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.

Note: If we approve the request for prior approval or precertification, you will be provided with a notice that identifies the approved services and the authorization period. You must contact us with a request for a new approval five (5) business days prior to a change to the approved original request, and for requests for an extension beyond the approved authorization period in the notice you received. We will advise you of the information needed to review the request for change and/or extension.

• Non-urgent care claims

For non-urgent care claims (including non-urgent concurrent care claims), we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for *Other services* that must have prior approval. We will notify you of our decision within 15 days after the receipt of the pre-service claim.

If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original **15-day** period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.