denial reasons, paid amount, and member responsibility information.
- **Eligibility.** Check coverage status, effective dates, and group name information.
- **Authorizations and referrals.** These functions are not available for self-service – calls will be directed to a Customer Service representative for further assistance.

Note: You will need to have your NPI or tax ID number, as well as the member's information, ready in order to complete the transactions listed above.

The Provider Automated System will be available starting December 1, 2015, by calling Customer Service at 1-800-ASK-BLUE. Look for additional information in future editions of *Partners in Health Update*. ◆

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Carenet pilot program underway

As part of an ongoing commitment to improve health outcomes for members, Independence is piloting an outreach program to encourage our Medicare Advantage HMO and PPO members with gaps in care to visit their doctors. As a participating network provider, you may receive a call from Carenet Healthcare Services (Carenet), an independent company. These calls from Carenet are to help our members schedule needed appointments with their primary care physician (PCP) or specialist. A Carenet representative will contact our member to see if they would like to set up an appointment. If the member accepts, Carenet will conference in the member's PCP or specialist's office to facilitate scheduling the appointment.

If you have any questions, please contact one of your Independence medical directors. ◆

ADMINISTRATIVE

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Update your provider information with us

Have you made any changes to your key provider information? It is important that you notify us of any changes to the following:

- your mailing address
- your phone number
- name of your practice
- your office hours
- your acceptance of new patients
- your plan to dissolve your practice

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

Professional providers

Please contact your Network Coordinator and notify them of any changes to your information.

Facility and ancillary providers

Per your contract, 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, Provider Networks and Value-Based Solutions
1901 Market Street, 27th Floor
Philadelphia, PA 19103

Independence Blue Cross
Attn: Legal Department
1901 Market Street, 43rd Floor
Philadelphia, PA 19103

Thirty days' advance notice is required for processing.

Note: This information does not apply to providers contracted with Magellan Healthcare, Inc., an independent company. Please contact your Magellan Network Coordinator if you have any questions. ◆

ADMINISTRATIVE

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Peer-to-peer reconsideration requests for Medicare Advantage members

For Medicare Advantage members, any request to change an initial adverse plan decision must be handled through the appeals process — not through peer-to-peer discussion. For a *pre-service* decision, a provider may request a peer-to-peer discussion as part of an optional, informal process designed to encourage dialogue between the requesting provider and the Independence medical directors. However, this process cannot be used to request a reconsideration of the initial adverse decision.

If you disagree with an adverse preapproval decision and wish it to be reconsidered, you must request an appeal by contacting Medicare member services at 1-800-645-3965 for Keystone 65 HMO members or 1-888-718-3333 for Personal Choice 65℠ PPO members. ◆

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Chronic care management for Medicare beneficiaries

About half of all adults — 117 million people — have one or more chronic health conditions, according to the Centers for Disease Control and Prevention. And one in four adults has two or more chronic health conditions.[1] Seven of the top ten causes of death in 2010 were from chronic diseases. Two of these chronic diseases — heart disease and cancer — together accounted for nearly 48 percent of all deaths.[2]

The Centers for Medicare & Medicaid Services (CMS) recognizes chronic care management (CCM) as one of the critical components of primary care that contributes to better health for individuals. CCM services provide aid with appointment scheduling and reminders, medication reconciliation, wellness checks, and much more.

Medicare beneficiaries, who have two or more chronic conditions expected to last at least 12 months, can authorize a physician to coordinate his or her care. If an Independence Medicare Advantage patient selects you as his or her authorized physician, please review Medical Policy #MA00.006: Care Management and Coordination Services for our coverage position for these services. To view this policy, visit our Medical Policy Portal at *www.ibx.com/medpolicy*, select *Accept and Go to Medical Policy Online*, select the *Medicare Advantage* tab from the top of the page, and then type the policy name or number in the Search field. ◆

[1]Ward BW, Schiller JS, Goodman RA. *Multiple chronic conditions among US adults: a 2012 update*. Prev Chronic Dis. 2014;11:130389.

[2]Centers for Disease Control and Prevention. *Death and Mortality.* NCHS FastStats website. *www.cdc.gov/nchs/fastats/deaths.htm*. Accessed December 20, 2013.

PFA

Reminder of recent changes to NaviNet®

As previously communicated, several new transactions and enhancements were introduced on the NaviNet web portal in September:

- **Eligibility and Benefits Inquiry.** A new Eligibility and Benefits Inquiry transaction was introduced in September to some providers; in October the new transaction will be deployed to all remaining offices. The member search criteria will be modified, and the presentation of the eligibility and benefits information will change. The Eligibility and Benefits screen will continue to include links to the member's capitated site information (where applicable), ID card, and product-wide provisions associated with the member's benefits plan. For more detailed information about this updated transaction, refer to the new *Eligibility and Benefits Inquiry Guide* available in the NaviNet Resources section of our Provider News Center at *www.ibx.com/pnc/navinet*.
- **Provider File Management.** This new transaction has replaced the Provider Change Form transaction. Provider File Management allows professional providers to modify practice information, add hospital affiliations, and add participating providers.
- **ICD-10.** Portal transactions that reference or leverage diagnosis codes were updated to include ICD-10 codes only. As a reminder, providers must now use ICD-10 codes when submitting referrals, encounters, and authorization requests or when searching for a diagnosis on NaviNet (for dates of service or dates of discharge [for facility inpatient claims] on or after October 1, 2015).
- **COB Questionnaire.** A new transaction was introduced with a new Coordination of Benefits (COB) Questionnaire. This electronic form allows providers to report and submit Other Party Liability coverage for members. Reporting COB information at the time of service helps claims process correctly.

Submitting authorizations with ICD codes

When submitting an authorization request through NaviNet, do not include the decimal point when entering diagnosis codes. Use the ICD-9 code (for dates of service prior to October 1, 2015) or ICD-10 code (for dates of service on or after October 1, 2015).

If you have any questions about these changes, please call the eBusiness Hotline at 215-640-7410. ◆

Independence physician quality measure rankings available on the BCBSA national provider finder

During the fourth quarter of 2015, Independence will submit updated physician ratings to the Blue Cross and Blue Shield Association (BCBSA), an association of independent Blue Cross and Blue Shield plans, to be displayed within their National Doctor and Hospital Finder at *http://provider.bcbs.com*. These ratings are also currently available on our local Find a Doctor/ Hospital tool at *www.ibx.com* within the Accreditation & Quality tab.

The following physician quality measures are rated:

- Cancer screening
  - Breast cancer screening
- Diabetes
  - Blood Sugar (Glucose) Testing
  - LDL-C (Bad Cholesterol) Screening – Patients with Diabetes
  - Kidney Disease (Nephropathy) Screening and Treatment
- Heart Disease
  - Beta-Blocker (PBH) Treatment after a Heart Attack
  - LDL-C (Bad Cholesterol) Screening for Heart Patients Conditions
- Immunizations
  - Chicken pox (VZV)
  - Measles, mumps, and rubella (MMR)
- Medication monitoring
  - Monitoring for Patients (Adults) on Persistent Medications
- Respiratory infections
  - Bronchitis – Avoidance of Antibiotic Treatment in Adults
  - Strep Test for Sore Throat – Appropriate Use of Antibiotics
  - Common Colds (Treatment) – Avoidance of Antibiotics
- Women's health
  - Breast cancer screening (same measure under cancer screening)

If you wish to review your scores in advance of our submission, please contact your Network Coordinator by **November 27, 2015.** ◆

PFA

View up-to-date policy activity on our Medical Policy Portal

Changes to Independence medical and claim payment policies for our commercial and Medicare Advantage Benefits Programs occur frequently in response to industry, medical, and regulatory changes. We encourage you to view the Site Activity section of our Medical Policy Portal in order to keep up to date with changes to our policies.

The Site Activity section is updated in real time as changes are made to the medical and claim payment policies. Topics include:

- Notifications
- New Policies
- Updated Policies
- Reissued Policies
- Coding Updates
- Archived Policies

For your convenience, the information provided in Site Activity can be printed to keep a copy on hand as a reference.

News & Announcements

In addition to the information posted in our Site Activity section, articles related to our website and medical and claim payment policies are periodically posted within the News & Announcements section. Simply select the appropriate link (Commercial, Medicare Advantage, or MAPPO Host) under the News & Announcements header on the Medical Policy Portal homepage to stay informed of the latest information.

To access the Site Activity section, go to our Medical Policy Portal at *www.ibx.com/medpolicy* and select *Accept and Go to Medical Policy Online*. From here you can select *Commercial* or *Medicare Advantage* under Site Activity to view the monthly changes. To search for active policies, select either the *Commercial* or *Medicare Advantage* tab from the top of the page. You can also get to our Medical Policy Portal through the NaviNet® web portal by selecting the *Reference Tools* transaction, then *Medical Policy*. ◆

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Upcoming changes to drug precertification requirements for 2016

Effective January 1, 2016, new precertification requirements will apply to our commercial and Medicare Advantage HMO and PPO members for the seven medical benefit drugs listed below:

- Adagen® (pegademase bovine)
- Blincyto® (blinatumomab)
- Cyramza® (ramucirumab)
- Kanuma™ (sebelipase alfa)*
- Lemtrada® (alemtuzumab)
- mepolizumab*
- talimogene laherparepvec*

These changes will be reflected in an updated precertification requirement list, which will be posted to our website at *www.ibx.com/preapproval* in December, prior to these changes going into effect. Look for more information about the availability of this new precertification requirement list in the December 2015 edition of *Partners in Health Update*. ◆

**Pending approval from the U.S. Food and Drug Administration*

Upcoming changes to medical benefit specialty drug cost-sharing for 2016

Effective January 1, 2016, Independence will update our list of specialty drugs that require cost-sharing. Cost-sharing applies to select medical benefit specialty drugs for members who are enrolled in Commercial Flex products and select customized plans. The member's cost-sharing amount is based on the terms of the member's benefit contract. Individual benefits should be verified using the NaviNet® web portal.

The current list will be expanded to include more than 70 specialty drugs, as well as all intravenous immunoglobulin (IVIG) formulations, eligible for coverage under the medical benefit.

The updated list will be posted to our website at *www.ibx.com/preapproval* in December, prior to these changes going into effect. The current 2015 cost-sharing list can be accessed through this link until December 31, 2015.

Look for more information on medical benefit specialty drug cost-sharing in the December 2015 edition of *Partners in Health Update*. ◆

Direct Ship Drug Program updates

Throughout 2015, Independence has been updating various aspects of our Direct Ship Drug Program. This program is a value-added service that allows our network providers to order select office-based drugs covered under the medical benefit without incurring cost. Independence works directly with our contracted specialty drug vendors to handle processing, payment, and delivery.

Some of our recent improvements to the program include:

- updating our website to highlight the advantages of the Direct Ship Drug Program;
- creating a downloadable list of all the drugs available through the program;
- facilitating delivery of select infusion drugs like infliximab (Remicade®).

Recent changes

Two additional changes were recently made to the program:

- **Updated order forms.** The Direct Ship Drug Program order forms have been updated to align with current medical policy coverage criteria and to remove ICD-9 coding options, which are obsolete as of October 1, 2015, when ICD-10 goes into effect. To avoid processing delays, providers must use the updated Direct Ship Drug Program order forms starting October 1, 2015. As a reminder, providers must report the ICD-10 code that *is most specific to* the member's diagnosis.
- **Dedicated fax line.** In order to increase processing efficiency, Independence has created a dedicated fax line for all Direct Ship Drug Program requests. Completed order forms should be faxed to 215-761-9580. This number is also printed at the bottom of the order forms.

Due to the nature of these changes, Independence is asking providers to immediately discard any copies of the old Direct Ship Drug Program order forms. Updated forms are available at *www.ibx.com/directship*. ◆

Important news about the annual Synagis® (palivizumab) distribution program

Independence is announcing the Synagis® (palivizumab) distribution program for the 2015-2016 respiratory syncytial virus (RSV) season, which is November through March in the northeastern United States. RSV is the most common cause of bronchiolitis and pneumonia among children younger than one year.

During the RSV season, Independence will approve the monthly administration of Synagis® (palivizumab) for infants and children, in accordance with the current recommendations from the American Academy of Pediatrics (AAP). These recommendations are subject to change based on updated recommendations as outlined in the AAP policy statement and *Red Book*®.

Medical necessity criteria for coverage

Synagis® (palivizumab) is a humanized monoclonal antibody that provides passive immunity against RSV. It is intended to decrease the morbidity and mortality associated with RSV lower respiratory tract disease in high-risk infants and children.

Immune prophylaxis using Synagis® (palivizumab) is considered medically necessary and covered for a maximum of five doses during the RSV season for infants and children who have any of the following high-risk conditions (according to the AAP criteria):

- chronic lung disease (CLD) of prematurity;
- history of preterm birth (born before 29 weeks, 0 days) for infants who are younger than 12 months at the start of the RSV season;
- congenital heart disease;
- severe neuromuscular disease;
- congenital abnormalities of the airway;
- cystic fibrosis with nutritional compromise and/or CLD;
- immunocompromised status (e.g., due to transplantation or chemotherapy).

An additional postoperative dose of Synagis® (palivizumab) is considered medically necessary and covered for infants or children younger than 24 months who are medically stable, meet any of the AAP criteria for immune prophylaxis, and have undergone one of the following procedures during RSV season:

- surgical procedures that use cardiopulmonary bypass;
- cardiac transplantation.

If an infant or child receiving monthly prophylaxis with Synagis® (palivizumab) experiences a breakthrough RSV hospitalization, then continued monthly prophylaxis with Synagis® (palivizumab) is not considered medically necessary due to the low likelihood of a second RSV hospitalization during the same season.

Synagis® (palivizumab) is not effective in the treatment of RSV disease, and it is not approved for this indication.

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How to obtain Synagis® (palivizumab) for office use

Synagis® (palivizumab) is covered under the member's medical benefit. For the 2015-2016 RSV season, it is mandatory for all participating providers to obtain Synagis® (palivizumab) through ACRO Pharmaceutical Services, an independent company.

The following guidelines apply when ordering Synagis® (palivizumab):

- The RSV Enrollment Form must include sufficient clinical information to meet our Synagis® (palivizumab) medical policy criteria, which are based on current AAP recommendations.
- Providers can go to the ACRO Pharmaceutical Services website at *www.acropharmacy.com/web/providers_pdf_forms.php* to download the *RSV Synagis Rx Form*. Providers should fax completed forms to 1-877-381-3806.
- Since Independence pays ACRO Pharmaceutical Services directly, providers neither pay for doses ordered through ACRO Pharmaceutical Services nor receive reimbursement for the actual pharmaceutical**.**
- Synagis® (palivizumab) will generally be approved for office administration only, unless a patient is receiving home nursing services for a separate indication.
- Upon approval of the request, Synagis® (palivizumab) will be shipped to the provider's office monthly during RSV season. Shipping for the 2015-2016 RSV season begins on Wednesday, October, 28, 2015, through Thursday, March 31, 2016. Up to five doses (one dose every 30 days) will be shipped per member.

To learn more

Review Medical Policy #08.00.22I: Immune Prophylaxis for Respiratory Syncytial Virus (RSV) to learn more. Visit our Medical Policy Portal at *www.ibx.com/medpolicy,* select *Accept and Go to Medical Policy Online*, select the *Commercial* tab, and then type the policy name or number in the Search field.

If you have questions about the Synagis® (palivizumab) distribution program, please call 1-800-ASK-BLUE.

Note: MedImmune, LLC, the makers of Synagis® (palivizumab), has a voluntary program called RSV Connection™. However, Independence does not participate in this program. ◆

PFA

Upcoming Medicare Advantage HMO and PPO benefit changes

Effective January 1, 2016, there will be several changes to our current Medicare Advantage HMO and PPO plans, including the introduction of a new plan — Keystone 65 Focus Rx HMO (Keystone 65 Focus). The Keystone 65 Focus plan offers members an affordable option with a $0 premium in Philadelphia and Bucks counties, and $25 premium in Chester, Delaware, and Montgomery counties. Please refer to the article *Keystone 65 Focus Rx HMO, our new Medicare Advantage benefit product* in this edition of *Partners in Health Update* for detailed information about this new plan.

The Keystone 65 Basic Rx HMO plan will be discontinued on December 31, 2015. Current members of the Keystone 65 Basic plan have two options this Annual Election Period:

1. Do nothing and be automatically enrolled into the Keystone 65 Select Rx HMO plan.
2. Enroll into a new plan by completing a Plan Change Form.

Additionally, highlights for 2016 include:

- reduced Maximum Out of Pocket (MOOP) across all Independence Medicare Advantage plans;
- new routine chiropractic and routine podiatry benefits;
- reduced copay for cardiac and pulmonary rehabilitation services;
- new hearing aid program through TruHearing®;
- two Medicare Advantage plans with a $0 drug deductible;
- minimal increases in premiums;
- reduced monthly premium for Choice Program.

Medicare Advantage HMO and PPO members should have already received their *2016 Annual Notice of Changes/ Evidence of Coverage*. They will have until December 7, 2015, to make any changes to their health care plans.

The following tables highlight some of the Medicare Advantage HMO and PPO benefits changes for 2016.

Medicare Advantage HMO and PPO monthly plan premiums

Plan type	Keystone 65 Focus HMO	Keystone 65 Select HMO	Keystone 65 Preferred HMO	Personal Choice 65℠ PPO
Medical only	Not available	Philadelphia/Bucks: $12 Chester/Delaware/ Montgomery: $37	Philadelphia/Bucks: $145 Chester/Delaware/ Montgomery: $204	Philadelphia/Bucks: $165
Medical with Choice Program (hearing, dental, vision)	Not available	Philadelphia/Bucks: $18 Chester/Delaware/ Montgomery: $43	Not available	Not available
Medical with Rx	Philadelphia/Bucks: $0 Chester/Delaware/ Montgomery: $25	Philadelphia/Bucks: $36 Chester/Delaware/ Montgomery: $75	Philadelphia/Bucks: $199 Chester/Delaware/ Montgomery: $272	Philadelphia/Bucks: $251 Chester/Delaware/ Montgomery: $134
Medical with Rx and Choice Program	Philadelphia/Bucks: $6 Chester/Delaware/ Montgomery: $31	Philadelphia/Bucks: $42 Chester/Delaware/ Montgomery: $81	Not available	Not available

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Medicare Advantage HMO and PPO benefits highlights

Service category	Keystone 65 Focus HMO	Keystone 65 Select HMO	Keystone 65 Preferred HMO	Personal Choice 65℠ PPO
Maximum out of pocket (MOOP)	$5,700 in network	$5,500 in network	$4,000 in network	$6,200 in network, $10,000 combined in network and out of network
Cardiac and pulmonary rehabilitation (referral required)	$5 copay	$5 copay	$5 copay	$5 copay
Routine chiropractic, up to 6 visits (referral required)*	$20 copay	$20 copay	$20 copay	$20 copay
Routine podiatry, up to 6 visits (referral required)*	$40 copay	$45 copay	$40 copay	$40 copay
Hearing services	With Choice Program - $40 copay once every 3 years. Hearing aid copay, $699 (standard) or $999 (premium) (one aid per ear per year) through TruHearing. Includes $0 copay for fitting and evaluation.	With Choice Program - $40 copay once every 3 years. Hearing aid copay, $699 (standard) or $999 (premium) (one aid per ear per year) through TruHearing. Includes $0 copay for fitting and evaluation.	$40 copay once every 3 years. Hearing aid copay, $699 (standard) or $999 (premium) (one aid per ear per year) through TruHearing. Includes $0 copay for fitting and evaluation.	$40 copay once every 3 years. Hearing aid copay, $699 (standard) or $999 (premium) (one aid per ear per year) through TruHearing. Includes $0 copay for fitting and evaluation.
SilverSneakers®	Included	Included	Included	Included
Prescription drug deductible	$0 (all tiers)	$320 (tiers 3-5)	$0 (all tiers)	$320 (tiers 3-5)
Primary care physician visits	$10 copay per visit	$20 copay per visit	$5 copay per visit	$15 copay per visit
Specialist visits	$40 copay per visit	$45 copay per visit	$40 copay per visit	$40 copay per visit
Emergency room (U.S. and worldwide)	$75 copay per visit (not waived if admitted)	$75 copay per visit (not waived if admitted)	$75 copay per visit (not waived if admitted)	$75 copay per visit (not waived if admitted)
Urgent care center	$20 copay (not waived if admitted to the hospital)	$30 copay (not waived if admitted to the hospital)	$20 copay (not waived if admitted to the hospital)	$20 copay (not waived if admitted to the hospital)
Outpatient surgery	$150 copay per visit for ambulatory surgical centers (ASC); $250 copay per visit for outpatient hospital facility	$150 copay per visit for ASCs; $400 copay per visit for outpatient hospital facility	$125 copay per visit for ASCs; $400 copay per visit for outpatient hospital facility	$150 copay per visit for ASCs; $400 copay per visit for outpatient hospital facility

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PRODUCTS

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Service category	Keystone 65 Focus HMO	Keystone 65 Select HMO	Keystone 65 Preferred HMO	Personal Choice 65℠ PPO
Inpatient hospital	$150 per day for days 1 – 4 ($600 per stay maximum) per admission	$290 per day for days 1 – 6 ($1,740 per stay maximum) per admission	$240 per day for days 1 – 6 ($1,440 per stay maximum) per admission	$900 per admission; unlimited days per admission
Dental, vision, hearing (non-Medicare covered)	Benefits available for additional $6 per month in plan premiums through the Choice Program	Benefits available for additional $6 per month in plan premiums through the Choice Program	**Dental:** $20 copay for exams and cleanings once every 6 months **Vision:** $40 copay once every 2 years; covered up to $100 every 2 years for eyewear **Hearing:** $40 copay once every 3 years; hearing aid copay of $699 (standard) or $999 (premium) per hearing aid per year	Dental and vision not covered. Routine hearing is now covered for 2016 through TruHearing.

**This is addition to Medicare covered services.*

Contact your Network Coordinator if you have any questions. ◆

TruHearing is a registered trademark of TruHearing, Inc., an independent company.

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

PFA

Benefit tier re-evaluation for Keystone HMO Proactive

Independence offers Keystone HMO Proactive, a lower-cost, tiered provider network product available both on and off the Health Insurance Marketplace. For this product, providers in Independence's commercial HMO network are categorized into one of three benefit tiers:

- **Tier 1 – Preferred:** Members pay the lowest cost-sharing for most services.
- **Tier 2 – Enhanced:** Members pay a higher cost-sharing for most services compared to Tier 1 – Preferred.
- **Tier 3 – Standard:** Members pay the highest cost-sharing for most services.

Re-evaluation of benefit tier placements for 2016

Independence reviews provider benefit tier placements annually for Keystone HMO Proactive. As such, we recently concluded our re-evaluation of benefit tier placements for our facility, ancillary, and professional providers for 2016.

Providers whose benefit tier is changing will receive a letter indicating their new benefit tier assignment. The new benefit tier will remain in place from January 1, 2016, through December 31, 2016.

Note: If you do not receive a letter regarding your benefit tier placement, then your benefit tier is not changing for 2016.

Benefit tier placement criteria for professional providers

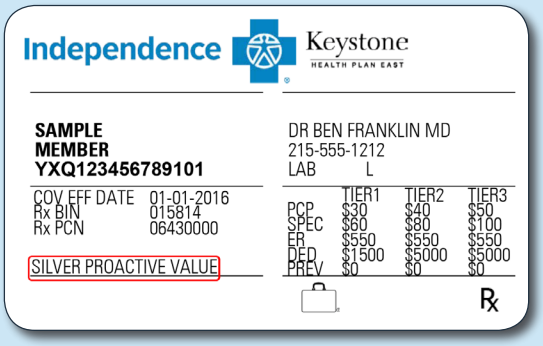
Like last year, benefit tier placement for professional providers is based upon criteria that include relative cost (i.e., contracted fee schedule), minimum quality standards (if applicable), and the tier of the facilities to which a provider's Independence patients are typically referred for hospital and outpatient surgical services.

Questions

If you have questions specific to Keystone HMO Proactive or your benefit tier placement, please contact your Network Coordinator. ◆

New offering for 2016

Beginning January 1, 2016, a new option, Keystone HMO Silver Proactive Value, will be added to our Keystone HMO Proactive tiered provider network product. This new offering is similar to the current Silver Proactive plan; however, it will include a deductible on Tier 1 to help lower the cost of the member's premium.



PFA

Keystone 65 Focus Rx HMO, our new Medicare Advantage benefit product

Independence will soon introduce Keystone 65 Focus Rx HMO (Keystone 65 Focus), a new Medicare Advantage HMO benefit product for 2016. Keystone 65 Focus uses a defined-network with more than 23,000 participating providers in southeastern Pennsylvania. Keystone 65 Focus members will enjoy the same benefits as with broader-network Medicare Advantage HMO benefit products while taking advantage of lower premiums and out-of-pocket costs due to their more defined network of providers.

Participating hospitals

The following hospitals are participating in the Keystone 65 Focus network. Please note that if an Independence-participating hospital does not appear on this list, it means the hospital is not participating in the Keystone 65 Focus network. Members who choose Keystone 65 Focus for their health care coverage should only be referred to the hospitals listed below for non-emergency services.

- Abington Health
  - Abington Memorial Hospital
  - Lansdale Hospital
- Aria Health
- Community Health Systems
  - Brandywine Hospital
  - Chestnut Hill Hospital
  - Jennersville Regional Hospital
  - Phoenixville Hospital
  - Pottstown Memorial Medical Center
- Doylestown Hospital
- Grand View Hospital
- Holy Redeemer Hospital and Medical Center
- Main Line Hospitals, Inc.
  - Bryn Mawr Hospital
  - Lankenau Medical Center
  - Paoli Hospital
  - Riddle Hospital
- St. Luke's Health System
- Thomas Jefferson University Hospital, Inc.
  - Methodist Hospital
  - Thomas Jefferson University Hospital

Keystone 65 Focus benefits

The following chart details specific information about the Keystone 65 Focus benefit product.

Service category	Keystone 65 Focus Rx HMO*		
		Philadelphia and Bucks County	Chester, Delaware, and Montgomery County
Monthly plan premium	Medical only	N/A	N/A
	Medical with Choice Program	N/A	N/A
	Medical with Rx	$0	$25
	Medical with Rx and Choice Program	$6	$31
Network	Defined network of physicians, ancillary providers, and hospitals		
Primary care physician (PCP) visits	$10 copay		
Specialist visits	$40 copay		
Emergency care	$75 copay (not waived if admitted)		
Urgent care†	$20 in-network urgent care centers ($10 for PCP; $40 for specialist) (not waived if admitted to the hospital)		
Worldwide coverage†	Emergency care and urgently needed care are covered worldwide, $75 copay per visit (not waived if admitted)		

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Service category	Keystone 65 Focus Rx HMO*
Routine chiropractic services	$20 copay per visit (up to 6 visits per year)
Routine podiatry services	$40 copay per visit (up to 6 visits per year)
Outpatient surgery	$150 copay per ambulatory surgical center visit $250 copay per outpatient hospital facility visit
Inpatient hospital	$150 per day for days 1 – 4; $600 maximum per stay; unlimited days per admission
Fitness program	SilverSneakers®
Preventive dental and vision care	Available only with the Choice Program option: $10 copay for dental exam and cleaning once every 6 months; $10 copay for a routine eye exam and up to $100 allowance for eyewear every 2 years
Hearing services	Available only with the Choice Program option: $40 copay for a routine hearing exam. Hearing aid benefit copay of $699 (standard) or $999 (premium) per hearing aid (one per ear per year)
Out-of-pocket maximum for 2016	$5,700
Prescription drugs (optional coverage)	
Deductible	No deductible for brand prescription drugs No deductible for generic tier 1 and tier 2 drugs
Copay	$2 preferred generic $15 generic $47 preferred brand $100 non-preferred brand 33% coinsurance specialty drug
Initial coverage limit	$3,310 in total drug cost
Coverage gap	Member pays 58% of generic drug costs and 45% of brand name drug costs until he or she reaches $4,850
Catastrophic	Member pays the greater of $2.95 generic and $7.40 brand or 5% coinsurance after reaching $4,850 catastrophic trigger
Mail order (90-day supply)	$4 preferred generic $30 generic $94 preferred brand $200 non-preferred brand 33% coinsurance specialty drug

**All Keystone 65 HMO members must use in-network hospitals and physicians with the exception of emergent or urgently needed care. Referrals are required for most services.*

†For urgently needed care received outside the United States, the emergency room copayment will apply.

Your participation status for the Keystone 65 Focus defined network

We recently mailed providers in our Keystone 65 HMO network eligibility criteria and their participation status for Keystone 65 Focus. If you have any questions about the eligibility criteria or another aspect of the Keystone 65 Focus defined network, please refer to the frequently asked questions on our website at *www.ibx.com/providers/focus*. If you still have questions after reviewing this information, please email us at *provinquiry@ibx.com*.

If you have Medicare patients who are interested in learning more about Keystone 65 Focus, please have them contact Customer Service toll-free at 1-800-645-3965 (TTY/TDD: 711), 8 a.m. to 8 p.m., seven days a week. Please keep in mind that providers must remain neutral when assisting patients with enrollment decisions. Any discussions with patients should be an objective assessment of the patient's needs and potential options. ◆

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

Quality ranking for primary care offices

We want to recognize offices that have demonstrated a dedication to high-quality patient care by achieving the highest rank in quality of care for the Quality Performance Measure (QPM) score program for measurement year 2014. The QPM score program, a component of the Quality Incentive Payment System program, is a comprehensive ranking system of quality measures for primary care offices with 150 or more commercial HMO/POS and Medicare Advantage HMO members. We congratulate the offices listed on the following pages for achieving excellence in aggregate in the following areas of preventive care:

- childhood and adolescent immunizations;
- childhood and adolescent well visits;
- cancer prevention in the areas of breast, cervical, and colorectal cancer screenings;
- heart care (cholesterol management for patients with cardiovascular conditions, beta-blocker treatment after a heart attack);
- asthma care (use of preferred medications for patients with chronic persistent asthma);
- diabetic care (HbA1c testing, LDL-C screening, eye exam rates, and nephropathy screening);
- chronic obstructive pulmonary disease care (use of spirometry testing in assessing and diagnosing);
- rheumatoid arthritis care (disease-modifying anti-rheumatic drug therapy);
- fracture care (osteoporosis management in women).

Note: Offices are listed alphabetically by group name or provider first name.

Tier 1 primary care offices	
Abington Bucks Internal Medicine	Buckingham Family Medicine
Abington Cedarbrook, IM	Bucks County Family Practice, PC
Alan C. Bilsky, M.D., LLC	Buxmont Medical Associates
Ambler Medical Associates – Blue Bell	Care Network Chadds Ford
Ambler Medical Associates – Spring House	Care Network Haverford
Ambler Pediatrics, PC	Care Network Highpoint
Amy Orloff, D.O., and Associates, PC	Care Network Springfield
Andorra Pediatrics	Center City Pediatrics, LLC
Aria Health Physician Services	Central Bucks Family Practice, PC (252 West Swamp Road, Doylestown, PA)
Aria Health Physician Services – Central Square Medical Office	Central Bucks Family Practice, PC (2370 York Road, Jamison, PA)
Aria Health Physician Services – Northeast Internal Medicine	Cheltenham Internal Medicine
Aria Health Physician Services – Oxford Internal Medicine	Chestnut Hill Family Care Associates
Aria Health Physician Services – Sweetbriar	Christine Zabel, D.O. – Primary Care Associates
Aria New Falls Medical Center	Colonial Family Practice
Arthur K. Smith, M.D.	Delphi Family Health Center
Bi County Medical Associates	Drexel Center for Women's Health
Broderman Internal Medicine Associates	Drexel Family Practice Associates at Manayunk
Brookside Family Practice and Pediatrics	Drexel Internal Medicine

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QUALITY MANAGEMENT

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Tier 1 primary care offices	
Drexel Medicine at Fairmount	Internal Medicine Associates of Abington, Maple Glen
E. Gary Lamsback, M.D.	J. Andrew Solis, M.D., PC
Einstein – Family Medicine at Elkins Park	Jefferson Internal Medicine Associates
Einstein – Germantown Family Medicine	Jefferson Medical Care
Einstein – Germantown Internal Medicine	Joseph W. Price, M.D.
Einstein – Germantown Professional Associates	Keith S. Rothman, M.D.
Einstein – Roxborough Internal Medicine	Kressly Pediatrics, PC
Einstein Wadsworth Internal Medicine	Lee A. Celio, M.D.
Ettinger and Zubkoff, M.D.	Lincoln Internal Medicine
Family Care Medical Center	LMG Family Practice, PC – Blue Bell
Family Practice Associates of King of Prussia	LMG Family Practice, PC – Chalfont
Family Practice Associates of Upper Dublin	Lower Bucks Pediatrics, PC
Family Practice of Honeybrook	M. Louis Vandebeek, M.D.
Founders Medical Practice, PC	Main Line Family Medicine, David R. Battaglia, M.D.
Fountain Medical Associates, PC	Main Line Family Medicine, Lauren S. Rosen, M.D.
G.S. Peter Gross, D.O., PC – South Eighth Street	Main Line Family Medicine, Susan Sandler, M.D.
Gardner Medical Associates	Main Line Healthcare City Line Family Medicine
Gateway Family Practice – Downingtown	Main Line Healthcare Lafayette Hill
Gateway Family Practice of Newtown	Marc M. Kress, M.D. & Associates
Gateway Internal Medicine – Brandywine	Margiotti & Kroll Pediatrics, PC
GPHA Chinatown Medical Association	Margiotti & Kroll Pediatrics, PC – Northeast
Great Valley Medical Associates, PC	Margiotti & Kroll Pediatrics, PC – Warrington
Han Anita Ott, D.O.	Meadowbrook Pediatrics, PC
Han Crozer Internal Medicine	Michael Lyons, M.D.
Han Crozer Medical Associates	Mt. Airy Family Practice
Han Dr. Conroy and Associates	Mt. Airy Pediatrics, PC
Han Glenn R. Ortley, D.O.	Murali Pediatrics, LLC
Hatboro Pediatrics, PC	Myers, Squire, & Limpert
Herbert Secouler, D.O.	Nemours DuPont Pediatrics Paoli
Horsham Pediatric Associates, PC	Ninth Street Internal Medicine Associates, LTD
Internal Medicine Associates of Abington	North Willow Grove Pediatrics

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Tier 1 primary care offices	
North Willow Grove Pediatrics, PC	Rittenhouse Internal Medicine – Philadelphia
Paoli Family Medicine	Rittenhouse Internal Medicine – Narberth
Peace Valley Internal Medicine, PC	Ronda G. Karp, D.O.
Pediatric Care Group, PC	S. Denise Hoffman, M.D., Family Medicine
Penn Family Care Family Medicine	Steven Sklar, D.O., PC
Penn Medicine at Radnor Internal Medicine	Sunshine Pediatrics, LLC
Penn Primary Care and Integrative Medicine – Whiteland	Temple Family Medicine at Fort Washington
Penncare – Bala Cynwyd Medical Associates	Temple Internal Medicine
Penncare – Dr. Michael Cirigliano	Tohickon Internal Medicine, LLC
Penncare – Edward S. Cooper, M.D., Internal Medicine	TPI Baiocchi and Rosenberg Temple Physicians Inc.
Penncare – Internal Medicine at Mayfair	Trivalley Primary Care – Indian Valley Office
Pennridge Pediatric Associates, Inc. (270 Main Street, Harleysville, PA)	Trivalley Primary Care – Lower Salford Office
Peter N. Christie, D.O.	Trivalley Primary Care – Upper Perkiomen Office
Pinnacle Physicians Group, LLC	Vicky P. Berberian, M.D.
Pinnacle Physicians Group, LLC – Frankford Avenue Family Practice	Whalen and McElmoyle Family Medicine – Langhorne Physician Services
Pinnacle Physicians Group, LLC – Stoltz and Hahn Medical Associates	William T. Chain, Jr., M.D.
Primecare Philadelphia, PC	Willow Grove Internal Medicine Associates
Providence Pediatric Practice, LLC	

Congratulations again to the primary care offices listed for demonstrating excellence in quality by achieving the highest rank in 2015 (based on 2014 data) for the QPM score program. ◆

Independence offers services to help patients communicate

For your patients who have difficulty communicating because of an inability to speak or understand English, Independence provides language assistance services through the AT&T Language Line. Please instruct these patients (or a friend or family member) to call the Customer Service number listed on the back of their member ID card and follow the prompts, or wait to speak to a Customer Service representative. Members can call to schedule interpreter services in advance of their next appointment.

Independence also offers telephone language-line services (TTY: 711) for members who are deaf or hearing-impaired. ◆

Independence members rate their physician experience

Independence uses composite scores from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) related to interactions between our members and their physicians to evaluate the experience between the two. These composite scores are calculated by the National Committee for Quality Assurance (NCQA) designated vendor, Morpace Marketing Research and Consulting, an independent company, and presented to Independence once the results are complete. Even though the composite indicators are the same, scores are measured based on questions and measures unique to commercial and Medicare Advantage plans.

Commercial plans

CAHPS scoring for commercial plans is measured according to the percentage of members who answered "Always/Usually" in regards to the following:

- **Getting Care Quickly.** The member is able to get care and appointments as soon as needed.
- **Getting Needed Care.** The member is able to have an easy time obtaining the care he or she believes is necessary and to schedule an appointment with a specialist.
- **Coordination of Care.** In the last 12 months, the member's personal physician has been kept informed and up to date about the care he or she has received from specialists or other health care providers.
- **How Well Doctors Communicate.** The physician shows the member respect by explaining the information in a way the member understands, is willing to listen to any questions or concerns, and spends enough time with the member.

Member Satisfaction CAHPS – commercial plans

Indicator	Keystone Health Plan East (KHPE)	Personal Choice®
Getting Care Quickly	87.08%	87.26%
Getting Needed Care	86.21%	90.39%
Coordination of Care	78.29%	86.22%
How Well Doctors Communicate	93.82%	95.77%

Medicare Advantage plans

CAHPS scoring for Medicare Advantage plans is measured according to the percentage of members who answered "Always" in regards to the following:

- **Getting Care Quickly.** The member receives care as soon as it is needed (urgent), obtains an appointment as soon as one is needed (routine), and sees a physician within 15 minutes of the scheduled appointment time.
- **Getting Needed Care.** The member is able to have an easy time obtaining the care and tests he or she believes are necessary and to schedule an appointment with a specialist.
- **Coordination of Care.** The physician was in possession of member medical records; the member had tests performed when determined it was necessary, and the physician followed up with test results; discussions were held regarding prescription medications; the member received assistance in managing his or her care; the physician was kept informed and up to date about care the member has received from specialists or other health care providers.
- **How Well Doctors Communicate.** The physician shows the member respect by explaining the information in a way the member understands, is willing to listen to any questions or concerns, and spends enough time with the member.

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Member Satisfaction CAHPS – Medicare Advantage plans

Indicator	Keystone 65 HMO	Personal Choice 65℠ PPO
Getting Care Quickly	59.2%	54.5%
Getting Needed Care	68.6%	66.8%
Coordination of Care	75.1%	75.9%
How Well Doctors Communicate	81.9%	83.4%

Results

When comparing Independence results versus national results, the experience for KHPE members falls at or below the 25th percentile, while Personal Choice members range between the 50th and 90th percentiles for positive outcomes. One key indicator is Coordination of Care. This indicator for KHPE fell within the 25th percentile while for Personal Choice it fell within the 90th percentile. For both Keystone 65 HMO and Personal Choice 65 PPO, member experience falls at or above the Centers for Medicare & Medicaid Services (CMS) National Distribution for positive outcomes.* Our goal is to reach the 90th percentile for all commercial measures and to continue to improve on the Medicare Advantage measures in order to exceed CMS National Distribution and achieve a 5 STAR rating.

Resources available to you

Independence values our network practitioners and the work involved in maintaining quality care. We offer a range of services and opportunities to help you maintain and improve care, including, but not limited to:

- Network Coordinators
- Care Management Services, including Complex Case Management and Condition Management (including Maternity Management)
- Behavioral Health Care services
- Pharmacy services

Additional information is available online at *www.ibx.com/providers* in the Resources for Patient Management section or in the Administrative Tools & Resources section of the NaviNet® web portal. ◆

**Plan comparison is reported via the NCQA Quality Compass tool and CMS National Distribution 2014 results, as 2015 results have not yet been published.*

Highlighting HEDIS®: Breast cancer screening

This article series is a monthly tool to help physicians maximize patient health outcomes in accordance with NCQA's* HEDIS®† measurements for high quality care on important dimensions of services.

Go to ***www.ibx.com/providers/resources/hedis.html*** to view previously published Highlighting HEDIS® topics. If you have feedback or would like to request a topic, email us at ***provider_communications@ibx.com***.

HEDIS® definition

Breast cancer screening: The percentage of women ages 50 – 74 who had a mammogram to screen for breast cancer.

Why this measure is important

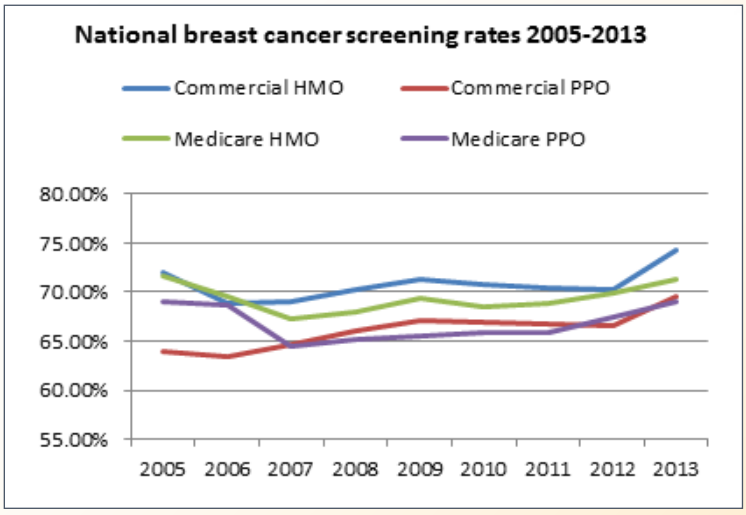
This measure looks at whether female members are being screened for breast cancer. It assesses the percentage of women between ages 50 and 74 who had a mammogram to screen for breast cancer.

Breast cancer is the second most common type of cancer among American women, with approximately 178,000 new cases reported each year. It is most common in women older than 50. Women whose breast cancer is detected early have more treatment choices and better chances for survival. Mammography screening has been shown to reduce mortality by 20 – 30 percent among women 40 and older. A mammogram can reveal tumors too small to be felt by hand; it can also show other changes in the breast that may suggest cancer.

— NCQA, HEDIS 2015 V1

National screening rates

The following chart shows the national average for commercial and Medicare breast cancer screening rates for HMO and PPO plans from 2005 – 2013.



Source: 2014 State of Health Quality

Do you know your rates?

We are committed to keeping you informed. To learn more about your screening rates by provider office for Independence members, please send an email to *starsinitiative@ibx.com*.

Quick tips for improvement

- ✓Develop a reminder system to help keep members up to date with screening.
- ✓Educate members about the importance of breast cancer screening and provide educational resources such as the National Cancer Institute website: *www.cancer.gov/types/breast*.
- ✓Provide members with information about screening procedures to help alleviate any anxiety or fear related to the screening. ◆

QIPS‡ and Stars§ alert

Breast cancer screening is a performance measure in the Quality Incentive Payment System (QIPS) program for measurement year 2015 for participating providers and is also a Medicare Stars measure.

**The National Committee for Quality Assurance (NCQA) is the most widely recognized accreditation program in the U.S.*

†The Healthcare Effectiveness Data and Information Set (HEDIS) is an NCQA tool used by more than 90 percent of U.S. health plans to measure performance on important dimensions of care.

‡QIPS is a reimbursement system developed by Keystone Health Plan East for participating Pennsylvania primary care physicians that offers incentives for high-quality, accessible, and cost-effective care.

§Stars is a program developed by the Centers for Medicare & Medicaid Services to measure quality health care. Ratings are published annually to help educate consumers prior to enrollment decisions.

Important Resources

Anti-Fraud and Corporate Compliance	
Hotline	1-866-282-2707 or www.ibx.com/antifraud
Care Management and Coordination	
Baby BluePrints®	215-241-2198 / 1-800-598-BABY (2229)*
Case Management	1-800-313-8628
Condition Management Program	1-800-313-8628
Credentialing	
Credentialing Violation Hotline	215-988-1413 or www.ibx.com/credentials
Customer Service	
Provider Services	1-800-ASK-BLUE (1-800-275-2583)
Electronic Data Interchange (EDI)	
Highmark EDI Operations	1-800-992-0246
FutureScripts® (commercial pharmacy benefits)	
Prescription drug prior authorization	1-888-678-7012
Pharmacy website (formulary updates, prior authorization)	www.ibx.com/rx
FutureScripts® Secure (Medicare Part D pharmacy benefits)	
FutureScripts Secure Customer Service	1-888-678-7015
Formulary updates	www.ibxmedicare.com
NaviNet® web portal	
Independence eBusiness Hotline	215-640-7410
Registration	www.navinet.net
Other frequently used phone numbers and websites	
Independence Direct Ship Drug Program (medical benefits)	www.ibx.com/directship
Medical Policy	www.ibx.com/medpolicy
Provider Supply Line	1-800-858-4728 or www.ibx.com/providersupplyline

**Outside 215 area code*

Independence

Visit our Provider News Center: www.ibx.com/pnc