



**SCRIPPS MEDICAL PLANS CUSTOM PROVIDER NETWORK**

**PROVIDER REFERENCE MANUAL**

**Effective January 1, 2010**

## Introduction

Scripps Medical Plans (Plan) is the health plan for eligible Scripps Health employees and their dependents. There are more than 10,000 members enrolled in the Scripps Medical Plans.

Beginning January 1, 2010 the Scripps Medical Plans benefits will be administered by HealthComp. HealthComp was selected based on its proven track record of excellent claims administration, dedication to customer service and flexibility in accommodating the unique needs of Scripps and its employees. Scripps will use HealthComp's administrative procedures for claims processing, pre-authorization and customer service.

Scripps Health Plan Services (SHPS), Scripps Health's managed care organization will be the Network Manager of the Scripps Custom Provider Network.

Scripps Medical Plans has developed a broad based, high quality provider network. Included in the Provider Manual are the following topics:

1. Key Contacts for Providers and Members
2. Scripps Medical Plans Benefit Options – summary description of the 3 options available to eligible employees and their dependents
3. HealthComp Responsibilities
4. Scripps Health Plan Services Responsibilities
5. Scripps Custom Provider Network Responsibilities

**Scripps Medical Plans**  
**Custom Provider Network**

**Key Contacts**

**Providers**

Scripps Medical Plans Care Center 877-552-7247  
(HealthComp for Claims and Medical Management)

Pre-certification Fax # 559-243-7012

PO Box 45018

Fresno, CA 93718-5018

Scripps Health Plan Services (*Network Management*) 858-784-5855

10170 Sorrento Valley Road – SV-4

San Diego, CA 92121

**Secure Internet Services**

Network providers have access to time-saving information online. You can interact with HealthComp electronically to obtain confidential information including:

- Search claims status
- Obtain provider forms
- Review Pre-certification guidelines

Please visit [www.MyScrippsHealthPlan.com](http://www.MyScrippsHealthPlan.com) and go to the Providers section.

**Members**

Website: [www.MyScrippsHealthPlan.com](http://www.MyScrippsHealthPlan.com)

Pre-certification and Claims Inquiries 877-552-7247

Prescription Drugs - MedImpact 800-788-2949

Vision – MESVision 800-877-6372

Chiropractic & Acupuncture – ASHP 800-678-9133

Available for Premier EPO Members only

Mental Health & Chemical Dependency 877-552-7247

Anthem Blue Cross is the Network Provider

## Scripps Medical Plans Options

The Scripps Medical Plans offers three medical options:

- Scripps Basic EPO
- Scripps Premier EPO
- Scripps PPO Plan – Tier 1 and Tier 2

The following table summarizes the three options. For a complete description of the benefits, exclusions, limitations and more you may review the Summary Plan Document at [www.MyScrippsHealthPlan.com](http://www.MyScrippsHealthPlan.com)

Feature	Scripps Basic EPO	Scripps Premier EPO	Scripps PPO Plan – Tier 1
Who Directs and Provides Care	Scripps Custom Network	Scripps Custom Network	Scripps Custom Network
Health Care Provider	Scripps Custom Network	Scripps Custom Network	Scripps Custom Network
Annual Deductible	\$0	\$0	\$100 per person \$300 per family
Annual Out-of-Pockets Max. (includes all copayments)	\$1,500 Per person \$3,000 Per family	\$ 800 Per person \$2,400 Per family	\$1,500 Per person \$3,000 Per family
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Primary Care Physician Visit*	\$20 copay	\$10 copay	80% after deductible
Specialist Visits	\$40 copay	\$30 copay	80% after deductible
Hospitalizations	Scripps Custom Network Hospitals only.	Scripps Custom Network Hospitals only.	Scripps Custom Network Hospitals only.
• Outpatient Surgery	100% (after \$50 copay)	100%	100% after deductible
• Inpatient Semi-Private Room	100% (after \$250 copay)	100%	100% after deductible
• Inpatient Physician	100%	100%	80% after deductible
Urgent Care	\$35 copay	\$35 copay	80% after deductible
Emergency Room	\$200 copay (waived if admitted)	\$150 copay (waived if admitted)	80% after deductible (waived if admitted)
Well Baby Care	\$10 copay	\$10 copay	80% after deductible
Periodic Health Evaluations & Immunizations	\$10 copay	\$10 copay	80% after deductible
Allergy Serum	100%	100%	80% after deductible
Diagnostic Lab & X-Ray	100%	100%	80% after deductible





Feature	Scripps Basic EPO	Scripps Premier EPO	Scripps PPO Plan – Tier 1
Who Directs and Provides Care	Scripps Custom Network	Scripps Custom Network	Scripps Custom Network
Durable Medical Equipment	100% after \$250 deductible	100% after \$250 deductible	80% after deductible
Outpatient Treatment (i.e. PT, OT)	\$20 copay (40 combined visits per year)	\$10 copay (60 combined visits per year)	80% after deductible (60 combined visits per year)
Chiropractic & Acupuncture Care (through ASH)	Not Covered	\$15 copay (20 combined visits per year)	Not Covered
Prescription Drugs <ul style="list-style-type: none"> <li>• Preferred List – Generic</li> <li>• Preferred List – Brand</li> <li>• Not on Preferred List</li> </ul>	<u>Retail Pharmacy</u> (30 day supply) \$5 copay  \$30 copay  \$50 copay	<u>Retail Pharmacy</u> (30 day supply) \$5 copay  \$30 copay  \$50 copay	<u>Retail Pharmacy</u> (30 day supply) \$5 copay  \$30 copay  \$50 copay
Prescription Drugs <ul style="list-style-type: none"> <li>• Preferred List – Generic</li> <li>• Preferred List – Brand</li> <li>• Not on Preferred List</li> </ul>	<u>Mail Service</u> (90 day supply) \$10 copay  \$60 copay  \$150 copay	<u>Mail Service</u> (90 day supply) \$10 copay  \$60 copay  \$150 copay	<u>Mail Service</u> (90 day supply) \$10 copay  \$60 copay  \$150 copay
Mental Health/Chemical Dependency <ul style="list-style-type: none"> <li>• Outpatient</li> <li>• Inpatient</li> </ul> Anthem Blue Cross in the Network Provider	\$20 copay (Network only) 100% (Network only)	\$10 copay (Network only) 100% (Network only)	\$10 copay (Network only) 100% (Network only)
Out-of Network Services are Not Covered under the Scripps Basic EPO and Scripps Premier EPO Plan			



\* Primary Care Physician (PCP) is a general practitioner, family practitioner, pediatrician, or internist.

## Identification Cards





Below is a representation of the identification cards issued to members of Scripps Medical Plans. The cards contain pertinent information about medical and pharmacy plan copays, claims mailing information, telephone numbers and other plan information.



### EPO Basic Medical Plan:

 	
<b>Scripps Medical Plans</b>	
Member Name: <b>JOHN A. DOE</b>	<b>Scripps Basic EPO Plan</b>
Member ID: ABC SH0123456	<b>Scripps Custom Network Providers</b>
Dependent Name: <b>JANE B. DOE</b>	www.MyScrippsHealthPlan.com
Group No: <b>S24</b>	Plan Code: <b>040</b>
Prescription Drugs:  (800) 788-2949	PCP Office Visit Copay: \$20
Rx BIN: 003585	Specialist Office Visit Copay: \$40
Rx Group/PCN: 56238	Emergency Room Copay: \$200
	Urgent Care Copay: \$35
Member Inquiries: (877) 552-7247	Prudent Buyer 





 www.anthem.com/ca	
<b>Precertification &amp; Claims Inquiries:</b> Scripps Medical Plans Member Services: (877) 552-7247	<b>Vision: MESVision</b> (800) 877-6372 www.MyScrippsHealthPlan.com
<b>Submit Claims to:</b> <u>All CA Professional, All Non-Network, and All Scripps Hospital Claims:</u> HealthComp Administrators EDI Payor # 85729 PO Box 45018 Fresno, CA 93718-5018	<b>Chiropractic &amp; Acupuncture: ASH</b> (800) 678-9133 www.MyScrippsHealthPlan.com
<b>Network Claims Outside of CA:</b> Submit claims to your local BCBS Plan. To ensure prompt claims processing, include the 3 digit alpha prefix that precedes the member's ID number.	<b>CA Network Hospital Claims:</b> Anthem Blue Cross PO Box 60007 Los Angeles, CA 90060-0007
<small>Anthem Blue Cross Life &amp; Health Insurance Company provides administrative services only and does not assume any financial risk or obligation with respect to claims. Blue Cross of California, using the trade name Anthem Blue Cross, administers claims on behalf of Anthem Blue Cross Life &amp; Health Insurance Company and is not liable for benefits payable. Independent licensees of the Blue Cross Association.</small>	



### EPO Premier Medical Plan:

 	
<b>Scripps Medical Plans</b>	
Member Name: <b>JOHN A. DOE</b>	<b>Scripps Premier EPO Plan</b>
Member ID: ABC SH0123456	<b>Scripps Custom Network Providers</b>
Dependent Name: <b>JANE B. DOE</b>	www.MyScrippsHealthPlan.com
Group No: <b>S24</b>	Plan Code: <b>040</b>
Prescription Drugs:  (800) 788-2949	PCP Office Visit Copay: \$10
Rx BIN: 003585	Specialist Office Visit Copay: \$30
Rx Group/PCN: 56238	Emergency Room Copay: \$150
	Urgent Care Copay: \$35
Member Inquiries: (877) 552-7247	Prudent Buyer 

 www.anthem.com/ca	
<b>Precertification &amp; Claims Inquiries:</b> Scripps Medical Plans Member Services: (877) 552-7247	<b>Vision: MESVision</b> (800) 877-6372 www.MyScrippsHealthPlan.com
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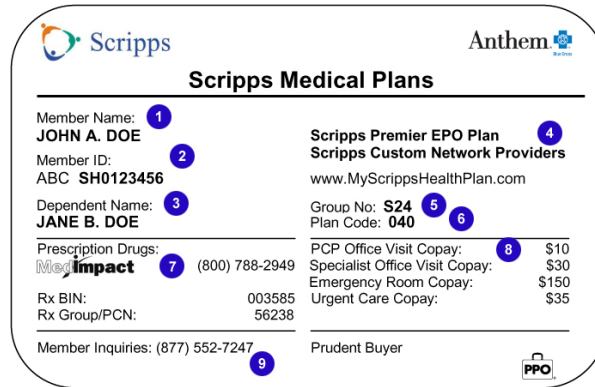
### PPO Medical Plan (Tier 1 and Tier 2):

 																			
<b>Scripps Medical Plans</b>																			
Member Name: <b>JOHN A. DOE</b>	<b>Scripps PPO Plan</b>																		
Member ID: ABC SH0123456	<b>Scripps Custom Network Providers</b>																		
Dependent Name: <b>JANE B. DOE</b>	www.MyScrippsHealthPlan.com																		
Group No: <b>S24</b>	Plan Code: <b>040</b>																		
Prescription Drugs:  (800) 788-2949	<table border="1"> <tr> <td></td> <td><b>Tier 1</b></td> <td><b>Tier 2</b></td> </tr> <tr> <td></td> <td><b>Scripps PPO</b></td> <td><b>BC PPO</b></td> </tr> <tr> <td>Ded:</td> <td>\$100</td> <td>\$400</td> </tr> <tr> <td>PCP:</td> <td>80%</td> <td>60%</td> </tr> <tr> <td>ER:</td> <td>80%</td> <td>80%</td> </tr> <tr> <td>Hospital:</td> <td>100%</td> <td>60%</td> </tr> </table>		<b>Tier 1</b>	<b>Tier 2</b>		<b>Scripps PPO</b>	<b>BC PPO</b>	Ded:	\$100	\$400	PCP:	80%	60%	ER:	80%	80%	Hospital:	100%	60%
	<b>Tier 1</b>	<b>Tier 2</b>																	
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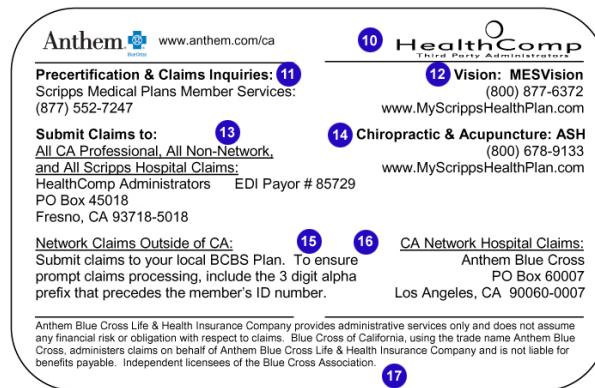
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**Please note that Anthem Blue Cross Preferred Providers are applicable ONLY for those enrolled in the Scripps PPO Plan Tier 2, enrolled as an Out-of-area dependent on the EPO Medical Plans or Mental Health/Chemical Dependency benefit. All other Plans utilize the Scripps Custom Network.**

# The Scripps Medical Plans ID Card Explained



- 1 Member/ Subscriber Name.
- 2 Member ID number.
- 3 Covered Dependent Name. Each covered dependent will receive an ID card.
- 4 The Scripps Medical Plans selection.
- 5 The Group #. Used by HealthComp to identify Scripps Medical Plans members.
- 6 The Plan Code. Used by the Blue Cross Association to identify Anthem as the independent licensee.
- 7 Pharmacy Benefit information used by pharmacies to fill RX's. Administered by MedImpact.
- 8 The medical plan copays.
- 9 Scripps Medical Plans Member Services phone number for health plan customer service, eligibility, and benefit related questions.



- 10 HealthComp logo, Scripps Medical Plans new third party administrator.
- 11 Scripps Medical Plans Member Services phone number for pre-certification or claim inquiries.
- 12 Vision benefits administered by MESVision.
- 13 Any Non-Facility Hospital Claims (which includes physician visits, labs, x-rays, etc.), any Non-Network Claims, and any claims incurred at a Scripps Hospital or Rady Children's Hospital San Diego need to be sent to HealthComp.
- 14 Chiropractic & Acupuncture benefits administered through ASH. (Premier EPO participants only)
- 15 Any claims incurred outside of CA need to be sent to the local BCBS Plan in the state where services are rendered. Contracted physicians in that state should have the claims submission address.
- 16 Any facility or hospital claims incurred at a Non-Scripps hospital need to be sent to Anthem Blue Cross.
- 17 Legally required Anthem Blue Cross disclaimer.

## **HealthComp Responsibilities**

**Member Eligibility** – HealthComp is responsible for implementing and maintaining an accurate database of eligible Scripps Medical Plans members.

### **Medical Management Programs**

HealthComp has a team of physicians and registered nurses that provide medical management services. The medical management staff works to promote the effective use of medical resources and maintain continuity of the members' care.

Scripps Medical Plans members are not required to obtain a referral from a primary care physician or any other physician in order to see another physician. Members may self refer to any licensed provider within the Scripps Custom Provider Network. Consult [www.MyScrippsHealthPlan.com](http://www.MyScrippsHealthPlan.com) or call 1-877-552-7247 for the most current provider listing.

### **Pre-certification**

The Plan makes pre-certification decisions based on your recommendations and the recommendations of nationally recognized medical guidelines that apply to certain procedures and services.

### **Pre-certification requests**

Please call Scripps Medical Plans Care Center at 877-552-7247 to speak to a pre-certification specialist or visit [www.MyScrippsHealthPlan.com](http://www.MyScrippsHealthPlan.com) to download a pre-certification form and fax to HealthComp at 1-559-243-7012.

### **Concurrent Review and Discharge Planning Process**

Please contact Scripps Medical Plans Care Center at 877-552-7247 to report an inpatient admission. You will be notified about the precertified length of stay. If you recommend that the stay be extended, additional days must be certified. You will need to contact HealthComp no later than the final authorized day. The Plan will review and process the request for an extended stay.

Concurrent review determines medical necessity, the appropriate care level, and goal length of stay. The facility will submit pertinent clinical information to HealthComp via fax or phone.

If you do not call when required, a penalty will be applied to the Members' applicable benefit.

*EPO Plan* - \$250 penalty

*PPO Plan* - 50% reduction in benefit

## When to Precertify

### *Inpatient:*

*Emergency admission:* within 48 hours of admission or as soon as reasonably possible.

*Urgent admission:* before patient is scheduled to be admitted.

*Other admissions:* at least 14 calendar days prior to admission.

### *Outpatient:*

*Emergency care:* as soon as reasonably possible.

*Non-emergency care:* at least 14 calendar days prior to admission or as soon as reasonably possible.

## Services and Procedures Requiring Pre-certification

The following services *require* pre-certification under all Plan options:

1. Hospital
  - Surgical
  - Non-surgical
  - Hospice facility
2. Organ and tissue transplants
3. Rehabilitation facility
4. Skilled nursing facility
5. Mental Health and Chemical Dependency Care
  - Hospital
  - Treatment facility
  - Partial hospitalization
  - Residential treatment center

The following procedures *require* pre-certification under all Plan options:

1. Artificial intervertebral disc surgery
2. Mommies 2-B Maternity Program, including antenatal testing, perinatal consultations and counseling
3. BRCA genetic testing
4. Conditionally eligible services:
  - Alpha 1-proteinase inhibitor – human
  - Botox injections
  - Cochlear devices and/or implantation
  - Cognitive skills development
  - GI tract imaging through capsule endoscopy
  - High frequency chest wall oscillation generator system
  - Hyperbaric oxygen therapy
  - Negative pressure wound therapy pump

- Onco Type DX
  - Osseointegrated implant
  - Osteochondral allograft, knee
  - Percutaneous implant of neuroelectrode array, epidural
  - Somatosensory evoked potential studies
  - Stereotactic radiosurgery
5. Dental implants and oral appliances
  6. Durable medical equipment
    - Customized braces
    - Electric or motorized wheelchairs and scooters
    - Limb prosthetics
  7. Elective (non-emergency) transportation by ambulance or medical van, and all transfers via air ambulance
  8. Home health care services, including home uterine monitoring
  9. Infertility services
  10. Lumbar spinal fusion surgery
  11. Medical injectables
    - Blood-clotting factors
    - Erythropoiesis stimulating agents (ESA) such as darbepoetin alpha (Aranesp), epoetin alpha (Epogen and Procrit) and epietin beta (Micera)
    - Growth hormone
    - Interferons when used for hepatitis C
    - Intravenous immunoglobulin (IVIG)
    - Synagis
    - Xolair
  12. Mental health and substance abuse care – outpatient services:
    - Psychological testing
    - Neuropsychological testing
    - Outpatient ECT
    - Outpatient detoxification
    - Psychiatric home care services
  13. Nutritional counseling after the initial 6 visits
  14. Orthognathic (jaw) surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint
  15. Pre-implantation genetic testing
  16. Uvulopalatopharyngoplasty, including laser-assisted procedures

17. Reconstructive procedures that may be considered cosmetic:

- Blepharoplasty, canthopexy, canthoplasty
- Breast reconstruction, breast enlargement
- Breast reduction, mammoplasty
- Excision of excess skin due to weight loss
- Gastroplasty, gastric bypass
- Lipectomy, removal of excess fat
- Pectus excavatum repair
- Rhinoplasty, rhytidectomy
- Sclerotherapy, surgery for varicose veins
- Surgical treatment of gynecomastia

### **Utilization Management**

Following nationally recognized standards, Utilization Management (UM) reviews healthcare services, assures services are provided at the appropriate levels of care, assures services are provided within the Scripps Medical Plans Custom Provider Network, and that timeliness standards are maintained. Utilization management includes pre-certification, concurrent utilization review, case management and quality management, and medical claims review. HealthComp utilizes Milliman Care Guidelines.

### **Quality Management**

HealthComp Quality Management is an integral part of both medical management and internal operations. Through our team of quality management professionals, our focus is to review and trend services and procedures for compliance to nationally recognized standards, and to recommend and promote improvements in the delivery of care and service to our members. HealthComp's quality management may include, but is not limited to, medical records review, site reviews, peer reviews and provider profiling.

Utilizing the tools of HealthComp's quality management program and in collaboration with all participating health providers, we are able to monitor and reassess the quality of care and services that are provided to the members of the Scripps Medical Plans.

Members may contact Scripps Member Services at 877-552-7247 to file a Grievance or Appeal. Providers may be contacted by Scripps Member Services to assist in the research of the member's Grievance or Appeal. Please respond promptly to all requests.

## **Case Management**

HealthComp utilizes case managers to assist members and providers in managing complex medical conditions. Providers are encouraged to refer members who they feel may benefit from case management services. Referrals to case management may be made by calling 1-877-552-7247.

## **Mommies 2-B Program**

This prenatal program is focused on providing a strong foundation of support for your patients and their babies. The program is also used as a screening tool to identify the possibility of a high or moderate risk pregnancy and coordinate effective medical care along with you the provider. Those participating in the program will receive personalized attention to include: educational materials, periodic newsletters, magazines, coupons, personal contact between the prenatal nurse and the patient, provider, and family, if advisable. A gift will be sent upon the birth of the baby, compliments of the Scripps Medical Plans.

## **Medical Policies**

HealthComp medical policies are an integral part of the utilization management process and are intended to help physicians decide on appropriateness while maintaining high quality in the delivery of care. These policies address questions of “what is a covered benefit or what is medically necessary for this clinical condition.” All medical policies are available through the HealthComp UM Department.

## **Disease Management**

HealthComp was selected by Scripps Medical Plans to provide you with access to information and tools necessary to help manage and improve the health of your patients. This program has three components:

- Health Risk Assessment/Disease Management,
- Prevention Reminders, and
- Pharmacy Review and Management. Member participation in this program is completely voluntary, confidential, and provided at no cost.

The information provided will be used to develop a care plan specifically for your patient. Any patient is eligible to participate in the program; however, we do focus on those with chronic health conditions such as heart disease, high blood pressure, high cholesterol, diabetes, asthma, chronic obstructive pulmonary disease (COPD) or those at risk of developing one of these conditions.

The Disease Management team consists of Nurses, Pharmacists, and other Ancillary staff who are committed to providing health management strategies specifically designed for the patients' needs. Our licensed clinical staff will determine health risk factors and help you to develop strategies tailored for your patient. The program is not intended to replace your care, but rather to provide a compliment to it.

## **Claims Administration** – Includes Claims Processing, Claims Resubmission and Provider Grievances

1. **Claims Adjudication** – HealthComp is responsible for accurately and promptly processing claims for the Scripps Medical Plans Custom Provider Network. HealthComp utilizes a claim scrubbing software program that automatically applies Medicare Correct Coding Initiative (“CCI”) edits. This software provides auditing logic for all modifiers allowing payment modification if appropriate. HealthComp will process claims based on the industry standards, CPT guidelines, CCI edits, Medicare guidelines and in compliance with State and Federal regulations.

HealthComp will adjudicate all “clean” claims within sixty (60) calendar days. A “clean” claim is one that includes all of the data elements listed in your Scripps Health contract.

2. **Claims Submission Instructions** – Unless defined differently in your Scripps Health contract, claims must be submitted to HealthComp within ninety (90) calendar days from date of service.
  - Claims Mailing Address: HealthComp Administrators  
PO Box 45018  
Fresno, CA 93718-5018
  - Claims may be submitted electronically. Please contact 800-442-7247 ext. 2394. EDI Payer I.D. 85729
  - Submit claims with all required data elements listed below and included in your Scripps Health Contract, utilizing the appropriate CMS1500 or UB-04 Claim Forms.

The CMS1500 or UB-04 shall include, but not be limited to, the following data elements:

- Member's full name and address
  - Member's identification number
  - Member's date of birth
  - Member's sex
  - Member's group number and plan code
  - Diagnostic codes and descriptions (ICD-9)
  - Date of service
  - Place of service
  - Procedures, services or supplies furnished. CPT codes (current year) shall be used for all professional services and HCPCS codes shall be used for supplies, equipment, injections, etc. Items not listed shall be billed utilizing CPT and HCPCS guidelines
  - Charges
  - Units
  - Pre-Certification Number, if applicable
  - Physician Group, Physician' name and Facility Name
  - Required National Provider Identifier ("NPI") Numbers
  - Physician/Provider address and telephone number
  - Physician/Provider tax identification number
3. Coordination of Benefits – If Scripps Medical Plans is not the primary payer based on the Coordination of Benefits (COB), the provider may submit a supplemental or COB claim within ninety (90) calendar days from the Date of Payment or Date of Contest or Denial, or notice from the primary payer. The Explanation of Benefits (EOB) from the primary payer must be included with the claim.
4. Claims Inquiries – Call **877-552-7247**
5. Claims Resubmission ("Corrected" Claims) – If a Provider identified that there was an error on the original claim that resulted in an incorrect reimbursement, a "corrected" claim may be submitted for reconsideration. HealthComp must receive a "corrected" claim within one hundred eighty (180) days from the date of the Explanation of Benefits (EOB). The following must be included with the "corrected" claim:
- New Claim clearly marked "corrected"
  - Copy of the EOB
  - Notation as to exactly what the correction is on the claim

## 6. Provider Grievances

Definition of Provider Grievance: A Provider Grievance is a provider's written notice to HealthComp,

- challenging, appealing or requesting reconsideration of a claim (or a group of substantially similar claims that are individually numbered) that have been denied, adjusted or contested;
- challenging, appealing or requesting reconsideration of a billing determination;
- challenging, appealing or requesting reconsideration of a request by HealthComp for reimbursement of a claim alleged to be overpaid; or
- any other contractual dispute.

*PLEASE NOTE: previously processed claims, including those paid at zero, which are resubmitted (including resubmissions accompanied by additional information attached such as records, certifications or itemized statements), should be marked as a "corrected claim". Please do not submit these types of claims as a Provider Grievance.*

Each Provider Grievance must be in writing and contain, at a minimum, the following information:

- Notation on the cover sheet that it is a Provider Grievance;
  - Provider's name;
  - Provider's Tax Identification Number; and
  - Provider's Contact Information.
- a) If the Provider Grievance concerns a single claim the following must also be provided:
- Member/Patient's name and date of birth;
  - The corrected claim (if appropriate);
  - Reports or other supporting attachments, i.e. progress notes, operative reports, etc.;
  - A clear identification of the items disputed;
  - HealthComp's claim number(s);
  - Copy of the HealthComp Explanation of Benefits Statement (EOB);
  - The date of service; and
  - A clear explanation of the basis for the Provider's belief that the manner in which HealthComp processed or paid the claim is incorrect.

- b) If the Provider Grievance involves a group of substantially similar claims each claim must be individually numbered.
- c) If the Provider Grievance does not involve a claim, a clear explanation of the issue in dispute and the Provider's position on such issue should be submitted, along with any other documentation the Provider would like to have considered by HealthComp.
- d) If the Provider Grievance concerns an enrollee or group of enrollees, the following written information must be provided:
  - The names and identification number(s) of the enrollee(s);
  - The date(s) of service; and
  - A clear explanation of the reason for the dispute.

Sending a Provider Grievance to HealthComp.

A Provider Grievance must be submitted to the HealthComp Appeals Department:

Via Mail: HealthComp PO Box 45018, Fresno, CA 93718-5018

Via Fax: 559-499-2464

**Time Period for Submission of Provider Grievance**

A Provider Grievance must be received by HealthComp within one hundred eighty (180) calendar days from the date of HealthComp's last action concerning the issue or claim involved. A Provider Grievance that does not include all required information, set forth above, may be returned to the Provider for completion. An Amended Provider Dispute, which is accompanied by the missing information, must be submitted to HealthComp within thirty (30) working days from the Provider's receipt of the returned Provider Grievance.

**Contacting HealthComp Regarding Provider Grievances**

Inquiries regarding the status or filing of a Provider Grievance must be directed to HealthComp Customer Service Department: 877-552-7247.

**Time Period for Resolution of a Provider Grievance**

HealthComp will issue a written determination within ninety (90) calendar days after receipt of the Provider Grievance (or the Amended Provider Grievance). The determination will include a full explanation of the facts considered by HealthComp and the rationale for their decision.

## **Claim Overpayments – HealthComp’s Request for Provider to Reimburse HealthComp for an Overpayment of a Claim or Claims**

- a. Time Period for Request of an Overpayment. HealthComp must submit a written request for a refund of an overpayment to the Provider within three hundred and sixty-five (365) calendar days from the Date of Payment.
- b. Notice of Overpayment of a Claim. If HealthComp determines that HealthComp has overpaid a claim or claims, HealthComp will notify the Provider in writing through a separate notice. The notice will clearly identify the claim, the name of the member/patient, the Date of Service(s) and a clear explanation of the basis upon which HealthComp believes the amount paid on the claim(s) was in excess of the amount due, including applicable State or Federal interest and penalties on the claim.
- c. Contested Notice. If the Provider contests HealthComp’s’ notice of overpayment of a claim, the Provider, within thirty (30) working days of the receipt of the notice of overpayment of a claim, must send written notice to HealthComp. The notice must state the basis upon which the Provider believes that the claim was not overpaid. HealthComp will process the contested notice in accordance with the Provider Grievance process described in this Provider Reference Manual.
- d. No Contest. If the Provider does not contest HealthComp’s notice of overpayment of a claim, the Provider must reimburse HealthComp within thirty (30) working days of the Provider’s receipt of the notice of overpayment of a claim.
- e. Offsets to Payments. HealthComp may only offset an uncontested notice of overpayment of a claim against Provider’s current claim submission when the Provider fails to reimburse HealthComp within the time frame set forth above. In the event that an overpayment of a claim or claims is offset against the Provider’s current claim or claims pursuant to this section, HealthComp will provide the Provider with a detailed written description. The Claims Department will send a letter within ten (10) calendar days identifying the specific overpayment or payments that have been offset against the specific current claim or claims.

## **Mental Health and Substance Abuse Services**

HealthComp administers Mental Health and Substance Abuse services for the Scripps Medical Plans members.

## **Scripps Health Plan Services Responsibilities**

Scripps Health Plan Services (SHPS) is the managed care organization owned by Scripps Health. We have worked with many of the Scripps Medical Plans Custom Network Providers. Our commitment is to uphold the Core Values of Scripps Health:

- Reliability
- Integrity
- Dedication to Excellence

Scripps Health Plan Services is responsible for the Network Management of the Custom Provider Network.

1. **Contract Management** – Under the direction of Scripps Health Medical Plan Board, negotiate Scripps Health Professional, Ancillary and Hospital contracts, ensure contract demographics and reimbursement are accurately loaded into the HealthComp Claims System, and assist with contract interpretation questions.
2. **Network Management** – Ensure provider demographics are accurate for Scripps Medical Plans Custom Provider Network Directory, act as liaison with HealthComp for Provider issues not resolved through standard processes, communicates updates to the contracted Scripps Custom Provider Network. **Please call Provider Relations at 858-784-5892 to update your practice information.**
3. **Provider Credentialing** – SHPS is responsible for credentialing and recredentialing the Scripps Medical Plans Custom Network Providers. Some Physician Groups may be delegated for credentialing and recredentialing. SHPS will conduct annual audits of delegated providers.
  - a) Practitioners should contact any Scripps Health Hospital Medical Staff Office if they are interested in hospital privileges for that facility. The same application will be used for hospital privileges as is used for Scripps Health Plan Services and Scripps Medical Plans Custom Provider Network credentialing.
  - b) The SHPS staff, as part of the credentialing and recredentialing process, performs Site Visits and Medical Record Review. You will be contacted in advance if a site visit or audit is needed.
  - c) Each contracted practitioner and allied health care professional, i.e. Physician Assistant (“PA”) and Nurse Practitioner (“NP”), is recredentialed no less than every 24 months. The credentialing staff will send out a practitioner profile and recredentialing questionnaire to be completed. In order to maintain an active status as a SHPS provider, you must complete and return all applications and other requested credentialing documents promptly.

## **Scripps Medical Plans Custom Network Provider Responsibilities**

### **Network Hospitals**

The following hospitals will be included in the Scripps Medical Plans Custom Provider Network. All participating physicians in the network must have privileges at one of these hospitals or must be in agreement to have their patients admitted at these hospitals by participating physicians:

- Scripps Green Hospital
- Scripps Memorial Hospital La Jolla
- Scripps Memorial Hospital Encinitas
- Scripps Mercy Hospital San Diego
- Scripps Mercy Hospital Chula Vista
- Rady Children's Hospital San Diego

### **Responsibilities for all Physicians**

1. Verifying eligibility of the Scripps Medical Plans member prior to the provision of covered services. Failure to verify member eligibility may result in claim denial.
2. Providing or arranging for covered services as defined in your contract with Scripps Health, including emergency medical services, to members twenty-four hours per day, seven days per week.
3. Providing to members (a) office visits during regular office hours and (b) office visits or home visits during non-office hours as determined medically necessary.
4. Scheduling time-specific appointments for routine medically necessary care
  - Within twenty-one (21) days of a member's request
  - Within two (2) days for urgent care
  - On the same day for emergency care
5. Ensuring that members' waiting time at the physician's office shall not exceed forty-five (45) minutes for scheduled appointments, unless the physician is unavailable due to an emergency.
6. Coordinating the provision of covered services to members by (a) counseling members and their families regarding members' medical care needs, (b) monitoring progress, care and managing utilization of services to facilitate the return of care to the Primary Care Physician (PCP) as soon as medically appropriate.
7. Maintaining staff membership and admission privileges in good standing at one of the Scripps Medical Plans Custom Provider Network hospitals, or making

arrangements for necessary hospital care at a Scripps Medical Plans Custom Provider Network Hospital.

8. Using participating medical facilities for the admission of members unless pre-authorization for admission at a non-participating hospital has been obtained from HealthComp or in the case of an emergency. The admitting physician will provide or arrange covered services for members while in a hospital or nursing home.
9. Prescribing or authorizing the substitution of generic medications and supplies when appropriate and by otherwise abiding by the Scripps Preferred Drug List. *(Refer to Pages 25-31 for additional information)*
  - Visit MyScrippsHealthPlan.com to access the formulary/preferred drug listing and links to the MedImpact website.
  - The Scripps Step Therapy Program requires the use of “first line” generic drugs before alternative or “second line” drugs are prescribed for the same conditions. Access to “second line” drugs requires prior authorization. **Contact MedImpact at 800-788-2949.**
  - Specialty Medications require prior authorization. **Contact MedImpact at 800-788-2949**
10. Rendering services to members who are diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) in the same manner and to the same extent as other members and under the compensation terms set forth in the Professional Services Agreement.
11. Complying with Scripps Medical Plans Medical Management policies and procedures administered by HealthComp.
12. Abiding by Scripps Medical Plans pre-authorization requirements found in the Medical Management Section of this manual and at HealthComp.com, and requesting pre-authorization when required for services you provide.
13. Using Scripps Medical Plans Custom Provider Network hospitals, specialists and ancillary providers.

### **Medical Records (Primary Care Physicians, Specialty Physicians and Primary Care Obstetricians)**

Participating physicians must follow the Medical Record standards adopted by the National Committee for Quality Assurance (NCQA) as the minimum acceptable standards. The Medical Records Standards may be obtained at NCQA's website [www.ncqa.org](http://www.ncqa.org).

## **Primary Care Services**

Primary Care Physician (PCP) assignment is not required by the Plan, but Scripps Medical Plans members are encouraged to establish a relationship with a PCP in the Scripps Medical Plans Custom Provider Network. In addition to the responsibilities noted previously, the Primary Care responsibilities include:

1. PCPs will be expected to assist in care coordination within the hospital or nursing facility, if requested
2. Providing preventive health care services in accordance with the Scripps Medical Plans. The preventive health services shall include but not be limited to:
  - Periodic health assessments, immunizations and tuberculosis screening (but not immunizations solely for travel), and other measures for the prevention and detection of disease. This includes instruction on personal healthcare measures and information on proper and timely use of appropriate medical resources.
3. Making a concerted effort to educate and instruct members about the proper utilization of the PCP office or urgent care facility in lieu of hospital emergency rooms. The PCP shall not refer or direct members to hospital emergency rooms for non-emergent medical services.

## **Primary Care Obstetrician (PCO)**

While members are not required to choose or be assigned to a primary care physician, an obstetrician may act in this capacity throughout the patient's pregnancy. Participating Primary Care Obstetricians (PCO) are responsible for:

1. Scheduling medically necessary care appointments for enrolled pregnant members to obtain initial and ongoing prenatal care within the following time frames:
  - First trimester: within fourteen (14) days of a request for an appointment.
  - Second trimester: within seven (7) days of a request for an appointment.
  - Third trimester: within three (3) days of a request for an appointment.
2. Scheduling time-specific office visits during an uncomplicated pregnancy based upon the recommended standards from the American College of Obstetrics and Gynecology (COG).
3. Maintaining responsibility for care until the first day of the first month following the sixtieth (60<sup>th</sup>) day after delivery with a minimum of one postpartum visit

approximately six (6) weeks postpartum. Patients at high risk shall have a return visit scheduled appropriate to their individual need.

4. Cooperating with perinatal case management and other perinatal support programs that may be available to the member.
5. Notify HealthComp Medical Management's Pre-Authorization Department of a member's pregnancy within two (2) weeks of the patient's first visit.

### **Specialty Care Physicians**

In addition to the Responsibilities for all Physicians noted previously, Specialty Care Physician responsibilities include:

1. Offering covered specialty care services to members in accordance with community customary standards of care and practices.
2. Providing specialty care services to Scripps Medical Plans members when referred by another provider OR if a member self refers to a specialist physician.
3. Providing services as applicable within the scope of his/her specialty practice to Scripps Medical Plans' members.

### **Ancillary Providers**

The term "Ancillary Providers" includes pharmacy, home health, durable medical equipment, home infusion care, vision, dental, transportation, therapy and other non-physicians providers. Scripps Medical Plans has developed a comprehensive ancillary provider network that providers should use. Ancillary providers responsibilities include:

1. Verifying eligibility of the Scripps Medical Plans member prior to the provision of covered services. Failure to verify member eligibility may result in claim denial.
2. Rendering covered services to Scripps Medical Plans members in accordance with the specific Ancillary Services Agreement requirements.
3. Maintaining sufficient facilities, equipment and personnel to provide timely access to medically necessary covered services.
4. Maintaining all licenses, certifications, permits, or other prerequisites required by law to provide covered services and submitting evidence that each is current and in good standing at the request of Scripps Health Plan Services (SHPS).
5. Rendering services to members who are diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) in the

same manner and to the same extent as other members and under the compensation terms set forth in the Professional Services Agreement.

6. Complying with Scripps Medical Plans Medical Management policies and procedures administered by HealthComp.

## **Monitoring**

Monitoring of provider activity will be performed by Quality Management, Medical Management, Provider Relations, Credentialing and Member Relations. The results of the monitoring activities will be directed to the corporate Medical Director, the Peer Review and Quality Management Oversight Committees as appropriate.

## **Advance Directives (Patient Self Determination Act)**

The Omnibus Budget Reconciliation Act of 1990 is intended to provide individuals with information about their state's laws regarding advanced directives and encourage compliance by health care providers with any advance directives. An advanced directive is any written document, made in advance of an incapacitating illness or injury, in which an individual specifically makes choices about health care treatments or names someone to make these treatment decisions if he or she is incapable.

Under this law, you are required to inform patients about their rights to institute an Advance Directive. Scripps Medical Plans informs the member of advance directive rights. However, since Scripps Medical Plans does not have direct contact with the members as patients:

- The physician must communicate information to each patient regarding the right to institute an advance directive and,
- The physician is required to document the results of this discussion in the patient's medical record file. If the patient completes an advance directive, a copy of it should be included in this file.

## **Vision Services**

Vision services are provided to Scripps Medical Plans members through a contract between Scripps Health and Medical Eye Services (MES). For information about the vision plan services, please call MES at (800) 877-6372. All vision claims should be submitted to MES.

## **Chiropractic/Acupuncture Services**

Chiropractic/Acupuncture services are provided through a contract with Scripps Health and American Specialty Health Plans (ASHP). ASHP can be reached at (800) 678-9133. All chiropractic/acupuncture claims should be submitted to ASHP.

## **Pharmacy**

The Program is administered by MedImpact. MedImpact maintains contracts with pharmacies (called network pharmacies) that extend a discount when medications are purchased there. The Prescription Drug Program offers the flexibility to purchase medications either at a retail network pharmacy or through the prescription mail order service. The MedImpact Pharmacy Network includes most national pharmacy chains. A complete list of participating pharmacies can be found on-line at [www.MyScrippsHealthPlan.com](http://www.MyScrippsHealthPlan.com).

### **Prescription Drugs All Medical Plan Options**

<i>Retail</i>	<i>(up to a 30-day supply)</i>
Rx Tier 1 – Generic	\$5 copay
Rx Tier 2 – Preferred Formulary	\$30 copay
Rx Tier 3 – Non-Preferred Formulary	\$50 copay

### **Prescription Drugs All Medical Plan Options**

<i>Mail order</i>	<i>(up to a 90-day supply)</i>
Rx Tier 1 – Generic	\$10 copay
Rx Tier 2 – Preferred Formulary	\$60 copay
Rx Tier 3 – Non-Preferred Formulary	\$150 copay

#### *Choice90*

*(up to a 90-day retail supply at select retail pharmacies)*

Rx Tier 1 – Generic	\$10 copay
Rx Tier 2 – Preferred Formulary	\$60 copay
Rx Tier 3 – Non-Preferred Formulary	\$150 copay

Specialty Injectable Drugs  
(up to a 30-day supply)

25% coinsurance per prescription  
Minimum copay \$ 50 per prescription  
Maximum copay \$100 per prescription  
Calendar year out of pocket maximum  
for specialty medications:  
\$2,500 per individual

A searchable Preferred Drug Listing is available at  
[www.MyScrippsHealthPlan.com](http://www.MyScrippsHealthPlan.com)

Diabetic Supplies

No copay

Diabetic Medications

Applicable Tier 1, Tier 2 or Tier 3 copay

If a brand drug (Rx Tier 2 or Rx Tier 3) is dispensed when an FDA approved generic equivalent is available, the cost to the member is the appropriate brand copay plus the difference in cost between the brand drug and the generic drug. If the member fills a prescription at a Non-Network Pharmacy, the member must pay 100% of the drug cost at the time of purchase and submit a claim form for reimbursement. Reimbursement will be 50% of the network pharmacy cost after the member's copay.

### **Pharmacy Pre-certification**

The pharmacy benefit includes a formulary or preferred medication list which contains medications that are safe and effective therapies. The prior certification process is in place to allow you to request coverage for the use of certain medications in situations where other medications available may not be appropriate.

Most requests are handled within two business days. If the submitted request is incomplete, additional time may be needed so you can submit all the information required for a review of the request. If the request has been approved, MedImpact will notify you and your office will be asked to inform the Plan Member that the prior certification has been approved. **You can call MedImpact at 1-800-788-2949** if you need more information.

If your request is not approved, MedImpact will notify you and will mail you a letter explaining why the request was not approved and will explain the appeals process. In this process, you can request reconsideration of the benefit determination.

Brand and Non-Preferred Brand Drugs that require pre-certification are as follows:  
**This list may be amended and therefore is not all inclusive. Contact MedImpact for current list of medications that require pre-certification**

General Use	Brand Name	Generic Name
ADRENERGICS, AROMATIC, NON-CATECHOLAMINE	DESOXYN	METHAMPHETAMINE HCL
ALKYLATING AGENTS	TEMODAR	TEMOZOLOMIDE
ALKYLATING AGENTS	TEMODAR	TEMOZOLOMIDE
ANALGESICS, NARCOTICS	BUPRENEX	BUPRENORPHINE HCL
ANALGESICS, NARCOTICS	SUBOXONE	BUPRENORPHINE HCL/NALOXONE HCL
ANALGESICS, NARCOTICS	SUBUTEX	BUPRENORPHINE HCL
ANTICONVULSANTS	LYRICA	PREGABALIN
ANTICONVULSANTS	TOPAMAX	TOPIRAMATE
ANTIEMETIC/ANTIVERTIGO AGENTS	EMEND	APREPITANT
ANTIEMETIC/ANTIVERTIGO AGENTS	EMEND	FOSAPREPITANT DIMEGLUMINE
ANTIFUNGAL AGENTS	LAMISIL	TERBINAFINE HCL
ANTIFUNGAL AGENTS	VFEND	VORICONAZOLE
ANTIFUNGAL AGENTS (CONTINUED 1)	SPORANOX	ITRACONAZOLE
ANTIFUNGAL AGENTS (CONTINUED 2)	VFEND IV	VORICONAZOLE
ANTIHYPERTENSIVE, DPP-4 INHIBITORS	JANUVIA	SITAGLIPTIN PHOSPHATE
ANTIHYPERTENSIVE, (DPP-4) INHIBITOR & BIGUANIDE COMB.	JANUMET	SITAGLIPTIN PHOS/METFORMIN HCL
ANTIHYPERTENSIVE, INCRETIN MIMETIC (GLP-1 RECEPTOR AGONIST)	BYETTA	EXENATIDE
ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR	ARAVA	LEFLUNOMIDE
ANTIMETABOLITES	CYTARABINE	CYTARABINE
ANTINEOPLASTIC EGF RECEPTOR BLOCKER RCMC ANTIBODY	HERCEPTIN	TRASTUZUMAB
ANTINEOPLASTIC, HISTONE DEACETYLASE INHIBITORS, HDIS	ZOLINZA	VORINOSTAT
ANTINEOPLASTIC LHRH (GNRH) AGONIST, PITUITARY SUPPR.	ELIGARD	LEUPROLIDE ACETATE
ANTINEOPLASTIC LHRH (GNRH) AGONIST, PITUITARY SUPPR.	LUPRON DEPOT	LEUPROLIDE ACETATE
ANTINEOPLASTIC LHRH (GNRH) AGONIST, PITUITARY SUPPR.	TRELSTAR DEPOT	TRIPTORELIN PAMOATE
ANTINEOPLASTICS, MISCELLANEOUS	ETOPOSIDE	ETOPOSIDE
ANTINEOPLASTICS, MISCELLANEOUS	TOPOSAR	ETOPOSIDE
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	GLEEVEC	IMATINIB MESYLATE
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	TARCEVA	ERLOTINIB HCL
ANTINEOPLASTIC SYSTEMIC ENZYME INHIBITORS	TASIGNA	NILOTINIB HYDROCHLORIDE

General Use	Brand Name	Generic Name
ANTIPSORIATICS AGENTS	TAZORAC	TAZAROTENE
ANTISERA	BAYGAM	IMMUNE GLOBULIN,GAMMA (IGG)
ANTISERA	CARIMUNE NF NANOFILTERED	IMMUNE GLOBULIN,GAMMA (IGG)
ANTISERA	FLEBOGAMMA	IMMUNE GLOBULIN,GAMMA (IGG)
ANTISERA	FLEBOGAMMA DIF	IMMUNE GLOBULIN,GAMMA (IGG)
ANTISERA	GAMASTAN S-D	IMMUNE GLOBULIN,GAMMA (IGG)
ANTISERA	GAMMAGARD LIQUID	IMMUNE GLOBULIN,GAMMA (IGG)
ANTISERA	GAMMAGARD S-D	IMMUNE GLOBULIN,GAMMA (IGG)
ANTISERA	OCTAGAM	IMMUNE GLOBULIN,G(IGG)/MALTOSE
ANTISERA	PRIVIGEN	IMMUNE GLOBULIN,GAMMA (IGG)
ANTISERA	VIVAGLOBIN	IMMUNE GLOBULIN,GAMMA (IGG)
ANTIVIRALS, GENERAL	VIRAZOLE	RIBAVIRIN
BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS	AVODART	DUTASTERIDE
BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS	FLOMAX	TAMSULOSIN HCL
BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS	PROSCAR	FINASTERIDE
CONTRACEPTIVES, IMPLANTABLE	IMPLANON	ETONOGESTREL
DIABETIC ULCER PREPARATIONS, TOPICAL	REGRANEX	BECAPLERMIN
DRUGS TO TX GAUCHER DX-TYPE 1, SUBSTRATE REDUCING	ZAVESCA	MIGLUSTAT
ENZYME REPLACEMENTS (UBIQUITOUS ENZYMES)	CEREZYME	IMIGLUCERASE
FOLLICLE STIM./LUTEINIZING HORMONES	BRAVELLE	UROFOLLITROPIN (FSH)
FOLLICLE STIM./LUTEINIZING HORMONES	CHORIONIC GONADOTROPIN	GONADOTROPIN, CHORIONIC, HUMAN
FOLLICLE STIM./LUTEINIZING HORMONES	FERTINEX	UROFOLLITROPIN (FSH)
FOLLICLE STIM./LUTEINIZING HORMONES	FOLLISTIM AQ	FOLLITROPIN BETA, RECOMB
FOLLICLE STIM./LUTEINIZING HORMONES	FOLLISTIM AQ	FOLLITROPIN BETA, RECOMB
FOLLICLE STIM./LUTEINIZING HORMONES	GONAL-F	FOLLITROPIN ALPHA, RECOMB
FOLLICLE STIM./LUTEINIZING HORMONES	GONAL-F RFF	FOLLITROPIN ALPHA, RECOMB

General Use	Brand Name	Generic Name
FOLLICLE STIM./LUTEINIZING HORMONES	MENOPUR	MENOTROPINS
FOLLICLE STIM./LUTEINIZING HORMONES	NOVAREL	GONADOTROPIN,CHORIONIC, HUMAN
FOLLICLE STIM./LUTEINIZING HORMONES	OVIDREL	HCG ALPHA,RECOMBINANT
FOLLICLE STIM./LUTEINIZING HORMONES	PREGNYL	GONADOTROPIN,CHORIONIC, HUMAN
FOLLICLE STIM./LUTEINIZING HORMONES	PROFASI	GONADOTROPIN,CHORIONIC, HUMAN
FOLLICLE STIM./LUTEINIZING HORMONES	REPRONEX	MENOTROPINS
GROWTH HORMONE RELEASING HORMONE (GHRH) & ANALOGS	GEREF	SERMORELIN ACETATE
GROWTH HORMONES	GENOTROPIN	SOMATROPIN
GROWTH HORMONES	HUMATROPE	SOMATROPIN
GROWTH HORMONES	NORDITROPIN	SOMATROPIN
GROWTH HORMONES	NORDITROPIN NORDIFLEX	SOMATROPIN
GROWTH HORMONES	NUTROPIN	SOMATROPIN
GROWTH HORMONES	NUTROPIN AQ	SOMATROPIN
GROWTH HORMONES	NUTROPIN AQ NUSPIN	SOMATROPIN
GROWTH HORMONES	OMNITROPE	SOMATROPIN
GROWTH HORMONES	SAIZEN	SOMATROPIN
GROWTH HORMONES	SEROSTIM	SOMATROPIN
GROWTH HORMONES	TEV-TROPIN	SOMATROPIN
GROWTH HORMONES	ZORBTIVE	SOMATROPIN
HEMATINICS,OTHER	ARANESP	DARBEPOETIN ALFA IN POLYSORBATE
HEMATINICS,OTHER	EPOGEN	EPOETIN ALFA
HEMATINICS,OTHER	PROCRIT	EPOETIN ALFA
HEPARIN AND RELATED PREPARATIONS	FRAGMIN	DALTEPARIN SODIUM,PORCINE
HEPARIN AND RELATED PREPARATIONS	INNOHEP	TINZAPARIN SODIUM,PORCINE
HEPATITIS B TREATMENT AGENTS	TYZEKA	TELBIVUDINE
HEPATITIS C TREATMENT AGENTS	COPEGUS	RIBAVIRIN
HEPATITIS C TREATMENT AGENTS	REBETOL	RIBAVIRIN
HEPATITIS C TREATMENT AGENTS	RIBASPHERE	RIBAVIRIN
HUMAN MONOCLONAL ANTIBODY COMPLEMENT(C5) INHIBITOR	SOLIRIS	ECULIZUMAB
HYPERTRICHOTIC AGENTS, SYSTEMIC/INCL. COMBINATIONS	PROPECIA	FINASTERIDE
IMMUNOMODULATORS	ALFERON N	INTERFERON ALFA-N3

General Use	Brand Name	Generic Name
IMMUNOMODULATORS	INTRON A	INTERFERON ALFA-2B,RECOMB.
IMMUNOMODULATORS	INTRON A	INTERFERON ALFA-2B,RECOMB.
IMMUNOMODULATORS	PROLEUKIN	ALDESLEUKIN
IMMUNOSUPPRESSIVES	PROGRAF	TACROLIMUS ANHYDROUS
IMMUNOSUPPRESSIVES	PROGRAF	TACROLIMUS ANHYDROUS
IMMUNOSUPPRESSIVES	RAPAMUNE	SIROLIMUS
KERATINOCYTE GROWTH FACTOR (KGF)	KEPIVANCE	PALIFERMIN
LEUKOCYTE (WBC) STIMULANTS	LEUKINE	SARGRAMOSTIM
LEUKOCYTE (WBC) STIMULANTS	NEULASTA	PEGFILGRASTIM
LEUKOCYTE (WBC) STIMULANTS	NEUPOGEN	FILGRASTIM
LHRH(GNRH)AGNST PIT.SUP-CENTRAL PRECOCIOUS PUBERTY	LUPRON DEPOT-PED	LEUPROLIDE ACETATE
LHRH(GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS	LUPRON DEPOT	LEUPROLIDE ACETATE
LUTEINIZING HORMONES	LUVERIS	LUTROPIN ALFA
PKU TX AGENT-COFACTOR OF PHENYLALANINE HYDROXYLASE	KUVAN	SAPROPTERIN DIHYDROCHLORIDE
PLATELET PROLIFERATION STIMULANTS	NEUMEGA	OPRELVEKIN
PULM.ANTI-HTN,SEL.C-GMP PHOSPHODIESTERASE T5 INHIB	REVATIO	SILDENAFIL CITRATE
SYSTEMIC ENZYME INHIBITORS	ARALAST NP	ALPHA-1-PROTEINASE INHIBITOR
SYSTEMIC ENZYME INHIBITORS	PROLASTIN	ALPHA-1-PROTEINASE INHIBITOR
SYSTEMIC ENZYME INHIBITORS	ZEMAIRA	ALPHA-1-PROTEINASE INHIBITOR
THROMBIN INHIBITORS,SEL.,DIRECT,& REV-HIRUDIN TYPE	REFLUDAN	LEPIRUDIN,RECOMBINANT
THYROID FUNCTION DIAGNOSTIC AGENTS	THYROGEN	THYROTROPIN ALFA
TOPICAL LOCAL ANESTHETICS	LIDODERM	LIDOCAINE
TX FOR ATTENTION DEFICIT-HYPERACT(ADHD)/NARCOLEPSY	PROVIGIL	MODAFINIL
UNCLASSIFIED DRUGS	PROGRAF 0.5MG/1ML SUSP	PROGRAF
VINCA ALKALOIDS	VINBLASTINE SULFATE	VINBLASTINE SULFATE
VITAMIN A DERIVATIVES, TOPICAL COSMETIC AGENTS	AVAGE	TAZAROTENE

The Prescription Drug Program does not cover:

- Anabolic steroids (except Oxandrolone <e.g. Oxandrin>)
- Anti-obesity medications
- Anti-wrinkle agents (except Tretinoin topical for individuals through age 25 years)
- Charges for the administration or injection of any drug
- Cosmetic hair removal products
- DESI drugs: Drugs determined by the Food & Drug Administration as lacking substantial evidence of effectiveness
- Drugs requiring a prescription by state law but not by federal law (state controlled)
- Experimental drugs, as determined by the Plan, or drugs labeled for investigational use
- Fluoride supplements (except for sodium fluoride chewable tablets for covered participants through age 6)
- Hair growth stimulants
- Immunization agents, blood or blood plasma
- Over-the-counter medications
- Pigmenting/de-pigmenting agents (except for Aminolevulinic acid hcl <e.g. Levulan>, Methoxsalen <e.g. Oxsoralen> and Nitrocellulose <e.g. New Skin Aerosol Spray>)
- Prescription drugs or supplies received for a work-related injury or sickness, if entitled to benefits under any workers' compensation, occupational disease or similar law(s)
- Therapeutic devices or appliances unless listed as covered
- Topical contraceptives such as diaphragms (e.g. Ortho-Diaphragm) and intrauterine devices (IUDs) (e.g. Mirena)
- Vitamins not specifically listed as covered