# CHAPTER 2: PRODUCT INFORMATION

## UNIT 3: OTHER GOVERNMENT PROGRAMS

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What Is My Service Area?

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**

The PA ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.

The DE ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.

The WV ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

# 2.3 MEDIGAP BLUE (PA ONLY)

**Introduction**

Medigap Blue, Highmark's Medicare supplemental product for individual direct-pay customers on Pennsylvania, is designed to assist beneficiaries by paying certain amounts not covered by the Medicare program. Depending on the design of the program, a supplemental product can pay Medicare deductibles, coinsurances, and/or other specific kinds of expenses.

What Is My Service Area?

**Standardization among Medigap plans**

In the 1990's, the Omnibus Budget Reconciliation Act (OBRA) required insurers throughout the United States to standardize the benefits available under their direct-pay Medigap products. The purpose of this standardization was to simplify seniors' purchasing decisions for Medicare supplemental coverage. All "Plan A" products, for example, must provide the same benefits. Therefore, the only real points of comparison among the contenders would be price and customer service.

The legislation provided for a maximum of ten standardized benefit plans. States were permitted to limit these plans further, and the Commonwealth of Pennsylvania chose to eliminate three of the originally proposed benefit packages. All Pennsylvania insurers in the Medigap market were required to offer Plan A and Plan B; they could also offer Plans C, D, E H, and I. Highmark chose to offer Plans A, B, C, E, H, and I. the plans are detailed in the chart below.

**Benefits available**

This chart outlines the benefits provided in each of the six plans:

| | PLAN | | | | | |
|---|---|---|---|---|---|---|
| **SERVICE** | **A** | **B** | **C** | **E** | **H** | **I** |
| Basic Benefits (including hospice coinsurance) | X | X | X | X | X | X |
| Skilled Nursing Facility Coinsurance | | | X | X | X | X |
| Part B Deductible | | | X | | | |
| Foreign Travel Emergency | | | X | X | X | X |
| Part B Excess Charges | | | | | | X |
| Preventive Health Benefits | | | | X | | |
| At-Home Recovery | | | | | | X |

**Note:** Basic benefits in these closed plans have no hospice coinsurance.

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# 2.3 MEDIGAP BLUE (PA ONLY), Continued

**Highmark plan changes in 2010**

In the year 2010, changes were made to the list of Medigap Blue plans that Highmark offers. Plan F and High Deductible (HD) Plan F were added as of January 1, 2010, and Plan N was added as of June 1, 2010.

Also effective June 1, 2010, Plans E, H, and I were closed to new enrollment; however, historic enrollment may still exist in these plans.

**Core benefits for all Medigap Blue plans**

All six of the Medigap Blue benefit packages offered by Highmark provide the following core benefits:

- Hospital coinsurance for days sixty-one (61) through ninety (90)

- Hospital coinsurance for Lifetime Reserve Days – days ninety-one (91) through one hundred fifty (150)

- Three hundred sixty-five (365) additional hospital days after Lifetime Reserve Days have been exhausted
- First three pints of blood (not covered by Medicare)
- Medicare Part B coinsurance

What Is My Service Area?

**Benefits under Plans A, B, C, F High Deductible, and N**

The table below compares the benefits available under the six Medigap Blue plans currently offered by Highmark. Plans that have been closed to new enrollment are not included in this chart, but can be referenced in the previous chart in this section. Plans E, H, and I may still contain historic enrollment. Plans A, B, and C are offered on both charts.

| | PLAN | | | | | |
|---|---|---|---|---|---|---|
| **SERVICE** | **A** | **B** | **C** | **F** | **F HD** | **N** |
| Basic Benefits (including hospice coinsurance) | X | X | X | X | X | X with copays |
| Part A Deductible | | X | X | X | X | X |
| Skilled Nursing Facility Coinsurance | | | X | X | X | X |
| Part B Deductible | | | X | X | X | |
| Foreign Travel Emergency | | | X | X | X | X |
| Part B Excess Charges | | | | X | X | |
| At-Home Recovery | | | | | X | |

**REMINDER: Always verify benefits**

It is the responsibility of the provider to verify that the member's benefit plan provides the appropriate benefits for the anticipated date of service prior to rendering service. You can verify a member's coverage by using NaviNet,® performing an electronic HIPAA Eligibility/Benefit Inquiry, or by calling the Provider Service Center.

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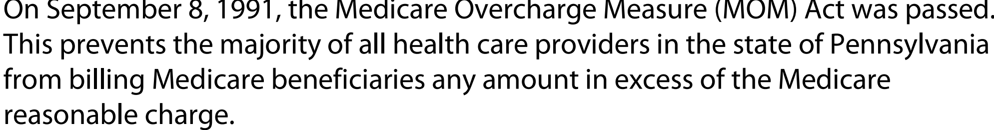
# 2.3 MEDIGAP BLUE (PA ONLY), Continued

**Medigap supplemental general information**



On September 8, 1991, the Medicare Overcharge Measure (MOM) Act was passed. This prevents the majority of all health care providers in the state of Pennsylvania from billing Medicare beneficiaries any amount in excess of the Medicare reasonable charge.

There are certain providers and suppliers who may charge beneficiaries for the difference between the billed amount and the Medicare allowance. You should contact the appropriate Medicare office for a listing of those types of providers.

When a member is enrolled in Medicare Part B and has supplemental coverage through Medigap Blue, Medicare is the primary carrier. Submit the claim to the member's Medicare carrier first for processing.

What Is My Service Area?

**Medigap Blue claim submission**

If you do not submit claims electronically, and payment under the supplemental coverage has not been received within thirty (30) days after the Medicare payment and you have checked claim status, send a copy of the Explanation of Medicare Benefits (EOMB) statement to:

Highmark
Medigap Claims
P.O. Box 898845
Camp Hill, PA 17089-8845

- Please do not highlight any information on the EOMB statement. Use an asterisk (*) or some other form of notation to indicate the patient whose claims need to be processed under their supplemental coverage.
- The member's contract identification number and correct address should be on the EOMB statement; otherwise, please submit a completed CMS-1500 claim form.
- In the case of Medicare electronic remittance, a screen print of the electronic remittance and a copy of the 1500 Claim Form should be sent to the address listed above.
- The beneficiary's Highmark agreement number and correct address should appear in the upper left hand corner of all documents submitted for processing.

# 2.3 SIGNATURE 65 (PA ONLY)

**Overview**

Signature 65 is designed to complement Medicare Part A and Part B covered services. Under this contract, Highmark will pay twenty (20) percent of the Medicare Part B allowance after the Medicare annual deductible has been satisfied.

What Is My Service Area?

**Core Benefits**

Signature 65 is a Highmark group product available in Pennsylvania that provides coverage for the following core benefits (benefits vary by group):

- Medicare Part A deductible
- Hospital coinsurance for approved Medicare benefits
- Skilled Nursing Facility coinsurance for approved Medicare benefits
- Three hundred sixty-five (365) additional hospital days
- The first three (3) pints of blood per calendar year
- Medicare Part B coinsurance

**Carve-out**

There are many groups that prefer to purchase the same benefits for their retired employees over age 65 (those with Medicare Part A and Part B) as they do for their active employees. In these arrangements, claims are processed by Medicare first, then through Highmark.

Any payment made by Medicare is subtracted (carved-out) from the payment made by Highmark. Payment is made only for those services eligible under the group's Highmark benefits, even if the service was eligible under Medicare Part B.

# 2.3 DELAWARE MEDICARE SUPPLEMENTAL PROGRAMS

**Overview**

Highmark Delaware's Medicare complementary and supplement programs help to pay some of the expenses not paid by Medicare. This may include payment of the Medicare deductibles and/or coinsurance depending on the individual plan.

What Is My Service Area?

**Medicfill®**

Highmark Delaware's Medicfill® coverage is a health insurance plan designed to supplement Medicare coverage after an individual has retired or become eligible for Medicare as a result of a disability. Medicare is the primary payer; Highmark Delaware is the secondary payer.

Usually, the individual or dependent must be enrolled in and retain Medicare Parts A and B to be eligible for Medicare supplementary coverage.

**Carve-out plans**

There are many groups that prefer to purchase the same benefits for their retired employees over age 65 (those with Medicare Part A and Part B) as they do for their active employees. In these arrangements, claims are processed by Medicare first, then through Highmark Delaware.

Any payment made by Medicare is subtracted (carved-out) from the payment made by Highmark Delaware. Payment is made only for those services eligible under the group's Highmark Delaware benefits, even if the service was eligible under Medicare Part B.

# 2.3 WEST VIRGINIA MEDICARE SUPLEMENTAL PROGRAMS

**Overview**

Highmark West Virginia has Medicare standardized supplemental plans and Medicare complementary plans (pre-standardized). Standardized supplemental plans are available to individuals only, while complementary plans are available to both employer groups and individuals.

The individual or dependent must be enrolled in and retain Medicare Parts A and B to be eligible for Medicare supplementary or complementary coverage.

What Is My Service Area?

**Medifil**

Medifil is Highmark West Virginia's Medicare supplemental product for individuals who are retired and over age 65, or have become eligible for Medicare as a result of a disability. It is designed to assist Medicare beneficiaries by paying certain amounts not covered by the Medicare program. Medicare is the primary payer; Highmark West Virginia is the secondary payer.

Highmark West Virginia offers the standardized Plans A, C, F, F (High Deductible), and N. Depending on the design of the plan, a supplemental product can pay Medicare deductibles, coinsurance, and/or other specific kinds of expenses.

**Carve-out coverage**

There are many groups that prefer to purchase the same benefits for their retired employees over age 65 (those with Medicare Part A and Part B) as they do for their active employees. In these arrangements, claims are processed by Medicare first, then through Highmark West Virginia.

Any payment made by Medicare is subtracted (carved-out) from the payment made by Highmark West Virginia. Payment is made only for those services eligible under the group's Highmark West Virginia benefits, even if the service was eligible under Medicare Part B.

# 2.3 PENNSYLVANIA CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

What Is My Service Area?

**Introduction**

Highmark makes health care programs available to uninsured children in Pennsylvania through the subsidized Children's Health Insurance Program of Pennsylvania (CHIP). CHIP coverage offers programs for all uninsured children regardless of household income.

**Background**

The Children's Health Insurance Program (CHIP) is modeled after the Caring Program for Children, which was pioneered by Highmark through its Caring Foundation more than 25 years ago. CHIP expanded in 2007 with the legislation to Cover All Kids. CHIP now offers coverage to every uninsured child in Pennsylvania, regardless of household income. CHIP covers children from birth through 18 years of age.

This program is administered by Highmark on behalf of the Commonwealth of Pennsylvania Department of Human Services (DHS).

**Free, Low-Cost, and Full-Cost CHIP**

The more a child's family earns, the more cost sharing they will have in the form of higher premiums and copays.

- Free CHIP is funded through a portion of the state cigarette tax as well as federal funding. Families owe nothing for their child's premium and there are no copayments for office/ER visits and drugs.
- Low-Cost CHIP includes three levels with varying costs based on family income. Families pay some of the cost of CHIP coverage for each level of Low-Cost CHIP and copays for office/ER visits and drugs. Low-Cost CHIP began receiving federal money in addition to state money when CHIP expanded under Cover All Kids.
- Full-Cost CHIP provides health care coverage to children in households who are over the income limits for Free and Low-Cost CHIP. Families pay the full cost of CHIP coverage at this level and copays for office/ER visits and drugs.

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# 2.3 PENNSYLVANIA CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP), Continued

**Health care providers make the programs possible**

It is only through a partnership with our providers that these programs are successful and Highmark can continue its social mission to provide health care coverage to as many children in Pennsylvania as possible.

Highmark extends its sincere appreciation to its providers for their continued commitment to provide services to children who qualify for these programs.

Please remember that you do not have to verify income or eligibility for these programs. Eligibility and income are determined before enrollment and annually thereafter by the Plan.

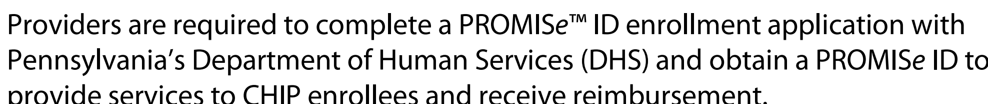
What Is My Service Area?

**Utilizes Highmark provider networks**

One of the keystones of this program is that families are "held harmless" from balance billing when covered services are provided by a network provider. To achieve that, CHIP uses the Premier Blue Shield preferred provider network to provide services to these children in the Central Region, the Keystone Health Plan West (KHPW) managed care network in the 29-county Western Region, and the First Priority Health (FPH) managed care network in the 13-county Northeastern Region.

Prescription drugs are provided using the National Network. Vision coverage is administered by Davis Vision and dental coverage is provided by United Concordia's network.

**PROMIS*e*™ ID enrollment required to service CHIP enrollees**



Providers are required to complete a PROMIS*e*™ ID enrollment application with Pennsylvania's Department of Human Services (DHS) and obtain a PROMIS*e* ID to provide services to CHIP enrollees and receive reimbursement.

For more information about this requirement, please see the *Highmark Provider Manual's* **Chapter 3.1: Network Participation Overview**.

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# 2.3 PENNSYLVANIA CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP), Continued

**Payment directly to participating providers**

As with our commercial group programs, Highmark pays Premier Blue Shield, KHPW, and FPH network providers directly, and they agree to accept our payments as payment-in-full for covered services.

Highmark sends payments for services of out-of-network providers directly to the child's parents, who are responsible for paying the charges. Out-of-network providers are not obligated to accept Highmark's payment as payment in full. It is critical in all cases that enrollees check the network status of their provider.*

**Note:** Highmark will deny any claims from providers who have not completed enrollment with Pennsylvania's DHS and obtained a valid PROMIS*e* ID.

For more information about CHIP payment, please see the manual's **Chapter 6.7: Payment/EOBS/Remittances**.

** This does not apply to emergency care.*

What Is My Service Area?

**Eligibility requirements for CHIP**

The Highmark CHIP Administrative Unit performs eligibility and enrollment functions for children with CHIP coverage. The Individual Markets area performs marketing and outreach for CHIP to locate children and educate the community about the CHIP program. Children must meet these eligibility guidelines:

- Be a resident of Pennsylvania prior to applying for this coverage (except newborns);
- Be a U.S. citizen, a permanent legal alien, or a refugee as determined by the U.S. Immigration and Naturalization Service;
- Be under age 19;
- Not be covered by any health insurance plan, self-insured plan, or self-funded plan. And not be eligible for or covered by Medical Assistance offered through the *Department of Human Services* or other governmental health insurance;
- Be eligible based on family size and income;*

Why blue italics?

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# 2.3 PENNSYLVANIA CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP), Continued

**Eligibility requirements for CHIP *Continued...***

- For all new applicants whose annual income falls in the Low-Cost and Full-Cost CHIP ranges, they must show that the child has lost health insurance because a parent lost their job or the child is moving from another public insurance program (not applicable if the child is under the age of two); and
- Full-Cost CHIP families must also show that access to coverage is unavailable and unaffordable.

** Depending on income levels, children may be eligible for either Free or Low-Cost CHIP insurance. If eligible for Low-Cost or Full-Cost CHIP insurance, families will be required to pay a monthly premium for their child's health insurance (as well as some copays).*

What Is My Service Area?

***Why blue italics?***

**PH-95 eligibility for Medical Assistance**

In Pennsylvania, children under the age of 18 with certain disabilities or special health needs may qualify for Medical Assistance (also known as Medicaid), regardless of parental income. This eligibility is called PH-95, "Children with Special Needs." *The Pennsylvania Department of Human Services requires Highmark to review billing and claims management information to identify any child that may be potentially eligible for PH-95 Medical Assistance.*

*Each child identified with certain special health conditions that would likely qualify for Medicaid PH-95 Program will be sent to the treating provider for completion of a **Physician Certification for Child with Special Needs** form. Starting in July of 2021, the forms will be sent using Adobe eSign which also provides a copy for the Physician's records. Additionally, Physicians will be able to attach documents to the Adobe form, if desired.*

***The Fax form process will be discontinued when the Adobe eSign form process begins.***

*If a child is identified as eligible for Medical Assistance per PH-95, the child will be referred to the Central Unit at County Assistance where the information will be reviewed and a determination made.*

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# 2.3 PENNSYLVANIA CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP), Continued

Why blue italics?

**Completing the Physician Certification for Child with Special Needs form**

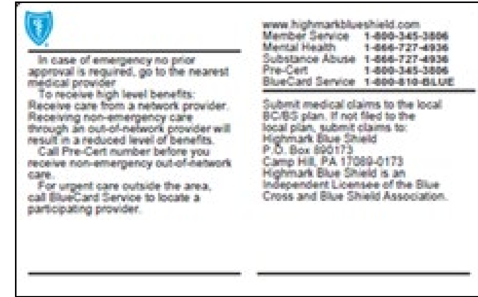
*To complete the Physician Certification for Child with Special Needs form:*

- *The certification must be completed by a psychologist, physician, or medical professional under the physician's supervision and authority ( e.g. physician assistant or certified nurse practitioner)*
- *The treating physician must note if the child is not considered disabled at all; temporarily disabled for less than 12 months; temporarily disabled for MORE than 12months; or permanently disabled*
- *The date, name of each diagnosis (the ICD-10 code and the description), and any functional limitations and their impacts must be supplied*
- *The form must be signed by the treating physician*

**CHIP ID cards**

A child enrolled in CHIP will have the same Highmark insurance card as any commercial or group member. The symbol "Y-18" will appear on ID cards for CHIP enrollees. It can be found in the bottom left-hand corner on the front of the card. You may use NaviNet® to determine eligibility, coverage, and claim status.

**Central Region:**

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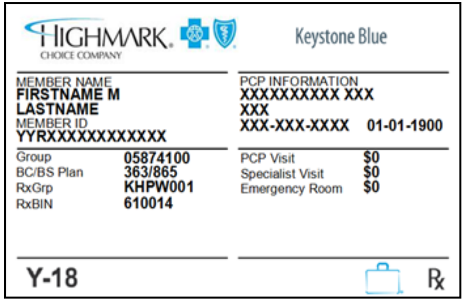
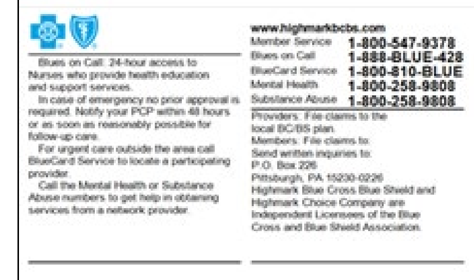
# 2.3 PENNSYLVANIA CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP), Continued

What Is My Service Area?

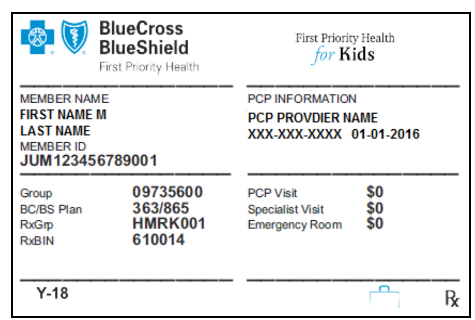
**CHIP ID cards** (Continued)

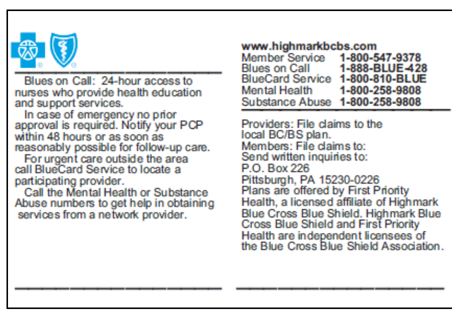
**Western Region:**




**Northeastern Region:**




**CHIP product offerings**

**PA Western Region:** CHIP benefits are offered through an HMO product utilizing the KHPW managed care network.

**PA Central Region:** CHIP benefits are offered through *PPO Plus* – a managed care program featuring a PCP component. *PPO Plus* utilizes the Premier Blue Shield network. Unlike traditional PPOs, all Act 68 and Managed Care regulations, including complaint and grievance rights, apply to *PPO Plus*.

**PA Northeastern Region:** CHIP benefits are offered through First Priority Health for Kids -- an HMO product utilizing the FPH managed care network.

**IMPORTANT! PCP required**

**All CHIP enrollees must select a PCP to manage their care.** Enrollees are encouraged to select a PCP within ten (10) days of enrollment in CHIP. If a PCP is not chosen, a PCP will be assigned. Enrollees are able to change the PCP assignment at any time.

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# 2.3 PENNSYLVANIA CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP), Continued

**Information for PCPs of CHIP enrollees**

Since the CHIP products offered in the Western, Central, and Northeastern Regions are managed care products, all CHIP enrollees must select a PCP to coordinate their care. All Act 68 and Managed Care regulations, including complaint and grievance rights, apply to the Western Region's Keystone Blue HMO product, the Central Region's PPO Plus product, and the Northeastern Region's First Priority Health for Kids HMO product.

Central Region CHIP enrollees will have an identification card with the PPO Plus product name in the upper right hand corner. For CHIP enrollees residing in the Western Region, the HMO product name, Keystone Blue, will appear in the upper right hand corner on the front of their ID cards. First Priority Health for Kids will be displayed in the upper right corner of the ID card for CHIP enrollees in the 13-county Northeastern Region. The chosen PCP's practice name will also be on the front of all enrollee identification cards (see ID card samples on the previous page).

Although CHIP enrollees are required to select a PCP to oversee their care, traditional "referrals" are not required. If it is necessary to recommend that a CHIP enrollee see a specialist or other provider, PCPs should make every attempt to refer enrollees to providers within the network with a valid PROMIS*e* ID.

- **In the Central Region:** Enrollees can go outside the Premier Blue Shield network and receive care at the lower level of coverage with higher out-of-pocket expenses.

**Information for PCPs of CHIP enrollees** (continued)

- **In the Western Region:** Enrollees must use the Keystone Health Plan West (KHPW) managed care network providers to receive 100 percent coverage unless the non-emergency covered benefits are not available within the network and are pre-authorized by Highmark.

What Is My Service Area?

- **In the Northeastern Region:** Enrollees must use First Priority Health (FPH) managed care network providers to receive 100 percent coverage unless the non-emergency covered benefits are not available within the network and are pre-authorized by Highmark.

Member Rights and Responsibilities for CHIP enrollees are available in **Chapter 1.5: Member Rights and Responsibilities**.

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# 2.3 PENNSYLVANIA CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP), Continued

**Accessibility expectations for CHIP providers**

To stay healthy, Highmark members must be able to see their physicians when needed. To support this goal, Highmark sets expectations for accessibility of primary care physicians (PCPs), medical specialists, behavioral health specialists, and obstetricians.

In addition, the Department of Human Services has set standards for specific time frames in which network providers should respond to CHIP enrollee needs based on symptoms. Please note that some standards for CHIP enrollees may differ from those Highmark sets for commercial members.

| CHIP PCP AND MEDICAL SPECIALIST EXPECTATIONS | |
|---|---|
| **Patient's Need:** | **Performance Standard:** |
| **Emergency/life threatening care**<br>Sudden, life-threatening symptom(s) or condition requiring immediate medical treatment (e.g., chest pain, shortness of breath) | Immediate response |
| **PCP urgent care appointments**<br>An urgently needed service is a medical condition that requires rapid clinical intervention as a result of an unforeseen illness, injury, or condition (e.g., high fever, persistent vomiting/diarrhea) | Office visit within one (1) day (twenty-four (24) hours) |
| **PCP regular care appointments**<br>Non-urgent but in need of attention appointment (e.g., headache, cold, cough, rash, joint/muscle pain) | Must be scheduled within two to seven (2-7) days (non-urgent) |

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# 2.3 PENNSYLVANIA CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP), Continued

What Is My Service Area?

| CHIP PCP AND MEDICAL SPECIALIST EXPECTATIONS (continued) | |
|---|---|
| **Patient's Need:** | **Performance Standard:** |
| **PCP routine care appointments**<br>Routine Wellness appointments<br>(e.g., asymptomatic/preventive care, well child/patient exams, physical exams) | • Physical and behavioral health assessments, general physical examination, and first examination must be scheduled within three (3) weeks of enrollment<br>• Subsequent routine wellness appointments must be scheduled within ten (10) days |
| **Specialist urgent care appointments**<br>Urgent medical condition. | Appointments within twenty-four (24) hours of referral |
| **Specialist routine care appointments**<br>1. Routine care appointments for the following specialty types:<br>a. Otolaryngology;<br>b. Orthopedic surgery;<br>c. Dermatology;<br>d. Pediatric dentist;<br>e. Allergy and immunology;<br>f. Pediatric endocrinology;<br>g. Pediatric gastroenterology;<br>h. Pediatric general surgery;<br>i. Pediatric hematology;<br>j. Pediatric infectious disease;<br>k. Pediatric nephrology;<br>l. Pediatric neurology;<br>m. Pediatric oncology;<br>n. Pediatric pulmonology;<br>o. Pediatric rehab medicine;<br>p. Pediatric rheumatology; and<br>q. Pediatric urology.<br>2. All other specialty provider types | 1. Office visit within fifteen (15) days<br>2. Highmark must schedule appointments for routine care within ten (10) business days of referral for all other specialty provider types not listed |
| **Persons with HIV/AIDS**<br>PCPs and specialists are to have scheduling procedures in place to allow for scheduling of appointments for enrollees that Highmark identifies at enrollment to be HIV positive or diagnosed with AIDs | PCPs and specialists must have procedures in place that allow scheduling an appointment with a PCP or specialist within seven (7) days from the effective date of enrollment |

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# 2.3 PENNSYLVANIA CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP), Continued

What Is My Service Area?

| CHIP PCP AND MEDICAL SPECIALIST EXPECTATIONS (continued) | |
|---|---|
| **Patient's Need:** | **Performance Standard:** |
| **After-hours care**<br>Access to practitioners after the practice's regular business hours | Acceptable process in place to respond twenty-four (24) hours per day, seven (7) days a week to enrollee issues:<br>• Answering service that pages the practitioner; or<br>• Answering machine message telling caller how to reach the practitioner after hours. |
| **In-office waiting times**<br>• Practitioners are encouraged to see patients with scheduled appointments within 15 minutes of their scheduled appointment time. A reasonable attempt should be made to notify patients of delays.<br>• Practitioners should see patients within no more than one hour when the physician encounters an unanticipated urgent medical condition or is treating an enrollee with a difficult medical need. | • Within fifteen (15) minutes.<br>• Practitioners should see patients within no more than one (1) hour when the physician encounters an unanticipated urgent medical condition or is treating an enrollee with a difficult medical need. |

| CHIP MATERNITY CARE EXPECTATIONS (Obstetrics) | |
|---|---|
| **Patient's Need:** | **Performance Standard:** |
| **Maternity Emergency** | • Immediate response |
| **Maternity 1st Trimester** | • Within three (3) weeks of first request<br>• Within ten (10) business days of the new enrollee being identified as being pregnant |
| **Maternity 2nd Trimester** | • Within seven (7) calendar days of first request<br>• Within five (5) business days of the new enrollee being identified as being pregnant |
| **Maternity 3rd Trimester** | • Within three (3) calendar days of first request<br>• Within four (4) business days of the new enrollee being identified as being pregnant |
| **Maternity High Risk** | • Within three (3) days of identification of high risk<br>• For new enrollees, within twenty-four (24) hours of identification of high risk to Highmark or the maternity care provider, or immediately if an emergency exists |

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# 2.3 PENNSYLVANIA CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP), Continued

What Is My Service Area?

**CHIP BEHAVIORAL HEALTH PROVIDER EXPECTATIONS**

| Patient's Need: | Performance Standard: |
|---|---|
| **Care for a life-threatening emergency**<br>Immediate intervention is required to prevent death or serious harm to patient or others | Immediate response |
| **Care for a non-life-threatening emergency**<br>Rapid intervention is required to prevent acute deterioration of the patient's clinical state that compromises patient safety | Care within six (6) hours |
| **Urgent care**<br>Timely evaluation is needed to prevent deterioration of patient condition | Office visit within forty-eight (48) hours |
| **Routine office visit**<br>Patient's condition is considered to be stable<br>**Note:** Physical and behavioral health assessments, general physical examination, and first examination must be scheduled within three (3) weeks of enrollment. | Office visit within ten (10) business days |
| **After-hours care**<br>Access to practitioners after the practice's regular business hours | Acceptable process in place to respond twenty-four (24) hours per day, seven (7) days a week to enrollee issues:<br>• Answering service that pages the practitioner; or<br>• Answering machine message telling caller how to reach the practitioner after hours. |
| **In-office waiting times**<br>• Practitioners are encouraged to see patients with scheduled appointments within 15 minutes of their scheduled appointment time. A reasonable attempt should be made to notify patients of delays.<br>• Practitioners should see patients within no more than one hour when the physician encounters an unanticipated urgent medical condition or is treating an enrollee with a difficult medical need. | • Within fifteen (15) minutes.<br>• Practitioners should see patients within no more than one (1) hour when the physician encounters an unanticipated urgent medical condition or is treating an enrollee with a difficult medical need. |

*Continued on next page*

# 2.3 PENNSYLVANIA CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP), Continued

What Is My Service Area?

**Acceptable after-hours methods**

The chart below outlines acceptable methods of handling after-hours calls from your Highmark CHIP patients.

| ANSWERING PROCESS | RESPONSE/MESSAGE | COMMENTS |
|---|---|---|
| **Answering Service or Hospital Service** | Caller transferred directly to physician | |
| | Service pages the physician on call (see comments) | A physician or clinical staff person is expected to return the call within thirty (30) minutes |
| **Answering Machine** | Message must provide the caller with a way to reach the physician on call by telephone or pager | Provide clear instructions on how to record a message on a pager (i.e., "you will hear a series of beeps, please enter your phone number, including area code, by pressing the number keys on your phone, then hang up"). A physician or clinical staff person is expected to return the call within thirty (30) minutes. |
| | Instruct caller to leave a message (see comment) | A physician or clinical staff person is expected to return the call within thirty (30) minutes |

**Outreach following missed appointments**

PCPs and specialists must conduct affirmative outreach whenever a CHIP enrollee misses an appointment. Three (3) attempts to contact the enrollee must be made and documented in the enrollee's medical record.

Attempts to contact the enrollee may include, but are not limited to: written attempts; telephone calls; and home visits. However, at least one (1) attempt must be a follow-up telephone call.

**Preventive services**

CHIP follows the Highmark Preventive Health Guidelines. This schedule is reviewed and updated periodically based on the advice of the American Academy of Pediatrics (AAP) and Bright Futures™, the U.S. Preventive Task Force, the Blue Cross and Blue Shield Association, and medical consultants. Accordingly, the frequency and eligibility of services is subject to change.

Highmark's Preventive Health Guidelines are available on the Provider Resource Center. Select **EDUCATION/MANUALS** from the main menu on the left, and then **Preventive Health Guidelines**.

The Bright Futures periodic screens must be conducted for all eligible CHIP enrollees to identify health and developmental problems. These screens must be in accordance with the most current periodicity schedule and recommended pediatric immunization

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# 2.3 PENNSYLVANIA CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP), Continued

What Is My Service Area?

**Preventive services** (continued)

schedules based on guidelines issued by the AAP and the Centers for Disease Control and Prevention (CDC).

To view the current periodicity schedule, click on the following link: **Bright Futures Periodicity Schedule**.

**Blood lead levels testing**

Pediatric preventive care must include blood lead levels testing of all children at ages one (1) and two (2) years old. In addition, blood lead level tests must be completed for all children aged three (3) through six (6) without a confirmed prior lead blood test consistent with current Pennsylvania Department of Health and Medical Assistance program requirements.

The following requirements/procedures apply for lead blood tests for CHIP enrollees:

- The lead blood test must be performed by a laboratory that participates in the CHIP network.
- The lead blood test can be performed with the routine hemoglobin test for anemia at twelve (12) months, per Bright Futures; or, one finger stick can be completed for both the hemoglobin and lead tests without a blood draw.
- You must submit claims for both the hemoglobin and lead blood tests if they are performed together.
- The lead blood test is reimbursable if submitted using procedure code **83655**.
- There is no out-of-pocket cost to members for lead blood tests.

**IMPORTANT**: You must submit the claim with the date that the lead blood test was performed along with the results of the test.

**Developmental screenings**

Developmental screenings can assist in early detection and intervention of autism, learning disabilities, and developmental delays. Currently, providers who care for CHIP enrollees are required to perform developmental screenings for patients according to AAP guidelines for annual screening of children three (3) years of age and younger for developmental disabilities.

The following requirements/procedures apply for developmental screenings for CHIP enrollees:

- You can perform developmental screenings during well-child visits.
- You must submit claims for both the developmental screening and the well-child visit if you perform the developmental screening during a well-child visit.
- Developmental screenings are reimbursable if submitted using procedure code **96110**.
- There is no out-of-pocket cost to enrollees for developmental screenings.

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# 2.3 PENNSYLVANIA CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP), Continued

[What Is My Service Area?]

**Maternal depression screening**

CHIP policy requires that maternal depression screening is covered per the Bright Futures Periodicity Schedule and CMS.

- Screening may be done in the PCP or pediatrician's office as part of the well-child visit and covered under the child's benefit when screening is for the direct benefit of the child.
- Validated screening tools specific to maternal depressions screening, such as the Edinburgh Postnatal Depression Scale or Post-Partum Depression Screening Scale, must be used.
- Claims for maternal depression screening under the child's CHIP benefit are to be submitted with procedure code **96161** with diagnosis codes that designate screening is done for the welfare of the child.
- There is no out-of-pocket cost to enrollees for maternal depression screening performed as a preventative service as part of the well child visit.

**Mental health assessments**

If a PCP determines that a mental health assessment is needed, the PCP must inform the enrollee, or enrollee's parent or legal guardian, on how to access these mental health services and coordinate access to these services, when necessary.

**Authorization requirements**

Authorization for select services is required for the CHIP HMO products in the Western and Northeastern Regions and also the CHIP *PPO Plus* product in the Central Region. (Please note that CHIP *PPO Plus* authorization requirements differ from traditional PPOs.)

The following services require authorization for CHIP enrollees:

- All inpatient admissions including mental health/substance abuse
- Any service that may potentially be considered experimental/investigational or cosmetic in nature
- Home health services
- Selected injectable and specialty tier program drugs
- Non-emergency outpatient advanced imaging and cardiology services (coordinated by eviCore healthcare effective January 1, 2019)*
- Durable medical equipment (DME) and orthotics and prosthetics
- Highmark's list of outpatient procedures requiring authorization (available on the Provider Resource Center under **CLAIMS, PAYMENT & REIMBURSEMENT**)

** For more information, please see the manual's* **Chapter 4.5: Outpatient Radiology and Laboratory**.

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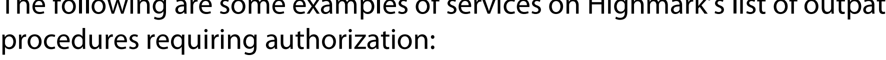
## 2.3 PENNSYLVANIA CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP), Continued




**Authorization requirements** (continued)

The following are some examples of services on Highmark's list of outpatient procedures requiring authorization:

- Diabetes education
- Enteral formula
- Nutritional counseling (except for the treatment of diabetes)
- Non-emergency mental illness and substance abuse treatment services
- Outpatient surgical services
- Respiratory and cardiac rehabilitation therapy

**Caring Program: Care coordination for special needs**

CHIP coverage in the Western, Central, and Northeastern Regions includes the Caring Program-- a comprehensive, community-based, care coordination program for children with special health care needs or chronic conditions. Nurses and other health care staff work directly with CHIP enrollees and their parents/guardians to help them understand their child's medical condition and treatment; coordinate services among physicians; help them locate and receive the services available to meet their child's needs; provide them with educational materials; and link to the community resources that can help their family. When appropriate, the staff can assist CHIP enrollees at their medical appointments and school meetings.

For questions regarding the Caring Program, please call **1-866-823-0892**. The Caring Program Customer Service is available Monday through Friday, 8:30 a.m. to 4:30 p.m. EST. If outside of business hours, please leave a message. All calls are returned within two (2) business days.

Information regarding the Caring Program can also be accessed by clicking on this link **Highmark CHIP** and entering your ZIP code to access the CHIP program page for your service area. Select **The Caring Program** from the menu on the left for access to more detailed information about the program.

**Pediatric Disease Management Program**

Highmark's Caring Program offers a pediatric disease management program to assist CHIP enrollees with four targeted conditions: diabetes, asthma, obesity, and tobacco use - prevention and cessation.

The program is designed to reinforce the physician's treatment plan for the patient. Its goal is to proactively engage these enrollees and their families for better understanding of their conditions and, with assistance from Highmark Case Management staff, to help them manage their disease.

All children enrolled in CHIP through Highmark who are identified as having

*Continued on next page*

## 2.3 PENNSYLVANIA CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP), Continued

What Is My Service Area?

**Pediatric Disease Management Program** (continued)

diabetes, asthma, obesity, or using tobacco are automatically registered as participants in the disease management program.

The program will provide the following services to CHIP enrollees and their families:

- Support from Highmark case management nurses and other health care staff to better manage their condition and periodically evaluate their health status
- Educational and informational materials to assist them in understanding and managing the medications prescribed by their doctors
- Assistance in effectively planning for office visits with their physicians and reminders as to when those visits should occur

The Highmark Case Management staff will notify a physician's office by letter or a telephone call to inform them when any of their CHIP patients are enrolled in the program. The assistance in care coordination and communication among the various entities involved in the child's care will be of benefit to the physician as well. Since membership in the program is voluntary, the CHIP enrollee who wishes to stop participating in the program can do so with a telephone call. To discuss a CHIP patient's involvement in the program, please contact us at **1-866-823-0892**.

**CHIP benefits and services**

CHIP covers a wide range of benefits and services, including medical care, prescription drugs, and dental and vision services. Except for emergency care and emergency ambulance services, benefits are provided only for services performed by a network provider with a valid PROMIS*e* ID.

**Medical benefits**

Commonly used CHIP medical benefits are outlined here. For detailed benefit information, please verify a CHIP enrollee's medical coverage via NaviNet® Eligibility and Benefits prior to rendering services.

| **Ambulance Services** | Precertification required for non-emergent only |
|---|---|
| **Hospital Services** | **Inpatient Care** - - Pre-admission review required:<br>• Inpatient consultations<br>• Anesthesia<br>• Diagnostic services<br>• Transplant services<br>**Outpatient Services:**<br>• Clinic services (in a hospital-affiliated clinic)<br>• Diagnostic services<br>• Emergency medical and accident<br>• Surgery |

*Continued on next page*

# 2.3 PENNSYLVANIA CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP), Continued

What Is My Service Area?

**Medical benefits** (continued)

| | |
|---|---|
| **Maternity** | • Prenatal and postnatal care<br>• Routine newborn care for the first 31 days |
| **Medical Visits** | • Primary care provider<br>• Specialists (includes Specialist Virtual Visits)<br>• Gynecologists<br>• Retail clinic<br>• Urgent care centers<br>• Telemedicine<br>• Second surgical opinion |
| **Mental Health** | • Inpatient care<br>• Partial hospitalization<br>• Outpatient visits<br>• Emergency psychiatric care |
| **Preventive Care**<br>Follows the Highmark Preventive Schedule | Includes the following, with no cost sharing or copays:<br>• Routine physical examinations<br>• Pediatric immunizations<br>• Well baby care<br>• Routine diagnostic screening<br>• Routine lead screening<br>• Mammograms, annual routine and medically necessary<br>• Routine gynecological exams, including a Pap Test |
| **Private Duty Nursing** | Requires precertification |
| **Substance Abuse** | • Detoxification<br>• Inpatient rehabilitation<br>• Outpatient services |
| **Surgical Services** | • Assistant at surgery<br>• Anesthesia<br>• Oral surgery |
| **Habilitative Services** | • Physical medicine<br>• Occupational therapy<br>• Speech therapy<br><br>Limited to a total of thirty (30) outpatient visits for each type of service per benefit period. This limit does not apply when services for habilitative purposes are prescribed for the treatment of mental illness or substance abuse. |

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# 2.3 PENNSYLVANIA CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP), Continued

What Is My Service Area?

**Medical benefits** (continued)

| | |
|---|---|
| **Therapy and Rehabilitative Services** | • Chemotherapy<br>• Dialysis treatment<br>• Radiation therapy<br>• Respiratory therapy<br>• Infusion therapy<br>• Inpatient rehabilitation<br>• Cardiac rehabilitation<br>• Physical medicine – limited to a total of sixty (60) outpatient visits per benefit period<br>• Occupational therapy - limited to a total of sixty (60) outpatient visits per benefit period<br>• Speech therapy - limited to a total of sixty (60) outpatient visits per benefit period<br>• Spinal manipulations – limited to twenty (20) visits per benefit period |
| **Other Medical Services** | • Allergy testing<br>• Autism spectrum disorders<br>• Durable medical equipment<br>• Home health care<br>• Hospice<br>• Skilled nursing facility<br>• Transplant services |

**Other CHIP covered services**

| | |
|---|---|
| **Dental** (administered by United Concordia) | The dental plan for CHIP enrollees meets the Minimum Essential Health Benefits requirements for pediatric oral health as required under the federal Affordable Care Act. |
| **Hearing** | • Hearing evaluation once every calendar year<br>• Audiometric examination once every calendar year<br>• Hearing aid – not more than one per ear in any two calendar years |
| **Prescription Drugs** | • Closed formulary with soft generic<br>• Copayments required for Low-Cost and Full-Cost CHIP<br>• 90 days at retail available |

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## 2.3 PENNSYLVANIA CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP), Continued

What Is My Service Area?

**Other CHIP covered services** (continued)

| **Vision** (administered by Davis Vision*) | • Eye examination and refraction (once every 12 months)<br>• Frame (one every 12 months)<br>• Lenses – single vision, bifocal, trifocal (one pair every 12 months)<br>• Contact lenses (pair)<br><br>*Davis Vision network providers accept reimbursement as payment in full for standard services. Non-Davis network providers are reimbursed at an out-of-network fee schedule. |
|---|---|

**CHIP claims submission**

All claims, except dental and vision claims, should be submitted just like any other Highmark Blue Shield claim. They may be submitted electronically or on a paper claim form. Please note that in all cases, the child is the enrollee. **Report "Patient's relationship to insured" as "self."** Do not report the name of the parent.

Electronic claims are preferred. However, if necessary, paper claims can be submitted to the following addresses:

| CENTRAL REGION: | WESTERN AND NORTHEASTERN REGIONS: |
|---|---|
| Highmark Blue Shield | Highmark Blue Shield |
| P.O. Box 890173 | P.O. Box 898819 |
| Camp Hill, PA 17089-0173 | Camp Hill, PA 17089-8819 |

| DENTAL | ROUTINE VISION |
|---|---|
| United Concordia Companies, Inc. | Davis Vision |
| Claims Processing | Vision Care Claims Unit |
| P.O. Box 69421 | P.O. Box 1501 |
| Harrisburg, PA 17106-9421 | Latham, NY 12110 |

**Timely filing**

The Pennsylvania Children's Health Insurance Program (CHIP) requires providers to submit all claims for services provided to CHIP enrollees to Highmark **within one hundred and eighty (180) days** from the date of service or discharge.

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# 2.3 PENNSYLVANIA CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP), Continued

**Complaints and grievances**

Under Pennsylvania's CHIP, an enrollee or enrollee's representative, which may include the enrollee's provider, may file a complaint or grievance. For detailed information, please see the CHIP section in the Highmark Provider Manual's **Chapter 5.5: Denials, Grievances, & Appeals**.

**FQHC/RHC payment and claim submission**

Section 503 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) requires payment for services provided by Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (R[illegible]nt to Medicaid Prospective Payment System (PPS) rat[illegible]he PPS rates are all-inclusive rates for encounter services provided, except for vaccine services.

What Is My Service Area?

For more information, including claim submission guidelines, please see the manual's **Chapter 6.7: Payment/EOBs/Remittances**

**CHIP enrollment**

If you know of children who may qualify for this program, please refer them to the appropriate telephone number for the Highmark CHIP Administrative Unit (PA Western, Central, and Northeastern Regions):

**1-800-KIDS-105** (1-800-543-7105); TTY Service: **Dial 711**

For more information on CHIP, please visit Pennsylvania's "We Cover All Kids" website at **http://www.chipcoverspakids.com**.

# 2.3 FEDERAL EMPLOYEE PROGRAM (FEP)

**Overview**

All federal government employees and qualified retirees are entitled to health insurance benefits under the Federal Employees Health Benefits (FEHB) Program. The FEHB allows insurance companies, employee associations, and employee unions (e.g., the National Association of Letter Carriers) to develop plans to be marketed to government employees.

Federal employees are given a wide range of insurance options, from catastrophic coverage plans with high deductibles to health maintenance organizations (HMOs). Some plans are offered nationwide while others are regionally-available plans. The number of choices for individual employees varies based on where they reside.

The Blue Cross Blue Shield Association (BCBSA) fee-for-service plan is offered to federal employees nationwide. The Federal Employee Program (FEP), also known as the Service Benefit Plan, has been part of the FEHB Program since its inception in 1960. More than 50 percent of all federal employees and retirees nationwide have chosen to receive their healthcare benefits through FEP. These subscribers and their families receive health coverage through the local Blue Plan where they reside.

**FEP benefit plan options**

Federal employees have traditionally been offered two Preferred Provider Organization (PPO) benefit packages nationally through FEP -- Standard Option and Basic Option. The same types of services are covered under both options, but at different payment levels.

For 2019, FEP introduced a new coverage option for the first time since the beginning of the FEHB Program -- FEP Blue Focus℠. The options now available to federal employees and retirees include:

- **Standard Option PPO** allows FEP members to seek covered services from both network participating and non-participating providers. When members use participating PPO providers, their out-of-pocket expenses, such as coinsurance and copayment amounts, will be less.
- **Basic Option PPO** has a lower premium than Standard Option and no deductibles, but members must use participating preferred providers to receive benefits.
- **FEP Blue Focus** is also a PPO product that uses the same network as the Standard and Basic options with no out-of-network benefits, except in certain situations such as emergency care. The “Core” benefits, which provide coverage for all of the essentials of good preventive health, are the base of the program. The Core benefits are covered at little or no cost to members when they use network providers.

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# 2.3 FEDERAL EMPLOYEE PROGRAM (FEP), Continued

**More about the new FEP Blue Focus benefit plan**

The benefits under FEP Blue Focus are divided into three key categories: Core, Non-core, and Wrap. These categories describe the cost share the member will pay based on the services used.

- **Core benefits**, the base of the program, have a low or no copayment and are not subject to a deductible or coinsurance. These benefits are most commonly used to receive general care and to maintain overall health and well-being, in addition to coverage for accidental injuries.

  Copays under the Core benefits are ten dollars ($10) per visit for the first ten (10) visits for a primary care provider, specialist, or other health care provider, such as a mental health doctor. Each member on the subscriber's coverage receives 10 visits per calendar year.

  On the eleventh visit in the calendar year, the member's cost-sharing will change to include the plan's deductible and thirty percent (30%) coinsurance. Preventive care visits, such as an annual physical, do not count toward the 10-visit limit and are at no cost to members.

- **Non-core benefits** provide coverage for any unexpected medical costs that may occur during the calendar year. All of these services are subject to an annual deductible and coinsurance. When the catastrophic out-of-pocket maximum is met, then services for the remainder of the calendar year are paid at 100 percent of the Plan allowance for services.

- **Wrap benefits** provide the final layer of protection and complete, or "wrap-up," the FEP Blue Focus benefit package. These are benefits that members may or may not have a need to use during the year. These benefits have visit limitations and/or different copayments or coinsurance than the Core and Non-core benefit levels. The calendar year deductible does not apply to these benefits.

FEP Blue Focus does not provide benefits for some services that are covered under the Standard and Basic options, such as routine dental care. A complete list of benefit exclusions is available in the **FEP Blue Focus Service Benefit Plan Brochure**, which is also available at **fepblue.org** . The appeals process for FEP Blue Focus is the same as for the Standard and Basic options.

**IMPORTANT! Services requiring prior authorization**

It is important to note that additional services require prior authorization under FEP Blue Focus that do not require prior authorization under the Standard and Basic options.

For prior authorization requirements for all FEP products, including a list of services requiring prior authorization, please see the manual's **Chapter 5.2: Authorizations**.

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# 2.3 FEDERAL EMPLOYEE PROGRAM (FEP), Continued

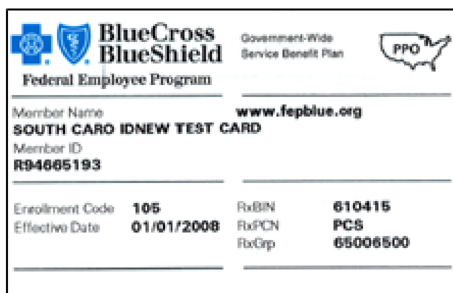
**Identifying FEP members**

Members who are part of the Blue Cross Blue Shield Association's Federal Employee Program (FEP) can be identified by the following:

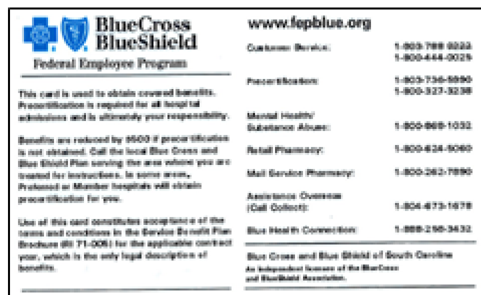
- The letter "R" in front of their member ID number instead of a three letter alpha prefix.
- The BlueCross BlueShield Federal Employee Program logo on their ID card.
- The FEP Blue Focus ID card has a thin blue border around the perimeter, which distinguishes it from the Standard Option card, which has a solid white border, and the Basic Option card, which has a shaded blue front.

**SAMPLE: Standard Option ID card**

**Front of card:**



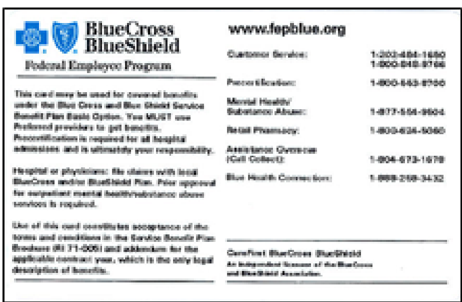

**Back of card:**




**SAMPLE: Basic Option ID card**

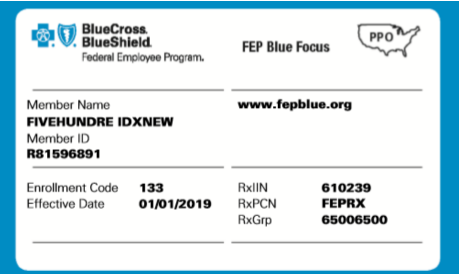
**Front of card:**

**Back of card:**

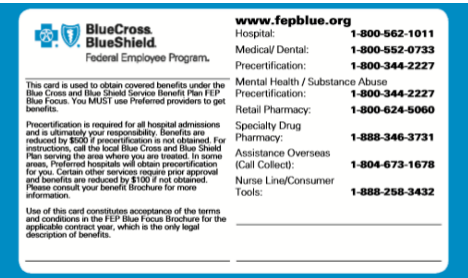



**SAMPLE: FEP Blue Focus ID card**

**Front of card:**




**Back of card:**

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# 2.3 FEDERAL EMPLOYEE PROGRAM (FEP), Continued

**Verifying eligibility & benefits**

Eligibility and benefits can be verified through NaviNet® for FEP members residing in Pennsylvania, Delaware, and West Virginia.

For out-of-state FEP members, or FEP members in Highmark's service areas if NaviNet is not available, please call the appropriate FEP Provider Service department:

- Pennsylvania: **1-866-763-3608**
- Delaware: **1-800-721-8005**
- West Virginia: **1-800-535-5266** or **304-424-7792**

Hours are Monday through Friday, 8:30 a.m. to 4 p.m. EST.

What Is My Service Area?

**Claim submission**

Claims for FEP members should be submitted to the local Blue Plan where services were rendered. Each local Plan is responsible for processing and paying claims for services received within that area. Highmark participating providers should submit all claims for FEP members to Highmark, ***except*** for the following:

- **Lab providers should file FEP claims in the state where the lab tests were performed, not where the specimen is drawn.** The provider locations are determined by the mailing address.
- **DME providers should file FEP claims in the state where the provider is located, not where the DME supplies are delivered.** The provider locations are determined by the mailing address.
- **Facilities (UB/837I billers) must submit claims for FEP members to their local Blue Cross plan.**
  - In Pennsylvania, Highmark is the Blue Cross licensee in the Western and Northeastern Regions, therefore, facilities in those service areas would submit claims for FEP members to Highmark.

    However, in the Central and Eastern Regions, where other Blue Plans hold the Blue Cross licensing for the service areas, facilities located in those service areas must submit claims for FEP members to those Blue Cross plans (Capital Blue Cross in the Central Region; Independence Blue Cross in the Eastern Region). Click on the **What Is My Service Area?** icon below to view the service area map and identify the applicable regions.
  - Since Highmark is the only Blue Cross Blue Shield licensee in Delaware and in West Virginia, facilities located in Highmark Delaware and Highmark West Virginia service areas will always submit claims for FEP members to their local Highmark plan.

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# 2.3 FEDERAL EMPLOYEE PROGRAM (FEP), Continued

| | |
|---|---|
| **Claim submission** (continued) | For special tips on professional claim submission for FEP members, please see the section on FEP Processing in **Chapter 6.4: Professional (1500/837P) Reporting Tips**. |
| **FOR MORE INFORMATION** | For more information on the Blue Cross Blue Shield Federal Employee Program, please visit **fepblue.org**. |