24

2024 Blue Cross and Blue Shield Service Benefit Plan - Standard and Basic Option
Section 3. How You Get Care
Page 24

- **Prescription drugs and supplies – Certain prescription drugs and supplies require prior approval.** Contact CVS Caremark, our Pharmacy Program administrator, at 800-624-5060, TTY: 711, to request prior approval, or to obtain a list of drugs and supplies that require prior approval. We will request the information we need to make our coverage determination. You must periodically renew prior approval for certain drugs. See Section 5(f) for more information about our prescription drug prior approval program, which is part of our Patient Safety and Quality Monitoring (PSQM) program.

  Please note that updates to the list of drugs and supplies requiring prior approval are made periodically during the year. New drugs and supplies may be added to the list and prior approval criteria may change. Changes to the prior approval list or to prior approval criteria are not considered benefit changes.

  Note: Until we approve them, you must pay for these drugs in full when you purchase them – even if you purchase them at a Preferred retail pharmacy or through our Specialty Drug Pharmacy Program – and submit the expense(s) to us on a claim form. Preferred pharmacies will not file these claims for you.

  Standard Option members may use our Mail Service Prescription Drug Program to fill their prescriptions. **Basic Option** members with primary Medicare Part B coverage also may use this program once prior approval is obtained.

  Note: Neither the Mail Service Prescription Drug Program, nor the Specialty Drug Pharmacy Program, will fill your prescription for a drug requiring prior approval until you have obtained prior approval. CVS Caremark, the program administrator, will hold your prescription for you up to 30 days. If prior approval is not obtained within 30 days, your prescription will be unable to be filled and a letter will be mailed to you explaining the prior approval procedures.

- **Medical foods covered under the pharmacy benefit require prior approval.** See Section 5(f) for more information.

• Surgery by Non-participating providers under Standard Option

You may request prior approval and receive specific benefit information in advance for non-emergency surgeries to be performed by Non-participating physicians when the charge for the surgery **will be $5,000 or more**. When you contact your local Blue Cross and Blue Shield Plan before your surgery, the Local Plan will review your planned surgery to determine your coverage, the medical necessity of the procedure(s), and the Plan allowance for the services. You can call your Local Plan at the customer service phone number on the back of your ID card.

Note: Standard Option members are not required to obtain prior approval for surgeries performed by Non-participating providers (unless the surgery is listed in this section as requiring approval) – even if the charge will be $5,000 or more. If you do not call your Local Plan in advance of the surgery, we will review your claim to provide benefits for the services in accordance with the terms of your coverage.

How to request precertification for an admission or get prior approval for *Other services*

First, you, your representative, your physician, or your hospital, residential treatment center or other covered inpatient facility must call us at the phone number listed on the back of your Service Benefit Plan ID card any time prior to admission or before receiving services that require prior approval.

Next, provide the following information:

- Enrollee's name and Plan identification number;
- Patient's name, birth date, and phone number;
- Reason for inpatient admission, proposed treatment, or surgery;
- Name and phone number of admitting physician;
- Name of hospital or facility;
- Number of days requested for hospital stay; and
- Any other information we may request related to the services to be provided.

Go to page 23. Go to page 25.