For Products issued by:
Capital Advantage Assurance Company®
Subsidiary of Capital Blue Cross

Preauthorization Program for Commercial Medical Benefits

MEDICAL SERVICES REQUIRING PREAUTHORIZATION

When members use an in-network provider (including a BlueCard® facility participating provider providing **inpatient services**) for services subject to preauthorization, the in-network provider is responsible for obtaining the preauthorization. If members use an out-of-network provider or a BlueCard participating provider providing **non-inpatient services**, the member is responsible for getting the required preauthorization. However, the out-of-network provider or BlueCard participating provider may request preauthorization on the member's behalf. Providers or members may call us toll-free at **1.800.730.7219** to obtain the necessary preauthorization. In-network providers should access the provider portal to request preauthorization. Out-of-network and out-of-area providers may access the out-of-area/network provider resources on CapBlueCross.com for direction to request preauthorization.

Providers or Members should request preauthorization of non-urgent admissions and services well in advance of the scheduled date of service. We will make a determination on your non-urgent request within 15 calendar days of receipt of all necessary information. Investigational procedures are not covered benefits. Providers and members may access our medical policies at CapBlueCross.com, and may contact us to see if we consider a service to be investigational.

We only pay for services and items that are considered medically necessary. Please refer to our medical policies for questions regarding medical necessity. Members should consult their Benefits Booklets, Capital Blue Cross' Medical Policies, or contact Member Services at the number listed on the back of their ID card for questions relating to terms and conditions of coverage. Preauthorization approvals are not a guarantee of payment. Payment for preauthorized services/items is subject to the member's benefits and eligibility on the date of service.

PREAUTHORIZATION OF MEDICAL SERVICES INVOLVING CARE THAT IS NEEDED URGENTLY

If the member's request for preauthorization involves care that is required urgently, the member or the member's provider must advise us of the urgent medical circumstances when submitting the preauthorization request. This is considered an urgent request. We will respond to an urgent request no later than 72 hours after we receive all necessary information for a determination. If the request is related to continuing health care services you are currently receiving, the request must be made at least 24 hours prior to the reduction or termination of your current treatment, and we will respond within 24 hours from the receipt of all necessary information for a determination.

FAILURE TO OBTAIN PREAUTHORIZATION

Failure to obtain preauthorization for a service could result in a payment reduction or denial for the provider and benefit reduction or denial for the member, based on the provider's contract and the member's Benefits Booklet or Contract. Services or items provided without preauthorization may also be subject to retrospective medical necessity review.

If the member presents their ID card to an in-network provider in the 21-county area and the in-network provider fails to obtain or follow preauthorization requirements, payment for services will be denied and the provider may not bill the member for the services performed.

EMERGENT SERVICES AND NON-ROUTINE MATERNITY ADMISSIONS

Preauthorization requirements do not apply to services provided by a hospital emergency department. If an acute inpatient admission results from an emergency department visit, notification must occur within two business days of the admission. All such services will be reviewed and must meet medical necessity criteria from the first hour of admission. Failure to notify us of an admission may result in an administrative denial.

Diagnostic services do not require preauthorization when emergently performed during an emergency room visit, observation stay, or inpatient admission.

Non-routine maternity admissions, including preterm labor and maternity complications, require notification within two business days of the date of admission.

Below is a non-exhaustive listing of services for which preauthorization is required. Items listed in the Details column are examples of services requiring preauthorization; however, members should view the Single Source

Preauthorization List **for a complete listing of services currently requiring preauthorization. We may from time to time change preauthorization requirements for items and services covered under your health plan.**

Category	Details	Comments
Inpatient Admissions	• Acute care • Long-term acute care • Non-routine maternity admissions and newborns requiring continued hospitalization after the mother is discharged • Skilled nursing facilities • Rehabilitation hospitals • Behavioral health admissions (mental health or substance use disorder diagnoses)	
Diagnostic Services	• Genetic testing. • High tech imaging such as but not limited to: Cardiac nuclear medicine studies including nuclear cardiac stress tests, CT (computerized tomography) scans, MRA (magnetic resonance angiography), MRI (magnetic resonance imaging), PET (positron emission tomography) scans, and SPECT (single proton emission computerized tomography) scans.	
Durable Medical Equipment (DME), Prosthetic, Appliances, Orthotic Devices, Implants		
Office Procedures When Performed in a Facility		
Outpatient Procedures/ Surgery	• Weight loss surgery (Bariatric) • Meniscal transplants, allografts and collagen meniscus implants (knee) • Ovarian and Iliac Vein Embolization • Photodynamic therapy • Radioembolization for primary and metastatic tumors of the liver • Radiofrequency ablation of tumors • Transcatheter aortic valve replacement • Valvuloplasty • Treatment of Varicose Veins and Venous Insufficiency	
Transplant Surgeries	Evaluation and services related to transplants	Preauthorization will include referral assistance to the Blue Distinction Centers for Transplant network if appropriate.
Reconstructive or Cosmetic Services and Items	• Removal of excess fat tissue (Abdominoplasty/Panniculectomy and other removal of fat tissue such as Suction Assisted Lipectomy) • Breast Procedures - Breast Enhancement (Augmentation) - Breast Reduction - Mastectomy (Breast removal or reduction) for Gynecomastia - Breast Lift (Mastopexy) - Removal of Breast implants • Correction of protruding ears (Otoplasty) • Repair of nasal/septal defects (Rhinoplasty/Septoplasty) • Skin related procedures	

Category	Details	Comments
	- Acne surgery - Dermabrasion - Hair removal (Electrolysis/Epilation) - Face Lift (Rhytidectomy) - Removal of excess tissue around the eyes (Blepharoplasty/Brow Ptosis Repair) - Mohs Surgery when performed on two separate dates of service by the same provider	
Medical Injectable drugs and Gene Therapies		
Investigational procedures, devices, therapies, and pharmaceuticals		Investigational procedures are not usually covered benefits. Members and providers may request preauthorization to determine if a service/item is investigational.
New to market procedures, devices, therapies, and pharmaceuticals		Preauthorization may be required up to two years after the entry of a new procedure, device, therapy or pharmaceutical into the market.
Select Outpatient Behavioral Health Services	• Partial Hospitalization Program • Intensive Outpatient Programs • Applied Behavioral Analysis (ABA)	
Other Services	• Bio-engineered skin or biological wound care products • Category IDE trials (Investigational Device Exemption) • Enhanced external counterpulsation (EECP) • Home health care • Eye injections (Intravitreal angiogenesis inhibitors) • Non-emergency air ambulance transports • Enteral feeding supplies and services	
Pain Management	• Interventional Pain Management • Joint injections	
Oncology Services	Radiation therapy and related treatment planning and procedures performed for planning	
Select Cardiac Services		

PLEASE NOTE: This listing identifies those services that require preauthorization only as of the date it was printed. This listing is subject to change. Members should call us at 1.800.730.7219 (TTY: 711) with questions regarding the preauthorization of a particular service.

For HMO and Gatekeeper PPO members, all care rendered by out-of-network providers requires preauthorization, with the exception of Emergency Services. This includes care that falls under the Continuity of Care provision of the Benefits Booklet or Contract.

This information highlights the standard Preauthorization Program. Members should refer to their Benefits Booklet or Contract for the specific terms, conditions, exclusions, and limitations relating to their coverage.