### Major Characteristics
- Blue Advantage HMO members must select a Blue Advantage HMO Primary Care Physician (PCP).
- Blue Advantage HMO physicians and professional providers may only bill for copayments, cost share, (coinsurance) and deductibles, where applicable.
- Some services may be self-referred to a Blue Advantage HMO physician or professional provider (i.e. annual well woman exam, annual routine eye exam) as indicated by the member's benefit plan.
- To receive benefits, all medical care must be directed by the selected Blue Advantage HMO PCP. A PCP referral is required to all Blue Advantage HMO Specialty Care Physicians and Professional Providers (SCP).
- To receive benefits, referrals to out-of-network physicians and professional providers must be authorized by the Medical Care Management Dept.
- Blue Advantage HMO members will receive their annual eye exam and eye wear from Davis Vision providers. Blue Advantage HMO members will continue to use Blue Advantage HMO contracted providers for medical eye care. Please include all appropriate diagnosis codes on your claims in order to accurately represent the services provided. To request network participation with Davis Vision, please call 800-584-3140.
- Blue Advantage HMO members under age 20 have an included dental benefit. For more information, refer to the member’s Blue Advantage HMO ID card.
For Blue Advantage HMO, BCBSTX encourages the provider’s office to:

- Ask for the member’s ID card at the time of a visit;
- Copy both sides of the member’s ID card and keep the copy with the patient’s file;
- Check eligibility and benefits, request for verification or inquire on claims status and/or claim problems, contact your electronic connectivity vendor, i.e. Availity or other electronic connectivity vendor or call the toll-free Provider Customer Service number indicated on the member’s ID card for the appropriate plan type.
- Utilize the [Exchange Web application] at [http://www.bcbsx.com/provider/tools/iexchange.html] to obtain approval of: referrals, select outpatient services and inpatient admissions, maternity notifications, or for notification within 48 hours of an emergency hospital admission. For case management, call the Medical Care Management Department at 855-896-2701.

Claims Submission:

- All claims should be submitted electronically. The Electronic Payor ID for BCBSTX is 84980.
- For support relating to claims that are being sent to the Availity platform, submitters should contact Availity Client Services at 800-AVAILITY (282-4546).
- For support relating to claims and/or other transactions available on the Availity portal or other Availity platforms, submitters should contact Availity Client Services at 800-AVAILITY (282-4546).
- Paper claims must be submitted on the Standard CMS-1500 (02/12) or UB-04 claim form.
- All claims must be filed with the insured’s complete unique ID number including any letter or 3-digit alpha prefix.
- Duplicate claims may not be submitted prior to the applicable 30-day (electronic) or 45-day (paper) claims payment period.
- If services are rendered directly by the physician or professional provider, the services may be billed by the physician or professional provider. However, if the physician or professional provider does not directly perform the service and the service is rendered by another provider, only the rendering provider can bill for those services. Note: This does not apply to services provided by an employee of a physician or professional provider, e.g. Physician Assistant, Surgical Assistant, Advanced Practice Nurse, Clinical Nurse Specialist, Certified Nurse Midwife and Registered Nurse First Assistant, who is under the direct supervision of the billing physician or professional provider.

Provider Record ID & Network Effective Dates:

- A minimum of 30 days advance notice is required when making changes affecting the provider’s BCBSTX status, especially in the following areas:
  1. Physical address (primary, secondary, tertiary);
  2. Billing address;
  3. NPI & Provider Record ID changes;
  4. Moving from Group to Solo practice;
  5. Moving from Solo to Group practice;
  6. Moving from Group to Group practice; and
  7. Backup/covering providers.

- New Provider Record ID effective dates will be established as of the date the completed application is received in the BCBSTX corporate office. This applies to all additions, changes, and cancellations.
- BCBSTX will not add, change or cancel information related to the Provider Record ID on a retroactive basis.
- Retroactive Provider Record ID effective dates will not be issued.
- Retroactive network participation will not be issued.
- Delays in status change notifications will result in reduced benefits or non-payment of claims filed under the new Provider Record ID.
- If the provider files claim electronically and their Provider Record ID changes, the provider must contact the Availity Health Information Network at 800-AVAILITY (282-4546) to obtain a new EDI Agreement.

For Provider Record ID questions or to obtain a Provider Record ID application, please contact the Provider Services department at 972-996-9610, press 3.

Blue Advantage HMO – Outpatient Clinical Reference Lab Services

All outpatient clinical reference lab services must be referred to Blue Advantage HMO’s exclusive lab provider - Quest Diagnostics, Inc.

The Affordable Care Act (ACA) includes a provision that gives Health Insurance Marketplace members who receive advanced premium tax credits (APTC) also known as subsidies, a three-month grace period to pay their premium.

- **Grace Period Overview:**
  - The three-month grace period is only required for enrollees who have made one full premium payment during the benefit year and who are receiving the APTC.
  - The health plan is responsible for adjudicating claims during the first month after a member enters the grace period. The claims adjudicated are for dates of service rendered within the first month of this grace period.
  - During the second and third months of the grace period, issuers have the choice of either pending the claims or adjudicating the claims and seeking a refund if the member doesn’t pay all outstanding premium payments.
  - If a member fails to pay all outstanding premiums by the end of the three-month grace period, the health plan must terminate the member’s coverage.

- **How will BCBSTX make providers aware?**
  - Eligibility and Benefits Determination will include a paid through date and be provided by:
    - Electronic and/or clearinghouse compliant with the HIPAA 270/271
    - Interactive Voice Response (IVR) / automated telephone system
    - Provider Customer Service
    - Reminders to check for grace period status will be included on correspondence related to:
      - Pre-determinations
      - Preauthorizations
      - Referrals

Dec. 15, 2018