APRIL 2021

NOTICES & ANNOUNCEMENTS

COVID-19 Provider Preparedness Updates

As the COVID-19 crisis evolves, we're continuing to update our COVID-19 Preparedness and our COVID-19 Related News pages. Be sure to check these pages frequently for updates including COVID-19: Texas Provider FAQs and COVID-19: FAQs for Medicare Providers.

COVID-19 Initiative Interfacility Transfer Without Prior Authorization Accommodation Expired

Blue Cross and Blue Shield of Texas (BCBSTX) has taken steps to make access to the testing and treatment for our members easier and less expensive during this national health emergency. We have extended the duration of these measures to continue serving our members.

The chart below details those dates. We will continue to monitor the situation and update as needed. Check our provider site and our COVID-19 Related News for the latest information on each initiative.

Initiative	Start Date	End Date
Chest CT Scan without Prior Authorization	March 2, 2020	Dec. 31, 2020
COVID-19 Testing Cost-Share Waiver	March 7, 2020	End of Health and Human Services (HHS) public health emergency
COVID-19 Testing-Related Visits Cost-Share Waiver	March 18, 2020	End of HHS public health emergency

COVID-19 Treatment Cost - Share Waiver	April 1, 2020	Dec. 31, 2020*
Credentialing Simplified	April 3, 2020	End of HHS public health emergency
Interfacility Transfer without Prior Authorization	April 1, 2020	Expired on Feb. 28, 2021**
Prior Authorization Extension	Services scheduled between Jan. 1 and June 30, 2020	Dec. 31, 2020
Telemedicine/Telehealth Expansion, Cost-Share Waiver	March 10, 2020	Members will have **access** to the expanded telemedicine services through **Dec. 31, 2020**. The **cost-share waiver will end on Dec. 31, 2020*** for **commercial** and **retail** members. Copays, deductibles and coinsurance will apply after Dec. 31, 2020. The **cost-share waiver will end on** Dec. 31, 2020* for **Medicare** members.

**Services that were originally scheduled to end May 31, 2020*

*** Service originally scheduled to end May 15, 2020*

COVID-19 Vaccines and Coverage

In the face of the COVID-19 pandemic, pharmaceutical companies have moved to produce vaccines. The Food and Drug Administration (FDA) awarded an Emergency Use Authorization (EUA) to three companies for their vaccines: Pfizer on Dec. 11, 2020, Moderna on Dec. 18, 2020, and Janssen Pharmaceutical Companies of Johnson and Johnson on Feb. 27, 2021.

Federal and state health officials are working with the medical community to distribute the COVID-19 vaccine.

Initially, the **federal government will pay for the vaccine**. Blue Cross and Blue Shield of Texas, or self-funded groups, will cover **administration** of the vaccine as noted below:

Fully insured:

- Vaccine and administration covered as a preventive service with no cost-share to members at in-network providers.
- Vaccine and administration covered with no cost-share to members if delivered at out-of-network providers through the end of the public health emergency.

Self-funded employer groups:

- Non-grandfathered self-funded employer groups - vaccine and administration covered as a preventive service with no cost-share to members at in-network providers.
- Vaccine and administration covered at no cost-share to members at out-of-network providers through the end of the public health emergency.
- Self-funded employer groups that don't cover preventive vaccines through their pharmacy benefit must cover the vaccine through their medical benefit.
- Grandfathered plans are not required to cover preventive services, including the COVID-19 vaccine.

Medicare Advantage and Medicare Supplement

- For 2020 and 2021, Medicare payment for the COVID-19 vaccine and its administration will be through the original fee-for-service Medicare program.
- Submit claims for administering the COVID-19 vaccine to the CMS Medicare Administrative Contractor (MAC) using product-specific codes for each vaccine approved.
- Members will have no cost-sharing on vaccines through Dec. 31, 2021.

Medicaid

- Most Medicaid members will have no cost-sharing on vaccines from in- and out-of-network providers. See the CMS Medicaid toolkit for more details.

Reimbursement:

- In-network providers will be reimbursed for the administration fee based on contracted rates.
- Out-of-network providers will be reimbursed based on established OON reimbursement policy that follows Medicare rates.

Balance billing: Providers are prohibited from billing patients for the vaccine or its administration, including balance billing, if the provider received the vaccine at no cost from the government.

Coding claims: CMS and the American Medical Association (AMA) have identified the codes to use in submitting claims. For more information, see CMS' guidance.

When **billing a vaccine administration code with an office visit**, if the vaccine is **not the primary purpose** of the office visit, **bill** the vaccine on a **separate claim**.

Code	Use	Description

91300	Vaccine	Pfizer-Biontech Covid-19 Vaccine SARSCOV2 VAC 30MCG/0.3ML IM
0001A	Admin	Pfizer-Biontech Covid-19 Vaccine Administration – First Dose ADM SARSCOV2 30MCG/0.3ML 1ST
0002A	Admin	Pfizer-Biontech Covid-19 Vaccine Administration – Second Dose ADM SARSCOV2 30MCG/0.3ML 2ND
91301	Vaccine	Moderna Covid-19 Vaccine SARSCOV2 VAC 100MCG/0.5ML IM
0011A	Admin	Moderna Covid-19 Vaccine Administration – First Dose ADM SARSCOV2 100MCG/0.5ML1ST
0012A	Admin	Moderna Covid-19 Vaccine Administration – Second Dose ADM SARSCOV2 100MCG/0.5ML2ND
91303	Vaccine	Janssen/Johnson & Johnson - Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, adenovirus type 26 (Ad26) vector, preservative free, 5x10 viral particles/0.5mL dosage, for intramuscular use
0031A	Admin	Janssen/Johnson & Johnson - Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, adenovirus type 26 (Ad26) vector, preservative free, 5x1010 viral particles/0.5mL dosage, single dose

Dosage: Candidate vaccines may require one or two doses. The Pfizer and Moderna vaccines require two doses. The Janssen/Johnson & Johnson vaccine is one dose.

More information:

- CDC COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations
- Provider Relief Fund – for reimbursement for administering the COVID-19 vaccine to the uninsured
- CMS Medicaid Toolkit – Coverage and Reimbursement of COVID-19 Vaccines, Vaccine Administration, and Cost Sharing under Medicaid, the Children's Health Insurance Program, and Basic Health Program
- CMS guidance on Medicare billing for the COVid-19 vaccine administration

We continue to monitor information provided by the CDC and other government and health officials. We'll provide updates when we have them. For the latest information on COVID-19, we recommend visiting the CDC's COVID-

19 website.

Telemedicine Expansion for 2021

In support of our members and employer groups during the ongoing national public health emergency (PHE), and in line with the new administration's information that we expect the PHE to continue for the duration of 2021, we are **expanding the telehealth services we'll cover through the end of 2021**. This means that we are no longer limiting coverage of telehealth services to the Centers for Medicare and Medicaid Services (CMS) and American Medical Association (AMA) permanent lists.

Instead, during 2021, **we will cover telehealth services beyond the CMS and AMA** telehealth lists. This includes, but is not limited to:

- Applied behavior analysis (ABA) services
- Intensive outpatient program (IOP) services
- Partial hospitalization programs (PHP)
- Physical therapy (PT)
- Occupational therapy (OT)
- Speech therapy (ST)

The details: The change will be **retroactive to Jan. 1, 2021.** It applies to our **fully insured** and **self-funded group** members. Self-funded groups may opt out of the expanded coverage. Always check eligibility and benefits to determine each member's options. Member **cost-share will still apply.**

Claims from Jan. 1, 2021 to now: We are working as quickly as possible to process new claims according to the expanded coverage and to adjudicate telehealth claims that may have been denied since Jan. 1, 2021.

Watch for updates related to this change on the Telemedicine and Telehealth Services page on the provider website.

Multiple Procedure Payment Reduction Claims Review

Blue Cross and Blue Shield of Texas (BCBSTX) will be conducting post pay claim reviews of certain diagnostic cardiovascular and ophthalmology services to ensure reimbursement adheres to BCBSTX reimbursement policy for Multiple Procedure Payment Reduction (MPPR) of the Technical Component (TC) of Certain Diagnostic Cardiovascular and Ophthalmology Procedures effective June 1, 2021.

What this means to you: If you submit claims with multiple diagnostic cardiovascular or ophthalmology services performed for the **same member**, on the **same day**, you may have been paid 100% for the technical component of **each** service. This is most common when services are submitted on separate claims for the same day and same member. If this occurred, services may be overpaid and a refund for an overpayment may be requested.

This could also **impact the member's cost-share**.

To avoid overpayment, please submit services for same member on the same day on a single claim.

MPPR policy applies to the following plans:

- Blue Advantage HMO℠ and Blue Advantage Plus℠ HMO
- Blue Choice PPO℠
- Blue Essentials℠ and Blue Essentials Access℠
- Blue Premier℠ and Blue Premier Access℠
- PAR Plan

View the MPPR policy here or go to the BCBSTX website under **Standards and Requirements, General Reimbursement Information, Reimbursement Schedules and Related information**. The information is secure and requires a password to access. Contact your BCBSTX Network Management Representative, you need the password or have additional questions.

Please be advised that the reimbursement information being disclosed within this notice contains confidential information proprietary to BCBSTX. The use and disclosure of this information is restricted under Texas Insurance Code Section 1301.136(b), Texas Insurance Code Section 843.321(b) and the terms of your BCBSTX agreements.

BEHAVIORAL HEALTH

Tiered Payment Rate Modifiers for ABA Effective April 1, 2021

Applied Behavior Analysis (ABA) Therapy is a treatment that is often rendered at a high intensity to individuals from vulnerable populations. The bulk of the therapy hours a member receives is rendered by an unlicensed technician under the supervision of a Qualified Healthcare Professional. To improve the quality of care for our members and be responsive to the needs of our provider network, we will be making some changes to reimbursement rates by allowing the use of modifier codes.

What's changing?

As part of our initiative to improve health care delivery as well as find solutions to aid in reducing unnecessary health care costs for everyone, we will be implementing a tiered payment rate based on modifiers for CPT® 97153 – ABA Adaptive Behavior Treatment by Protocol. We want our commercial members to receive the best health outcomes for the dollars spent on their care.

Reimbursement Details

Many providers have requested higher reimbursement rates when Licensed Behavior Analysts render this service. Additionally, many providers have inquired if rates were available that reflect their commitment to best practices by ensuring all their Registered Behavior Technician (RBT) staff obtain and maintain certification. Based on similar changes across the industry and feedback from our provider network, the reimbursement rate should reflect the

education, training and credentials of the clinicians providing care to our commercial members.
Based on the clinician rendering the services, the following modifiers should be used **effective April 1, 2021:**

- **HN:** RBT, Board Certified Assistant Behavior Analyst (BCaBA) or clinician with a bachelor's degree; rate will remain equivalent to the existing rate.
- **HM:** Clinician with less than a bachelor's degree and no RBT certification; rate will be reduced by 20%.
- **HO:** Board Certified Behavior Analyst (BCBA), Board Certified Behavior Analyst – Doctoral (BCBA-D) or clinician with a master's level or higher education; rate will increase by 20%.

If providers do not include a modifier with code 97153, the reimbursement will default to HM.

Using provider type modifiers to compensate providers of direct services will help to ensure ABA remains a high quality and accessible service for our members.

CLAIMS & ELIGIBILITY

Reminder Submit EFT and ERA Enrollments via Availity®

As a reminder, starting **May 3, 2021,** Blue Cross and Blue Shield of Texas (BCBSTX) will offer a single access point for enrollment in Electronic Funds Transfer (835 EFT) and/or Electronic Remittance Advice (835 ERA) via the Availity® Provider Portal. As of this date, faxed or mailed EFT or ERA enrollment applications including change/cancel requests will be returned and redirected to the electronic option.

Enrolling will increase efficiencies within your provider organization, allows for more convenience, and heightens security of patient and provider information.

Education and Training
While the electronic enrollment process is easily followed, BCBSTX is hosting complementary webinar trainings for you to learn how to enroll online via Availity. To register for a session, select your preferred date and time below:

- April 19, 2021 - 2 to 3 p.m.
- April 21, 2021 - 10 to 11 a.m.
- April 23, 2021 - 11 to 12 p.m.
- April 27, 2021 - 1 to 2 p.m.
- April 29, 2021 - 3 to 4 p.m.

If these dates and times are not convenient for your office, you may contact Electronic Commerce Services for training.

Already enrolled for 835 EFT and ERA delivery from BCBSTX?

- You do not need to enroll again.

- Availity's Transaction Enrollment tool should also be used to change and/or cancel your existing EFT or ERA delivery.

Refer to the EFT and ERA Enrollment User Guide for online enrollment assistance, which is located on the Electronic Funds Transfer/Electronic Remittance Advice page of our Provider website.

Electronic enrollment remains an opt-in arrangement. If you currently receive paper checks and/or provider claim summaries you can continue to do so.

If your provider organization feels they should be exempt from the online enrollment process, email our Electronic Commerce Services.

Hospitals and Routine Services and Supplies

Routine services and supplies are generally already included by the provider in charges related to other procedures or services. As such, these items are considered non-billable for separate reimbursement. The following guidelines may assist hospital personnel in identifying items, supplies, and services that are not separately billable (this is not an all- inclusive list):

- Any supplies, items and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services in a specific location are considered routine services and not separately billable in the inpatient and outpatient environments.
- All items and supplies that may be purchased over the counter are not separately billable.
- All reusable items, supplies and equipment that are provided to all patients:
  - During an inpatient or outpatient admission are not separately billable.
  - Admitted to a given treatment area or units are not separately billable.
  - Receiving the same service are not separately billable.

Overpayment of Multiple Surgical Procedures

On **June 1, 2021,** Blue Cross and Blue Shield of Texas (BCBSTX) will begin additional reviews of claims after payment to make sure they adhere to our reimbursement policy for multiple surgical procedures.

Key Point: Our payment policy states that when multiple procedures are performed by the same physician or physician group on the same patient in the same operative session, only the **primary procedure** will **pay 100%** of the allowed amount. **Secondary or subsequent procedures** will **pay at 50%.**

Multiple Surgical Procedure Guidelines

- **Primary procedure:** The surgical procedure with the **highest allowed amount** is the primary procedure and reimbursed at 100% of the allowed amount. If two procedures have the same allowed amount, **only one** will be considered primary. Other procedures are secondary or subsequent.

- **Secondary procedures:** Secondary procedures will be **reimbursed 50%** of the allowed amount.
- **Bilateral procedures:** If the surgical procedure for either side is the highest allowed amount, then one procedure will pay at 100% and the second at 50%, all other secondary procedures will also be reimbursed at 50%. If at least one other surgical procedure is the highest allowed amount, then the bilateral procedure (both sides combined) will be reimbursed at 75% and all other secondary procedures will be reimbursed at 50%.

For more information, refer to the **CPCP015 - Multiple Surgical Procedures - Professional Provider Services** on the Clinical Payment and Coding Policy page on the provider website for more detailed information.

What the Review Means?

If you submit claims with multiple billable units of the **same procedure,** for the **same member,** on the **same date of service,** at the **same location,** you may have been paid 100% for each procedure, despite our current payment policy. However, claims with dates of service on and after **June 1, 2021,** will be processed consistent with our payment policy. Some procedures may be exempt from this policy and pay 100% of the allowed amount.

If we overpay you, we'll **recoup** the amount overpaid against future claims. This could also **impact member cost-share,** so you may need to reimburse members.

Exclusions: Claims for members with the following benefit plans are excluded from this policy:

- BCBSTX is the secondary payer
- Medicare Supplement
- Medicaid

More information: If you have any questions, please call the number on the back of the member's ID card or contact your BCBSTX Provider Network Representative.

Telehealth Claim 'Place of Service'

Providers are responsible for accurately coding services performed on their claims. When submitting telehealth professional services using a HCFA 1500, the claims when billed with a telehealth procedure code or another CPT® or HCPCS procedure code with telehealth modifiers (G0, GT, GQ, or 95), need to be billed with place of service (POS) 02. **Starting May 1, 2021, if professional telehealth services are billed without POS 02, claims may be rejected and must be resubmitted with the correct POS.** If you have any questions, please contact your Network Management Representative.

Clinical Payment and Coding Policy Updates

The Clinical Payment and Coding policies on our website describe payment rules and methodologies for CPT®, HCPCS and ICD-10 coding for claims submitted as covered services. This information is a resource for our payment policies; it is not intended to address all reimbursement-related issues. We regularly add and modify clinical payment and coding policy positions as part of our ongoing policy review process. The

following have been recently added or updated:

- Telemedicine and Telehealth Services – Effective 02/12/2021
- Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU) – Updated to change the effective date for C9771 from 5/15/2021 to 07/01/2021

CLINICAL RESOURCES

Delivering Quality Care: Cervical Cancer Screening May Save a Life

To support quality care, we are providing information to providers and members to encourage discussions on health topics. Watch for more on health care quality in News and Updates.

Cervical cancer was once one of the most common causes of cancer deaths for women in the U.S. It is now the most preventable gynecological cancer, and the only one with both screening tests and a vaccine. Encourage our members to talk with you about having human papillomavirus (HPV) or Pap tests to screen for cervical cancer.

Why is cervical cancer screening important?

Cervical cancer is a slow-growing cancer that usually starts without symptoms. It is mainly caused by HPV. Regular screenings can detect cancer early, even before symptoms start. When cervical cancer is detected at an early stage, the five-year survival rate is over 90%. Learn more from the Centers for Disease Control and Prevention (CDC).

Closing care gaps

The U.S. Preventive Services Task Force recommends screening all women starting at age 21. Screening for cervical cancer is also recognized as a quality measure by the National Committee for Quality Assurance (NCQA). The NCQA uses the following criteria for screenings:

- Women ages 21 to 64 who had cervical cytology performed within the last 3 years
- Women ages 30 to 64 who had either:
  - cervical high-risk human papillomavirus (hrHPV) testing within the last 5 years or
  - cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years

View our preventive care guidelines on cervical cancer screenings.

Best practices

Share member-friendly resources, and talk with members about risk reduction and prevention such as:

- Having regular screenings starting at age 21
- Considering the HPV vaccine through age 45
- Limiting sexual partners
- Using condoms during sex
- Stopping smoking

Best practices also include using the proper codes when filing claims. Proper coding can help identify gaps in care, provide accurate data and streamline your administrative processes.

The above material is for informational purposes only and is not a substitute for the independent medical judgment of a physician or other health care provider. Physicians and other health care providers are encouraged to use their own medical judgment based upon all available information and the condition of the patient in determining the appropriate course of treatment. The fact that a service or treatment is described in this material is not a guarantee that the service or treatment is a covered benefit and members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any service or treatment is between the member and their health care provider.

Delivering Quality Care: Caring for the Colon

To support quality care, we are providing information to providers and members to encourage discussions on health topics. Watch for more on health care quality in News and Updates.

Colorectal cancer is the third most common cancer in the U.S., and the third leading cause of cancer deaths. Nearly one-third of adults ages 50 to 75 don't get recommended colorectal screenings, according to the Centers for Disease Control and Prevention (CDC). Discuss the importance of colorectal cancer screenings with your patients and encourage them to ask questions about colon health and cancer prevention.

Why is colorectal cancer screening important?

Colon cancer usually has no symptoms in its early stage. Screening before symptoms present themselves can catch the disease when treatment is most effective. The five-year survival rate for treatment of the earliest stage of colorectal cancer is about 90%.

Closing care gaps

Colorectal cancer screening is recognized as a quality measure by the National Committee for Quality Assurance (NCQA). The NCQA recommends screening adults ages 50 to 75 with any of the following tests:

- Annual fecal occult blood test (FOBT)
- Stool DNA (FIT-DNA or Cologuard®) every three years
- Flexible sigmoidoscopy every five years
- Computed tomography (CT) colonography every five years
- Colonoscopy every 10 years

View our preventive care guidelines on colorectal cancer screenings.

Best practices

- In your patients' records, document the date a colorectal cancer screening is performed or include the pathology report indicating the type and date of screening.
- Discuss with patients why it's important to return for follow-up visits.
- Reach out to patients who cancel appointments and help them reschedule as soon as possible.

- Use the proper codes when filing claims. Proper coding can help identify gaps in care, provide accurate data and streamline your administrative processes.

Checking eligibility and benefits

Member eligibility and benefits should be checked using Availity® Provider Portal or your preferred vendor before every scheduled appointment. Eligibility and benefit quotes include members' coverage status and other important information, such as applicable copays, coinsurance and deductibles. Ask to see members' ID card and photo ID to guard against medical identity theft.

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MEDICARE ADVANTAGE PLANS

Blue Cross Medicare Advantage (PPO)SM and Blue Cross Medicare Advantage (HMO)SM Annual Health Assessment Incentive

Due to COVID-19, many Blue Cross Medicare Advantage (PPO) and Blue Cross Medicare Advantage (HMO) members haven't completed their annual health assessment (AHA). It's important to encourage these members to set up an in-person or telehealth AHA. For every eligible AHA you complete for Blue Cross Medicare Advantage (PPO) and Blue Cross Medicare Advantage (HMO) members, you'll receive an incentive payment of $100, in addition to your contracted rate.

The CAHPS® Survey: We All Play a Role

Every year, the Centers for Medicare & Medicaid Services sends our members the Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. Review information about who gets the survey and when and how you can help improve member experiences.

PHARMACY

- Pharmacy Program Updates: Quarterly Pharmacy Changes Effective April 1, 2021 – Part 2

UTILIZATION MANAGEMENT

Medical Necessity Review of Observation Services

As a reminder, our policy is to provide coverage for observation services when it is determined to be medically necessary based on the medical criteria and guidelines outlined in the MCG Care Guidelines. Claims for observation services are subject to post-service review, and we may request medical records for the determination of medical necessity.

Reminder: Commercial Plan Appeals Process for 2020 eviCore® Adverse Determinations

As a reminder, for dates of service on or after Jan. 1, 2021, AIM Specialty Health® is the utilization management vendor for Blue Cross and Blue Shield of Texas (BCBSTX) commercial Prior Authorization (PA) requests that were formerly handled by eviCore Healthcare®. To assist providers with this transition, in December 2020, a notice appeared on the eviCore website to alert providers of the appeals run-out process, which will continue through April 2021.

If you submitted a PA (pre-service) request through eviCore and that request was denied or if eviCore conducted a post-service (post-claim) medical necessity review resulting in an adverse determination, your letter will instruct that peer-to-peer discussions and appeals must be requested through eviCore. Please note that, for these pre- and post-service adverse determinations, eviCore will continue to process peer-to-peer and appeal requests **through April 30, 2021, only**. After April 30, 2021, eviCore will redirect any peer-to-peer and appeal requests to BCBSTX.

The vendor that issued the pre- or post-service adverse determination will process any related peer-to-peer or appeals requests through April 30, 2021. For any adverse determination after Jan. 1, 2021, follow the instructions in the letter you receive from BCBSTX.

More information

Learn more about utilization management, including prior authorization and post service review, **on our website**. Find information about our prior authorization program with **AIM at this microsite**.

Contact Us

View our quick directory of contacts for BCBSTX.

Update Your Information

Do you need to update your location, phone number or other important details on file with BCBSTX? Do we have the most current email address for you and your staff? Use our online forms to request information changes. Are you receiving a copy of the Blue Review by email? If not, contact your local BCBSTX Network

Management Representative to have up to 10 of your office email addresses added.

File is in portable document format (PDF). To view this file, you may need to install a PDF reader program. Most PDF readers are a free download. One option is Adobe® Reader® which has a built-in screen reader. Other Adobe accessibility tools and information can be downloaded at http://access.adobe.com.

By clicking this link, you will go to a new website/app ("site"). This new site may be offered by a vendor or an independent third party. The site may also contain non-Medicare related information. In addition, some sites may require you to agree to their terms of use and privacy policy.

Checking eligibility, benefit information and/or if a service has been prior authorized is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered. If you

AIM Specialty Health is an independent medical benefits management company that provides utilization management services for Blue Cross and Blue Shield of Texas (BCBSTX).

eviCore is a trademark of eviCore health care, LLC, formerly known as CareCore, an independent company that provides utilization review for select health care services on behalf of BCBSTX.

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Prime Therapeutics LLC is a pharmacy benefit management company. BCBSTX contracts with Prime to provide pharmacy benefit management and related other services. BCBSTX, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime.

The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a physician. Physicians are to exercise their own medical judgment. Pharmacy benefits and limits are subject to the terms set forth in the member's certificate of coverage which may vary from the limits set forth above. The listing of any particular drug or classification of drugs is not a guarantee of benefits.

Members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any medication is between the member and their health care provider.

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

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