Because it matters how you’re treated.

2014 Benefit Update Meeting

Presented by
Provider Relations & Education

Note: Contents are subject to change and are not a guarantee of payment.
Workshop Agenda

• Welcome & Introductions
• Improving Quality
• Medicare Advantage
• Medicare Advantage Pharmacy Update
• BlueChoice HealthPlan Medicaid
• ICD-10 CM Updates
• Web Services
• National Imaging Associates (NIA)*
• Appeals
• BlueCard®

*NIA is an independent company that handles preauthorization for certain imaging services on behalf of BlueCross and BlueChoice HealthPlan.
Workshop Agenda

- Federal Employee Plan (FEP)
- State Health Plan
- Preferred Blue®
- Savannah River Site
- New Groups
- BlueChoice HealthPlan
- Pharmacy Management
- Patient Protection and Affordable Care Act (PPACA)
- Health Insurance Marketplace
- Provider Recognitions
- Questions
Mission Statement

To serve as liaisons between BlueCross, BlueChoice® and the health care community to promote positive relationships through continued education and problem resolution.
Provider Services

Brian Butler
Senior Director

Brenda Bethel
Director

Marcelette Pearson
Manager

Tammy Ross
Manager

Mark Austin
Manager
These representatives handle education inquiries for institutions, professional offices and ambulatory surgical centers.
Provider Advocate Service Areas

BlueChoice HealthPlan Medicaid Provider Representative Territory Map

- Pea Dee
  Donna Thompson
  803.241.3995

- Lowcountry
  Denille Douglas
  803.382.5776

- Upstate
  Donese Pinckney
  803.382.5125

- Midlands
  Jon Keith
  803.382.5085

BlueChoice HealthPlan is an independent licensee of the Blue Cross and Blue Shield Association. Healthy Connections is administered for BlueChoice HealthPlan by WellPoint Partnership Plan, LLC, an independent company.
Our department of internal and external provider advocates provide educational support for these lines of business:

• State Health Plan
• Federal Employee Program
• Medicare Advantage
• Dental
• BlueCross
• BlueChoice
• BlueChoice Medicaid

• Health Insurance Marketplace (Exchanges)
• Planned Administrators Inc. (PAI), a separate company that offers third party administration services on behalf of BlueCross
How We Do It

- On-site Visits
- Webinars
- Training Materials
- Newsletters and Bulletins
- Regional Workshops
- Direct Contact and Support
Improving Quality
## Rewarding Excellence

**Improve the health of the population**
- Eliminate avoidable hospital mortalities
- Ensure patients receive all appropriate evidence-based care
- Prevent incidents of harm

**Enhance the patient experience of care**
- Improve the patient’s overall care and reinforce loyalty to the facility providing care

**Reduce, or at least control, the per capita cost of care**
- Reward value, not volume
GOAL: To compensate hospitals for the quality of care provided to patients, not just the quantity of procedures performed.
Alternative Payment Model

How does it work?

• Use most recent, publically reported measures and initiatives
  • Center for Medicare and Medicaid (CMS) Hospital Inpatient Quality Reporting Program (IQR)
  • Value-Based Purchasing
  • CMS Hospital-Acquired Conditions Program (HAC)
  • CMS Readmission Program
Alternative Payment Model

How does it work?

• Increase based on points awarded for a total score.

• Bonus:
  • Highest rank among bed size peers
  • Highest improvement among bed size peers
  • Increase per measure for <10 percent improvement
Physicians may receive payments for up to two of these eligible programs:

- American Diabetes Association (ADA)/National Committee for Quality Assurance (NCQA) Diabetes Recognition Program
- American Heart Association (AHA)/American Stroke Association (ASA)/NCQA Heart/Stroke Recognition Program
- American Society for Hypertension (ASH) Specialists Program

A practice that achieves Patient-Centered Medical Home (PCMH) status may receive $2000.
Current Physician Recognition Program

• All participation is voluntary.

• To receive recognition under the current program, complete the Physician Recognition Program Payment Request form on our website, www.SouthCarolinaBlues.com.
What is HEDIS?

HEDIS (HĒ · DIS)

- Healthcare
- Effectiveness
- Data and
- Information
- Set

- HEDIS is a performance measurement tool that NCQA coordinates and administers.

- More than 90 percent of America's health plans use it.
What is HEDIS?

• NCQA has set a deadline of May 15 of each year for health plans to gather HEDIS data.

• Retrospective review of services and performance of care.

• We use results to measure performance, identify quality initiatives and provide educational programs for providers and members.
Why Do We Need HEDIS?

- Health benefits are consuming increasing percentage of expenses. Purchasers seeking ways to assess the relative value of care.
- HEDIS offers a way for some consumers to choose a plan. State and federal regulators may use HEDIS data as part of their oversight processes.
- Provides “apples-to-apples” comparison of organizations.
- We want to make sure we are providing our members with the BEST quality and assessment of care possible.
What is Your Role in HEDIS?

• You play a central role in promoting the health of our members.
• You and your office staff can make the HEDIS process easier by:
  • Providing the appropriate care within the designated timeframes.
  • Documenting all care in the patient’s medical record.
  • Coding claims completely.
  • Responding to our requests for medical records within five business days.

We appreciate your cooperation and timeliness in submitting medical record information!
We produce “Gaps in Care” reports, which identify:

- Which patients need certain medical services -- mammogram screenings, cholesterol screenings, immunizations, etc.
- Potential barriers, such as a patient not showing up for a scheduled office visit, or work that was done but not coded completely.
• Helps us know where to focus our resources to help members and providers.
• Supplements your efforts in caring for your patients. It is a service we provide in our partnership to ensure members are receiving quality care.
• We also develop provider incentives that will help improve our members’ health.
• We currently evaluate 27 different measures, which are reported separately for each population (commercial, Medicare, Medicaid and eventually Health Care Exchanges).

• Measures are typically focused on:
  • Appropriate screenings (i.e., mammograms)
  • Quality of care measures (i.e., A1c control in diabetics)
  • Avoidance of unwarranted care (i.e., avoidance of antibiotics)
We have identified 11 measures in which we believe you can have a major impact:

1. Adult BMI assessment
2. Appropriate testing for children with pharyngitis
3. Appropriate treatment for children with upper respiratory infection
4. Avoidance of antibiotic treatment in adults with acute bronchitis
5. Childhood immunization status (combination 2)
6. Chlamydia screening in women (total rate)
We have identified 11 measures in which we believe you can have a major impact:

7. Osteoporosis management in women who had a fracture
8. Use of appropriate medications for people with asthma
9. Use of imaging studies for low back pain
10. Use of spirometry testing in the assessment and diagnosis of COPD
11. Weight assessment and counseling for nutrition, physical activity for children/adolescents (the total of all ages for each of the three rates)
Some suggestions to improve quality of care and HEDIS measures based on NCQA evaluations and best practices:

- Electronic medical records (EMRs) have the option to code and calculate the BMI for you. Take advantage!
- If pharyngitis is suspected, consider a strep test.
- Avoid unnecessary prescriptions. Wait three days before prescribing antibiotics for upper respiratory infections for patients ages 3 months to 18 years.
Tips on Improvement

• Avoid antibiotics for bronchitis in adults.
• Some exceptions may be:
  • Patient is 65 or older
  • Has been diagnosed/treated for HIV, malignant neoplasm, emphysema, chronic obstructive pulmonary disorder (COPD) or cystic fibrosis in the past year
  • Has been treated/diagnosed with a condition that would warrant antibiotic treatment (ex: food poisoning, sexually transmitted disease (STD), tonsillitis) in the past 30 days
• Discuss with patients the importance of getting vaccinations on a regular schedule.

• Discuss with patients the importance of chlamydia screenings. Testing methods now include a urine test which is cost effective and noninvasive.
Tips on Improvement

• Consider alternative tests for colorectal cancer screenings, such as fecal occult blood test and flex sigmoidoscopy.

• Based on patient demographics, consider the possibility of an on-site DEXA scanner. Otherwise, consider establishing a partnership with a local imaging center that has a DEXA scanner.

• Increase the use of controller medication for patients with asthma.
Tips on Improvement

• Reduce the use of imaging for low back pain. Remind patients that healing can take up to four weeks.

• If a patient is diagnosed with COPD, emphysema or chronic bronchitis, confirm with spirometry.
We want to show the nation the excellence of our providers!

• If a member does not appear to have received treatment according to claims, we request charts to try to show they received appropriate care.

• Complete coding on your claims helps reduce the number of chart requests you may receive.
What is a Clinic Day?
• A day dedicated to our members used to fill gaps in care.

Why should I host a Clinic Day?
• Boost your HEDIS scores
• Meet quality measures
• Provide patients with essential care
What can we do to assist you?

• Assist in identifying patients due for these services

• Assist with appointment scheduling and appointment reminders, if needed

• Host a table at the provider office on the scheduled Clinic Day
Maternity: Birth Outcomes Initiative (BOI)

- This applies to all BlueCross and BlueChoice lines of business (including BlueChoice HealthPlan Medicaid).
- Effective for dates of service on or after August 1, 2012 providers must follow these coding guidelines on all claims for deliveries.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>GB</td>
<td>39 weeks gestation or more</td>
</tr>
<tr>
<td>CG</td>
<td>less than 39 weeks gestation <em>(follow ACOG guidelines)</em></td>
</tr>
<tr>
<td>UA</td>
<td>prolonged labor when a vaginal delivery fails to progress and converts to a Cesarean section use as a secondary modifier in conjunction with GB or CG</td>
</tr>
<tr>
<td>No Modifier</td>
<td>elective non-medically necessary deliveries less than 39 weeks gestation</td>
</tr>
</tbody>
</table>
Go to these websites for additional information on birth outcomes:


- **SC Department of Health and Human Services:** [https://www.scdhhs.gov/organizations/boi](https://www.scdhhs.gov/organizations/boi)

- **American Congress of Obstetricians & Gynecologists (ACOG):** [http://www.acog.org/Resources_And_Publications/Patient_Safety_Checklists_List](http://www.acog.org/Resources_And_Publications/Patient_Safety_Checklists_List)
Member Incentive Programs

- Great Expectations® program for BlueChoice plans
- My Health Matters program for BlueCross employees
- Other management programs related to diabetes, heart disease and high cholesterol
Medicare Advantage
CMS Star Ratings

• CMS uses the 5-star rating system to monitor plans to ensure they meet Medicare’s standards for quality of care and customer service.

• Current star ratings criteria are based on these categories:
  • Member satisfaction
  • Customer responsiveness and service
  • Quality of care
CMS Star Ratings

- Medicare uses information from member satisfaction surveys, plans and health care providers to give overall performance star ratings to Medicare health plans.
- These ratings help members compare plans based on quality and performance.
The overall plan rating gives a single summary score that makes it easy to compare plans based on quality and performance.

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys
- Health Outcomes Survey (HOS)
- HEDIS measures
CMS Star Ratings

5-STAR PLAN RATINGS

Medicare uses information from member satisfaction surveys, plans, and health care providers to give overall performance star ratings to Medicare health and prescription drug plans. These ratings help you compare plans based on quality and performance. A plan can get a rating from one to five stars. A 5-star rating is considered excellent. The overall plan rating gives you a single summary score that makes it easy for you to compare plans based on quality and performance.

What do the plan ratings measure?

Medicare Health Plans
For plans covering health services, the overall score for quality of those services covers 17 different topics in five categories:

- **Staying healthy**
  Includes how often members get various screening tests, vaccines, and other check-ups that help them stay healthy.
- **Managing chronic (long-term) conditions**
  Includes how often members with different conditions get certain tests and treatments that help them manage their conditions.
- **Ratings of health plan responsiveness and care**
  Includes ratings of member satisfaction with the plan.
- **Health plan member complaints and appeals**
  Includes how often members filed a complaint against the plan.
- **Health plan telephone customer service**
  Includes how well the plan handles calls from members.

Medicare Health Plans
For plans covering drug services, the overall score for quality of those services covers 17 different topics in four categories:

- **Drug plan customer service**
  Includes how well the drug plan handles calls and makes decisions about member appeals.
- **Drug plan member complaints and Medicare audit findings**
  Includes how often members filed a complaint about the drug plan and findings from Medicare’s audit of the plan.
- **Member experience with drug plan**
  Includes member satisfaction information.
- **Drug pricing and patient safety**
  Includes how well the drug plan prices prescriptions and provides updated information on the Medicare website. Includes information on how often members with certain medical conditions get prescription drugs that are considered safer and clinically recommended for their condition.

For plans covering both health and drug services, the overall score for quality of those services covers all of the topics listed above.

Learn More About Plan Ratings
Visit the Medicare Plan Finder Tool on www.medicare.gov to learn more about plans and see their ratings. You can find a plan’s overall rating on the Plan Results page or view a complete summary of all plan’s quality and performance ratings by clicking “Plan Ratings” on the Plan Results page.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Recall: $181.26</td>
<td>$15.10</td>
<td>Annual Drug Deductible: $320</td>
<td>All Your Drugs on Formulary: N/A</td>
<td>★★★ 3 out of 5 stars</td>
</tr>
</tbody>
</table>

Continued on page 2
Utilization Management

• Authorizations and continued stay reviews are required on all Medicare Advantage inpatient admissions. Our staff coordinates with hospital staff on discharge coordination and transitional services.

• These services ensure members receive appropriate care and follow-up when hospitalized as well as identify those beneficiaries who may need more case management upon discharge.
Inovalon and Medicare Advantage

- Inovalon is an independent company that handles clinical documentation services on our behalf.
- They assist us in recording the patient condition information we are mandated to report to CMS through:
  - Medical Record Reviews (paper or electronic)
  - Subjective/Objective/Assessment Plan (SOAP) notes
- Inovalon reminds our MA members to get the care they need via encounter facilitation letters, telephone calls and in-home patient visits.
Advanced Beneficiary Notice (ABN)

What is an ABN?
• Providers will issue an Advanced Beneficiary Notice of Noncoverage (ABN) to Medicare beneficiaries when it’s expected Medicare will deny payment. It is not used for supplemental items or services provided under the Medicare Advantage program as outlined by Medicare.

Does BlueCross accept ABNs?
• Yes. Please follow the same rules for Medicare Advantage members as you do for traditional Medicare.
What is Considered an Acceptable ABN?

Here is an example of an acceptable ABN on www.SouthCarolinaBlues.com. A written agreement on your letterhead should include all required information as outlined for a valid ABN:

- Provider’s information
- Beneficiary’s full name
- Beneficiary’s plan ID card number
- Specific items or services believed to be non-covered
What is Considered an Acceptable ABN?

A written agreement on your letterhead should also include:

- Specific reason(s) as to why the service is non-covered
- Estimated cost of the non-covered items or services
- Statement indicating Medicare Advantage will not pay for the service(s) and the beneficiary will be responsible for the charges
- Beneficiary’s dated signature
• One-time “Welcome to Medicare” physical is covered.  
  – G codes G0402-G0405

• An annual wellness visit is covered each year

• Preventive services that are covered:  
  http://www.cms.gov/Medicare/Prevention/PreventionGenI  
  nfo/Downloads/MPS_QuickReferenceChart_1.pdf
<table>
<thead>
<tr>
<th>Service</th>
<th>2014 Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEDUCTIBLE</td>
<td></td>
</tr>
<tr>
<td>In &amp; Out of Network Combined</td>
<td>$350</td>
</tr>
<tr>
<td>MAXIMUM OUT OF POCKET</td>
<td></td>
</tr>
<tr>
<td>In Network</td>
<td>$6700</td>
</tr>
<tr>
<td>In &amp; Out of Network</td>
<td>$10,000</td>
</tr>
</tbody>
</table>

Medicare Blue Updates

BlueCross BlueShield of South Carolina and
BlueChoice HealthPlan of South Carolina

Independent licensees of the Blue Cross and Blue Shield Association
## Medicare Blue Updates

<table>
<thead>
<tr>
<th>Service</th>
<th>2014 Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital Care</td>
<td>$295 copay per day for days 1-5</td>
</tr>
<tr>
<td>Additional Days (6+)</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Inpatient Mental Health Care</td>
<td>$295 copay per day for days 1-5/ $0 copay for days 6-190</td>
</tr>
<tr>
<td>Skill Nursing Facility</td>
<td>$25 copay per day for days 1-20/$152 copay per day for  days 21-100</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>0% coinsurance</td>
</tr>
<tr>
<td>Doctor Office visits</td>
<td>$15 copay</td>
</tr>
<tr>
<td>Specialist</td>
<td>$49 copay</td>
</tr>
<tr>
<td>Outpatient Mental Health Care</td>
<td>$40 copay</td>
</tr>
<tr>
<td>Outpatient Mental Health Care - Partial Hospitalization</td>
<td>$49 copay</td>
</tr>
<tr>
<td>Podiatry Services (Medicare covered)</td>
<td>$49 copay</td>
</tr>
<tr>
<td>Service</td>
<td>2014 Benefit</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>Outpatient Substance Abuse</td>
<td>$49 copay</td>
</tr>
<tr>
<td>Outpatient Services – ASC</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Outpatient Rehab</td>
<td>$49 copay</td>
</tr>
<tr>
<td>Diabetes Self-Management Training</td>
<td>$15 primary care copay/$49 specialist copay</td>
</tr>
<tr>
<td>Diabetes Supplies and Shoes</td>
<td>$10 copay</td>
</tr>
<tr>
<td>Diagnostic Tests</td>
<td>$49 copay</td>
</tr>
<tr>
<td>X-Rays</td>
<td>$15 primary care copay/$49 specialist copay</td>
</tr>
<tr>
<td>Diagnostic Radiology</td>
<td>$150 primary care copay</td>
</tr>
<tr>
<td>Therapeutic Radiology</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Lab Services</td>
<td>$15 copay</td>
</tr>
<tr>
<td>Hearing Services</td>
<td>$49 copay for Medicare approved</td>
</tr>
</tbody>
</table>

As of 1/1/2014, follows Medicare guidelines for radiology procedures.
## Medicare Blue Saver Updates

<table>
<thead>
<tr>
<th>Service</th>
<th>2014 Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DEDUCTIBLE</strong></td>
<td></td>
</tr>
<tr>
<td>In Network</td>
<td>$0</td>
</tr>
<tr>
<td>Out Of Network</td>
<td>$1250</td>
</tr>
<tr>
<td><strong>MAXIMUM OUT OF POCKET</strong></td>
<td></td>
</tr>
<tr>
<td>In Network</td>
<td>$6700</td>
</tr>
<tr>
<td>In &amp; Out Of Network</td>
<td>$10,000</td>
</tr>
</tbody>
</table>
# Medicare Blue Saver Updates

<table>
<thead>
<tr>
<th>Service</th>
<th>2014 Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital Care</td>
<td>$295 copay per day for days 1-5/$0 copay for days after the 6th day</td>
</tr>
<tr>
<td>Inpatient Mental Health Care</td>
<td>$295 copay per day for days 1-5/$0 copay for days 6-190</td>
</tr>
<tr>
<td>Outpatient Mental Health Care - Partial Hospitalization</td>
<td>$49 copay</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>$25 copay for days 1-20/$152 copay for days 21-100</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>0% coinsurance</td>
</tr>
<tr>
<td>Doctor Office Visits</td>
<td>$15 copay</td>
</tr>
<tr>
<td>Specialist</td>
<td>$49 copay</td>
</tr>
<tr>
<td>Podiatry Services (Medicare covered)</td>
<td>$49 copay</td>
</tr>
<tr>
<td>Outpatient Mental Health Care</td>
<td>$40 copay</td>
</tr>
<tr>
<td>Outpatient Substance Abuse</td>
<td>$49 copay</td>
</tr>
<tr>
<td>Outpatient Services - ASC</td>
<td>20% coinsurance</td>
</tr>
</tbody>
</table>
## Medicare Blue Saver Updates

<table>
<thead>
<tr>
<th>Service</th>
<th>2014 Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Hospital</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>$175 copay</td>
</tr>
<tr>
<td>Outpatient Rehab</td>
<td>$49 copay</td>
</tr>
<tr>
<td>Diabetes Self-Management Training</td>
<td>$15 copay primary care physician/$49 specialist copay</td>
</tr>
<tr>
<td>Diabetes Supplies and Shoes</td>
<td>$10 copay</td>
</tr>
<tr>
<td>Diagnostic Tests</td>
<td>$49 copay</td>
</tr>
<tr>
<td>X-Rays</td>
<td>As of 1/1/2014, follows Medicare guidelines for radiology procedures</td>
</tr>
<tr>
<td></td>
<td>$15 primary care copay/$49 specialist copay</td>
</tr>
<tr>
<td>Diagnostic Radiology</td>
<td>$150 copay</td>
</tr>
<tr>
<td>Therapeutic Radiology</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Lab Services</td>
<td>$15 copay</td>
</tr>
<tr>
<td>Hearing Services</td>
<td>$49 for Medicare approved</td>
</tr>
</tbody>
</table>
Medicare Advantage Rx
Prime Therapeutics will replace CVS Caremark as the PBM for Medicare Advantage in 2014. Prime Therapeutics and Caremark are independent companies that offer prescription drug benefits on behalf of our plans.

- New preferred mail-order pharmacy, Prime Mail
- New contact information for prior authorizations and coverage determinations
- New pharmacy ID cards
- Improved formularies
Prime Contact Information

• E-scribe National Council for Prescription Drug Plan (NCPDP) Mail (3211377) Specialty (5710098)

• Prime Mail Fax: 877-774-6360

• Prime Mail Address for Controlled Substances: P.O Box 650041, Dallas, TX, 75265-0041

• Coverage Determinations & General Inquiries: 800-693-6651

• Coverage Determinations Fax: 1-800-693-6703

• Website:  www.myprime.com
Five Tier Design:

Tier 1: Preferred Generic (includes Star Rating drugs)
Tier 2: Non-preferred Generics
Tier 3: Preferred Brands
Tier 4: Non Preferred Brands
Tier 5: Specialty (Medicare Advantage specialty definition >$600 and high-risk medications, including generics)
Major Formulary Drug Changes

• Removal of acetaminophen (APAP) products containing more than 325mg of APAP

• Humulin/Humalog products are preferred insulin products

• Coverage of amphetamine ER ONLY

• More quantity limits based on clinical guidelines (i.e. zolpidem 90 tabs per year)
BlueChoice HealthPlan
Medicaid
BlueChoice HealthPlan Medicaid is in its sixth year of business

- We now have 63,231 members
- We are approved in all 46 counties

Changes in the Medicaid market

- Medical Home Networks (MHN) are changing to Managed Care Organizations (MCO)
- Members will have the option to stay with their current plans or choose another plan between December 2013 and April 2014
Verifying Eligibility

Checking eligibility is critical for every visit. Each member has 90 days to switch plans after assignment and can lose eligibility at any time of the year based on a change in his or her status.

- Member ID card
- SC [https://portal.scmedicaid.com/](https://portal.scmedicaid.com/)
- Customer Care Center: 866-757-8286
- [www.BlueChoiceSCMedicaid.com](http://www.BlueChoiceSCMedicaid.com)
Members must carry their State-issued Healthy Connections ID cards.
Available Resources:

- Provider Directory
- Provider Operations Manual
- Services Requiring Authorizations
- Forms
- Pharmacy Information
- Health Education
- Screening, Brief Intervention, and Referral to Treatment (SBIRT) Info

Always look for the Healthy Connections logo to identify the Medicaid product.
Get member lists, check eligibility, view claim status and more.

For assistance with access:
provideraccessssc-sm@wellpoint.com
Provider Directory

- To access the searchable directory, from the home page look for Provider Directory and click on Search Now.
- You can search for a specific physician or physician group, or get a personalized directory of your county or the entire state.
- This is a live version of our directory and we update it daily.
• MCO plans are required to offer at a minimum the same benefits as Healthy Connections Fee for Service (FFS). Plans can choose to offer additional benefits.

• A complete description of core services is in the Member Handbook (Evidence of Coverage) and/or the Provider Operations Manual, both on our website.
Value-Added Benefits

In addition to core benefits, BlueChoice HealthPlan Medicaid also offers several value-added benefits that Healthy Connections does not offer:

- We cover circumcisions as a part of the initial inpatient stay, as well as in the office for up to 30 days of life.
- We provide free manual breast pumps for our pregnant members.
- We provide gift cards to members who complete their annual wellness checks and pregnant members who attend all prenatal visits.
These beneficiaries continue to be exempt from copay requirements:

- Children under 19 years of age
- Pregnant women
- Institutionalized individuals
- Individuals receiving emergency services in the emergency room
- Individuals receiving Medicaid hospice services
- Members of a federally recognized Indian Tribe (exempt when services are rendered by the Catawba Service Unit in Rock Hill and when referred to a specialist by Catawba)
These services are not subject to copays:

- Preventive services for adults
- Urgent care services for adults
- Medical equipment and supplies provided by DHEC
- Family planning
- End Stage Renal Disease services
- Infusion centers
• We have an exclusive agreement with LabCorp for all labs.
• Labs sent to LabCorp do not require precertification.
• You can send anatomical pathology and cytology specimens to a local contracting pathology group or to LabCorp without precertification.
• See our website for a complete list of labs that can be done in your office and billed to BlueChoice HealthPlan Medicaid.
Beginning October 2013, MEDTOX laboratories began providing your office with free lead screening kits that include:

- A blood sample card
- Lancets
- A plastic, sealable storage bag
- Requisition form
- Prepaid envelope
Precertifications

In-Network Precertification Process

• Providers can contact via fax: 800-823-5520 or phone: 866-902-1689

• List of services requiring PA is available at www.BlueChoiceSCMedicaid.com

Out-of-Network (OON) Referrals

• Effective 10/14/13, OON referrals must be authorized. We will seek in-network alternatives on all OON requests.
Please note: The list of services requiring authorization provided on the website is not an all-inclusive list. Please contact Utilization Management if you have questions about a particular CPT code.
• Four prescriptions are allowed in a calendar month (for adults only – children have no limit)
• Point of Service (POS) Pharmacy Override – four-prescription limit can be overridden at the discretion of the pharmacist
• To request precertification, contact ExpressScripts by calling 800-470-0933 or faxing request to 866-807-6241. ExpressScripts is an independent company that offers precertification services on behalf of BlueChoice HealthPlan.

• Specialty pharmaceuticals are now managed by Coram, contact at 877-267-2679. Coram is an independent company that manages specialty pharmacy benefits on behalf of BlueChoice HealthPlan.
Precertifications: Pharmacy

• Prescription Drug List (PDL) including a list of drugs requiring precertification is on our website.

• Please be aware that you can download the PDL to your EMR. This can make it easier and more efficient for your nurses and physicians to prescribe.
Claim Filing Limits
• All providers are allowed 365 days to submit claims.

Electronic Data Interchange (Payer ID 00403)
• Preferred and fastest way to submit your claims.
• For set up and information call 800-470-9630.

Corrected Claims and Correspondence
• If you need to submit a corrected claim, file an appeal or submit any type of correspondence please mail to:

  BlueChoice HealthPlan Medicaid
  ATTN: Medicaid Claims
  PO Box 100124
  Columbia, SC 29202-3124
Appeals

• We must receive appeals within **30 days** from the process date to consider them for review.

• You must submit appeals with the Provider Dispute Resolution Form
Original and Corrected Claims

**Original Claims**
- You must submit original claims within **365** days of the date of service

**Corrected Claims**
- We must receive corrected claims within **90** days from the process date to consider them for payment.
- You must submit corrected claims with the Claim Follow-Up Form.
Participating providers get our monthly newsletter. Topics include:

- Coding tips
- Current DHHS bulletins
- Updates on authorization requirements and policy changes
- HEDIS information

If you don’t currently receive BlueBlast or have suggestions for future topics, please contact your provider representative.
Remember: all contact information for BlueChoice HealthPlan Medicaid is different than commercial BlueChoice HealthPlan.

- **Website:** [www.BlueChoiceSCMedicaid.com](http://www.BlueChoiceSCMedicaid.com)

**Customer Care Center:** (verify eligibility, benefits, claims status, general questions, etc.)
- **Voice:** 866-757-8286  
  **Fax:** 912-233-4010 or 912-235-3246  
  **TTY:** 866-773-9634  
  **Monday to Friday:** 8 a.m. to 6 p.m.

**24-Hour Nurse Line**
- **Voice:** 866-577-9710  
  **TTY:** 800-368-4424

**Utilization Management** (Prior Auth and Hospital/Facility Admission Notification):
- **Voice:** 866-902-1689  
  **Fax:** 800-823-5520  
  **Monday to Friday:** 8 a.m. to 5 p.m.

**Case Management** (Care Coordination and WIC Information):
- **Voice:** 877-833-5736  
  **Fax:** 866-406-2808  
  **WIC:** 800-868-0404  
  **Monday to Friday:** 8 a.m. to 5 p.m.  
  **24 hours a day, 7 days a week**

**ExpressScripts** (Pharmacy Benefits)
- **Voice:** 800-470-0933  
  **Fax:** 866-807-6241  
  **Monday to Friday:** 8 a.m. to 9 p.m.  
  **Saturday to Sunday:** 8 a.m. to 6 p.m.
ICD-10-CM
Why the Transition?

ICD-10 codes refine and improve operational capabilities and processing by:

• Supplying detailed information on condition, severity, comorbidities, complications and location

• Increasing diagnosis code length to seven characters to expand coding flexibility
ICD-10 Compliance

- ICD-10 code sets are required for transactions with Date of Service or Date of Discharge on or after October 1, 2014.

- Applies to ALL BlueCross lines of business for:
  - Eligibility requests
  - Precertifications/authorizations
  - Claims
# ICD-10 Compliance

## ICD-9 to ICD-10 Code Expansion

<table>
<thead>
<tr>
<th></th>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis Codes</td>
<td>14,567</td>
<td>69,823</td>
</tr>
<tr>
<td>Procedure Codes</td>
<td>3,882</td>
<td>71,924</td>
</tr>
<tr>
<td>Total</td>
<td>18,449</td>
<td>141,747</td>
</tr>
</tbody>
</table>
Phases to Implementation

1. Planning
2. Communication and Awareness
3. Assessment
4. Operational Implementation
5. Testing
6. Transition
Two Phases of Provider Testing

Phase I (DRG-focused testing) – Available now.

• BlueCross supplies spreadsheet of paid inpatient facility claims to hospital.
• Hospital codes claims using ICD-10 codes and returns to BlueCross.
• Claims are processed through the ICD-10 DRG software.
• BlueCross and the hospital compare ICD-9 and ICD-10 DRG assignment to identify payment impacts.
Two Phases of Provider Testing

Phase II (Transaction-focused testing) – Available early 2014.

- Provider creates claims with ICD-10 codes in the HIPAA-compliant X12 format.
- Provider submits claim files to the BlueCross electronic gateway*.
- We process claims in a “production-like” test environment that simulates a post-Oct. 1, 2014 production environment.

*Providers that use a clearinghouse must arrange test submissions with their vendors.
• After you have identified your work processes and current systems coded for ICD-9, speak with your practice management vendor about implementation plans for ICD-10.

• Budget for time and costs related to ICD-10 implementation – expenses for system changes, staff training needs and resource materials.

• Talk with your payers, clearinghouses and billing services about how implementing ICD-10 might affect your contracts.
Web Services
The new version of our website went live September 2013.
Education Center

- BlueNewsSM for Providers
- Training Documents
  - VRU Guide
  - Web Precert
- Palmetto Provider University
- HIPAA Critical Center
- Quality Initiatives
Demographic Changes

- Any time there is a change in your practice demographics, contact Provider.cert@bcbssc.com or fax a completed form to 803-264-4795.
- This ensures we update all lines of business, including BlueCross, BlueChoice and BlueChoice HealthPlan Medicaid.
- Changes include:
  - Adding a physician
  - Terminating a physician
  - Adding a satellite location
  - Change in address, phone number or email address
  - Panel status
My Insurance Manager and VRU

Please use the Web/VRU and/or the HIPAA electronic transactions for:

- Claim status
- Eligibility/benefits
- Precertification
- Appeals
- Review medical policies
- Much, much more.
Web Precertifications

Preferred method of submissions for all providers!

• We accept/process 100 percent of referral requests
• 80 percent of Fast Track submissions receive an automatic precertification
• We grant most other precertifications within four to 24 hours of submission
• Provide complete information to avoid delays
Web Precertifications

Preferred method of submissions for all providers!

• You can submit clinical documentation right in the notes field if necessary
• Our internal staff of precertification technicians and nurses works very closely together to review and authorize your patients’ procedures as quickly as possible
Use our BlueCard Precertification tool to check medical policies and get general precertification requirements for out-of-area Blue patients. You can also get the contact information you need to initiate precertifications.
• BlueCross Plans launched a new tool January 1, 2014, that lets you access out-of-area members’ Blue Plan (Home Plan) provider portals to conduct electronic pre-service review.

• You can access our version of this tool through My Insurance Manager℠

• Electronic Provider Access (EPA) will enable you to use My Insurance Manager to gain access to a BlueCard member’s Home Plan provider portal through a secure routing mechanism.
BlueCard Precertification

• Once in the Home Plan provider portal, you can electronically submit for precertification through its site.

• A separate sign-on is not required once you have been routed to the Home Plan landing page.

• The availability of EPA on January 1, 2014, will vary depending on the capabilities of each Home Plan.
<table>
<thead>
<tr>
<th>BCBS SC</th>
<th>BCBS HI</th>
<th>Anthem BCBS MO</th>
<th>Anthem BCBS VA</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCBS AL</td>
<td>BC Idaho</td>
<td>Anthem BCBS NV</td>
<td>Anthem BCBS WI</td>
</tr>
<tr>
<td>BCBS AR</td>
<td>Regence</td>
<td>Anthem BCBS NH</td>
<td>Anthem BCBS GA</td>
</tr>
<tr>
<td>BS CA</td>
<td>Anthem IN</td>
<td>Excellus</td>
<td></td>
</tr>
<tr>
<td>Anthem BCBS CO</td>
<td>Wellmark</td>
<td>Empire BCBS</td>
<td></td>
</tr>
<tr>
<td>Anthem BCBS CT</td>
<td>BCBS KS</td>
<td>BCBS ND</td>
<td></td>
</tr>
<tr>
<td>Highmark BCBS</td>
<td>Anthem BCBS KY</td>
<td>Anthem BCBS of OH</td>
<td></td>
</tr>
<tr>
<td>CareFirst</td>
<td>Anthem BCBS ME</td>
<td>Capital</td>
<td></td>
</tr>
<tr>
<td>BCBS FL</td>
<td>BCBS MI</td>
<td>NEPA</td>
<td></td>
</tr>
<tr>
<td>Anthem BC CA</td>
<td>BCBS MS</td>
<td>BCBS TN</td>
<td></td>
</tr>
</tbody>
</table>

These plans are expected to have completed implementation and go live January 2014.
Blue Cross and Blue Shield Association Updates

<table>
<thead>
<tr>
<th>July 2014</th>
<th>September 2014</th>
<th>April 2015</th>
<th>July 2015</th>
<th>Pending</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCBS NC</td>
<td>Independence BlueCross</td>
<td>Horizon BCBS NJ</td>
<td>Premera BCBS AK/WA</td>
<td>BCBS LA</td>
</tr>
<tr>
<td>BCBS NM</td>
<td>Excellus BCBS Rochester*</td>
<td>BCBS MN</td>
<td>BCBS VT</td>
<td>BCBS WY</td>
</tr>
<tr>
<td>BCBS NE</td>
<td>Excellus BCBS Central NY*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BCBS IL</td>
<td>Excellus BCBS UticaWater*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BCBS MA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BCBS OK</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BCBS RI</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BCBS TX</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Electronic PSR available for most services September 2014. Electronic PSR for high-tech for radiology will be available January 2014.

- These plans are in process of enacting the precertification requirement by the dates shown.
National Imaging Associates (NIA)
National Imaging Associates (NIA) is an independent company that handles precertification for certain imaging services on behalf of BlueCross and BlueChoice.

Non-emergency procedures requiring pre-authorization are: Computerized Axial Tomography (CAT) Scan, Positron Emission Tomography (PET) Scan, Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA).

Visit www.RadMD.com or call 866-500-7664 to request pre-authorization or to check the status of a pre-authorization request.
<table>
<thead>
<tr>
<th>BlueCross BlueShield of South Carolina</th>
<th>BlueChoice HealthPlan</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="http://www.radmd.com">www.radmd.com</a></td>
<td><a href="http://www.radmd.com">www.radmd.com</a></td>
</tr>
<tr>
<td>• Computerized Axial Tomography (CAT) Scans</td>
<td>• Computerized Axial Tomography (CAT) Scans</td>
</tr>
<tr>
<td>• Magnetic Resonance Imaging (MRI)</td>
<td>• Magnetic Resonance Imaging (MRI)</td>
</tr>
<tr>
<td>• Magnetic Resonance Angiography (MRA)</td>
<td>• Magnetic Resonance Angiography (MRA)</td>
</tr>
<tr>
<td>• Positron Emission Tomography (PET) Scans</td>
<td>• Positron Emission Tomography (PET) Scans</td>
</tr>
<tr>
<td></td>
<td>• Cardiac Computed Tomography Angiography (CCTA)</td>
</tr>
<tr>
<td></td>
<td>• Nuclear Cardiology Exams</td>
</tr>
</tbody>
</table>
Here are groups effective January 1, 2014 with NIA and the respective alpha prefixes.

- Arthrex-AEW and AXG
- Compass Minerals-KMS
- FL Cancer Specialists-FCO
- Gilman Investment-GMN
- Resolute FP US INC.-BOA
For More Information

Visit our websites for more information, including a complete list of alpha prefixes for members who require authorization through NIA, NIA reference guides and frequently asked questions.
Appeal Requests

Appropriate Reasons to Appeal:
- Medical necessity
- Extenuating medical circumstances
- Unusually complex procedures

Inappropriate Appeal Requests:
- Benefit exclusions
- Non-covered services
- Corrected claim
- Membership issues

Need the form?
http://web.southcarolinablues.com/UserFiles/scblues/Documents/Providers/Medical%20Review%20Form%208-27-12_Interactive.pdf
Refund Process Update

• When you identify an overpayment on a member’s account, you should complete an overpayment form found on these sites:

  • BlueCross  
  • BlueChoice  

• Provide documentation supporting the refund and include a check for the appropriate amount.

• Please send the information to the appropriate address on the form.
BlueCard
Meet Eliza

This is her BlueCross of Massachusetts ID card.

<table>
<thead>
<tr>
<th>Member Name</th>
<th>Dependent One</th>
<th>Dependent Two</th>
<th>Dependent Three</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member ID</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>XYZ123456789</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group No.</td>
<td>023457</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BIN</td>
<td>987654</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit Plan</td>
<td>HIOPHT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effective Date</td>
<td>00/00/00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Plan | PPO
---|----
Office Visit | $15
Specialist Copay | $15
Emergency | $75
Deductible | $50

Rx

113
Provider submits claim to local Plan.

Local Plan applies pricing according to the provider’s contract and electronically forwards the claim to the member’s Home Plan.

Home Plan processes according to member’s benefits and transmits data back to local Plan.

Home Plan sends EOB to member. Local Plan sends remittance and payment to provider.
<table>
<thead>
<tr>
<th>Request</th>
<th>BlueCross BlueShield of South Carolina</th>
<th>Member’s Home Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility and Benefits</td>
<td><strong>800-676-BLUE (2583)</strong></td>
<td>View ID card for pre-authorization telephone number.</td>
</tr>
<tr>
<td>Pre-Authorization</td>
<td>View ID card for pre-authorization telephone number.</td>
<td>View ID card for pre-authorization telephone number.</td>
</tr>
<tr>
<td>Claim Submission</td>
<td>File ALL claims electronically to your local Plan.</td>
<td></td>
</tr>
<tr>
<td>Claim Status</td>
<td><a href="http://www.southcarolinablues.com">www.SouthCarolinaBlues.com</a></td>
<td></td>
</tr>
</tbody>
</table>
• The Association has selected Verisk Health, Inc. to gather medical records behalf of BlueCross Plans for non-claims related purposes.
• Verisk is the Medical Records Retrieval Coordinator (MRRC) to support risk adjustment, Healthcare Effectiveness Data and Information Set (HEDIS), and other government-required programs related to the Affordable Care Act (ACA).
Medical record retrieval functions involve:

- Retrieving and digitizing records (e.g., PDF)
- Associating images to patient information for better indexing
- Delivering records to requesting Plans through a secure online portal
- Storing records electronically for reference
Federal Employee Program (FEP)
## 2014 Benefit

### Catastrophic Out of Pocket:

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Payment Level Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual (Self only)</td>
<td>100% payment level begins after $5,000 in network with Preferred providers or $7,000 for Non-Preferred providers</td>
</tr>
<tr>
<td>Individual and Family</td>
<td>100% payment level begins after you pay $6,000 with Preferred providers and or $8,000 for Non-Preferred providers</td>
</tr>
</tbody>
</table>

Catastrophic out-of-pocket maximum includes the calendar year deductible, in addition to coinsurance and copays.
<table>
<thead>
<tr>
<th>Visits allowed</th>
<th>50 per calendar year</th>
</tr>
</thead>
</table>

2014 Benefit

Nursing Home Care:

- Visits allowed: 50 per calendar year

FEP Standard Option
<table>
<thead>
<tr>
<th>2014 Benefit</th>
<th>Catastrophic Out of Pocket:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual (Self only)</td>
<td>100% payment level begins after $5,500 in network with Preferred providers</td>
</tr>
<tr>
<td>Individual and Family</td>
<td>100% payment level begins after you pay $7,000 with Preferred providers</td>
</tr>
</tbody>
</table>

Catastrophic out-of-pocket maximum includes the calendar year deductible, in addition to coinsurance and copays.
<table>
<thead>
<tr>
<th>Service</th>
<th>2014 Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical procedures performed outside the office setting</td>
<td>$200 copay per performing surgeon</td>
</tr>
<tr>
<td>Inpatient admission to a Preferred facility</td>
<td>$175 copay per day up to a maximum of $875 for unlimited days</td>
</tr>
<tr>
<td>Maternity inpatient admission</td>
<td>$175 copay to a Preferred facility</td>
</tr>
<tr>
<td>Service</td>
<td>2014 Benefit</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Diagnostic Tests (EEGs, ultrasounds and X-rays)</td>
<td>$40 copay when performed by a Preferred professional provider</td>
</tr>
<tr>
<td>Diagnostics Tests (MRIs, CT scans, genetic tests and nuclear medicine)</td>
<td>$100 copay when performed by a Preferred professional provider</td>
</tr>
<tr>
<td>Diagnostic tests and radiological services (MRIs, CT scans, genetic tests and nuclear medicine)</td>
<td>$150 copay when performed by a Preferred facility (i.e. hospital or ambulatory surgery center)</td>
</tr>
<tr>
<td>Neurological testing</td>
<td>$40 copay when performed by a Preferred professional provider or facility</td>
</tr>
</tbody>
</table>
**Service** | **2014 Benefit**
--- | ---
*Genetic testing for breast cancer (BRCA Testing)* | Available to eligible females, age 18 and over, who have not been diagnosed with breast or ovarian cancer. BRCA testing is limited to one BRCA test per lifetime at a Preferred facility.

*Specific criteria must be met prior to having this test rendered.*
Please visit www.fepblue.org for a complete listing of the 2014 FEP benefits.
State Health Plan
State Health Plan

Standard Plan

Savings Plan
## State Health Plan: Standard Plan

### DEDUCTIBLES

<table>
<thead>
<tr>
<th>Service</th>
<th>2013 Benefit</th>
<th>2014 Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Deductible</td>
<td>$350</td>
<td>$420</td>
</tr>
<tr>
<td>Family Deductible</td>
<td>$700</td>
<td>$840</td>
</tr>
</tbody>
</table>

### COPAYS

<table>
<thead>
<tr>
<th>Service</th>
<th>2013 Benefit</th>
<th>2014 Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visits</td>
<td>$10</td>
<td>$12</td>
</tr>
<tr>
<td>Outpatient Facility Services</td>
<td>$75</td>
<td>$90</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$125</td>
<td>$150</td>
</tr>
</tbody>
</table>

### COINSURANCE MAXIMUM

<table>
<thead>
<tr>
<th>Service</th>
<th>2013 Benefit</th>
<th>2014 Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual-Network</td>
<td>$2000</td>
<td>$2400</td>
</tr>
<tr>
<td>Family-Network</td>
<td>$4000</td>
<td>$4800</td>
</tr>
<tr>
<td>Individual-Out of network</td>
<td>$4000</td>
<td>$4800</td>
</tr>
<tr>
<td>Family-Out of network</td>
<td>$8000</td>
<td>$9600</td>
</tr>
<tr>
<td>Service</td>
<td>2013 Benefit</td>
<td>2014 Benefit</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>--------------</td>
<td>--------------</td>
</tr>
<tr>
<td><strong>DEDUCTIBLES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual Deductible</td>
<td>$3000</td>
<td>$3600</td>
</tr>
<tr>
<td>Family Deductible</td>
<td>$6000</td>
<td>$7200</td>
</tr>
<tr>
<td><strong>COINSURANCE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MAXIMUM</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual-Network</td>
<td>$2000</td>
<td>$2400</td>
</tr>
<tr>
<td>Family-Network</td>
<td>$4000</td>
<td>$4800</td>
</tr>
<tr>
<td>Individual-Out of network</td>
<td>$4000</td>
<td>$4800</td>
</tr>
<tr>
<td>Family-Out of network</td>
<td>$8000</td>
<td>$9600</td>
</tr>
</tbody>
</table>
New Groups
## Preferred Blue
- BMW Pharmacy (BWF)
  - Stand-alone pharmacy benefit managed by Caremark
- Denny’s Restaurant (DNE)
- Southeast QSR & Carolina Family Restaurant Association (LSQ)
- JW Aluminum (KWJ)

## BlueChoice
- Berkeley Electric
- Island Capital
Preferred Blue
Preferred Blue

South Carolina

Member Name
Jane Q Doe
Member ID
ABC123456789012

RxBIN
004336
RxGRP
SCB15
Plan Code
380
Mammography Network

www.SouthCarolinaBlues.com

BCBS Plan Name

Member Name
SUBSCRIBER NAME

Member ID
XXX123614046483

RxBIN
004336
RxGRP
SCBXX
PLAN CODE
380

PPO
Website: www.SouthCarolinaBlues.com

- Preferred method for eligibility, benefits, authorization requests and claim status. This service is available to you 24 hours a day!

Voice Response Unit (VRU): 800-334-2583

- General inquiries, verification of member eligibility, benefits, authorization status and claims status. Service representatives are available by telephone for more complicated questions Monday through Friday from 8:30 a.m. until 8 p.m.
Health Care Services: 800-327-3238

• Authorization for services

Companion Benefit Alternatives (CBA): 800-868-1032

• Mental health and substance abuse referrals and authorizations. CBA is a separate company that manages behavioral health benefits on behalf of BlueCross and BlueChoice.
Savannah River Nuclear Services and Savannah River Remediation
Alpha Prefixes

Savannah River Nuclear Services
- SDB-Pre-65 Retirees
- SRS-COBRA
- SRS-Active Employees

Savannah River Remediation
- SYE-Pre-65 Retirees
- URR-COBRA
- SCB-Active Employees
**Active Plans and Pre-65 Retiree Plans**

- Members must meet deductibles for in-network, out-of-network and prescription benefits
- Deductibles will increase by $200 for individual and $400 for family – all plans
Changes to Copays and Coinsurance

• No change to copay amounts for any service, however, copays will now count towards the out-of-pocket maximum.

• Coinsurance amounts are changing for the Standard and Prime plans. Effective January 1, 2014, coinsurance will be 15 percent.

Exception:

<table>
<thead>
<tr>
<th>Service</th>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>OON Chiropractic Care</td>
<td>80%</td>
</tr>
<tr>
<td>Use of Emergency Room for Routine Care</td>
<td>70%</td>
</tr>
</tbody>
</table>
### Pharmacy Programs

<table>
<thead>
<tr>
<th>Mandatory Generic</th>
<th>When generic medications are available but not used, medications will reimburse at 80% (Preferred) or 70% (Non-Preferred) plus any difference in cost between generic and brand-name drug.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step Therapy</td>
<td>Members required to try cost-effective “First Choice” medications before trying or “stepping up to” more expensive “Second Choice” medications.</td>
</tr>
<tr>
<td>Quantity Management</td>
<td>Program limits the amount of medication covered by the plan. The plan will cover higher amounts of some medications when medically necessary.</td>
</tr>
<tr>
<td>Prior Authorization</td>
<td>Certain drugs require prior authorization before the plan will cover. Additions as of 1/1/14: Insulins: Apidra, Humalog, and Humlin, Breo Ellipta; Rayos; Kazano, Nesina, Oseni, Tradjenta, Jentadueto</td>
</tr>
<tr>
<td>Specialty Pharmacy</td>
<td>Accredo (as of 11/11/13). Accredo is an independent company that offers specialty pharmacy benefits on behalf of BlueCross and BlueChoice.</td>
</tr>
</tbody>
</table>
Pharmacy Updates

• As of January 1, 2014, the preferred Insulin changed to Novolog or Novolin.

• Members currently using Humalog, Humulin and/or Apidra received a letter stating their current prescriptions will require prior authorization. If granted, non-preferred rates (70 percent) will apply.
Greenville Hospital System (GHS) Members
Greenville Hospital System (GHS) Members

- Greenville Hospital System (GHS) members will receive new cards mid-January, 2014. We sent a letter to members to advise them of this and requested they use the letter in lieu of a plan ID card until we issue new cards.

- Benefits and eligibility will be available for verification January 1, 2014. You can verify benefits using My Insurance Manager on www.SouthCarolinaBlues.com to send an electronic eligibility (270 transaction) to BlueCross. You can also call the Provider Voice Response Unit (VRU) at 800-868-2510. Please note you can use a member’s current GHS ID card to get the correct member ID number.
BlueChoice HealthPlan
HMO: Primary Choice
High Deductible Open Access Health Plans
Individual Plans: MyChoice

**My Choice Individual Coverage HDHP**

- **JOHN DOE**
- **ZCL00000000**

Plan: PPO
Plan Code: 380.04
RxBIN: 004336
PCN/GRP: CHC

Health Benefits:
- Deductible: $5000
- Preventive Care: NO DEDUCTIBLE

**My Choice Open Access VALUE PLAN**

- **JOHN DOE**
- **ZCL00000000**

Plan: PPO
Plan Code: 380.04
RxBIN: 004336
PCN/Grp: CHC

Doctors Care: $5
CVS Minute Clinic: $5
Primary Care: $40

RX PPO
Great Expectations for Health

- Alcohol Management
- Asthma
- Back Care
- Children’s Health
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease *(COPD)*
- Depression
- Diabetes
- Get In Control *(Hypertension & High Cholesterol)*

- Healthy and Active Kids *(Childhood Obesity)*
- Heart Disease
- Heart Failure
- Maternity
- Men’s Health
- Migraine
- Pre-Diabetes
- Quit Smoking
- Weight Management
- Women’s Health
Great Expectations® *for health* Programs

- Integrate disease management and preventive services to support the health of our members

- Members with identified risks receive:
  - New member/enrollment packet
  - Educational materials, such as newsletters and calendars
  - Written reminders for needed care such as screening tests, eye exams, physician follow-ups
Members with identified risks also receive:

- Coaching phone calls with a health specialist
- Case management for poorly controlled conditions
- Letters about elevated lab values, follow-up with physician
- Free tools for self management: blood sugar monitors, peak flow meters, etc.
Pharmacy Services
• **Medicare Advantage:**
  
  • Has its own formulary and drug management programs
  
  • Prime will be the new pharmacy benefits manager (PBM) starting in January

• **New ACA products:**
  
  • Caremark will be the PBM for both non-specialty and specialty drug coverage
  
  • There are Covered Drug List and drug management programs that are unique to these products
Overview BlueCross Pharmacy Management Update

• Preferred Drug List Changes
• Utilization Management Program Changes
  • Prior Authorization
  • Quantity Management
  • Step Therapy
• Specialty Pharmacy
Drug Updates

Drugs moving to a higher tier and their Preferred List alternatives.

- **Apidra, Humalog and Humulin***
  - Novolog, Novolin

- **Byetta**
  - Bydureon, Victoza
clozapine, clozapine ODT, olanzapine, risperidone, quetiapine, ziprasidone

- **Fazaclo**

- **Hepsera, Tyzeka**
  - Baraclude, Viread

- **Namenda IR**
  - donepezil (generic aricept)

*Humulin U-500 will remain tier 2, preferred*
Effective January 1, 2014 for most members

• Adding nine drugs to current prior authorization list and removing one drug

• New users must request and receive prior authorization approval to have coverage for these drugs in 2014

• Some current users must request prior authorization approval to continue using them in 2014

• Visit www.SouthCarolinaBlues.com and see the Prescription Drug Information page for details.
New Prior Authorization Drugs

- **Apidra, Humalog and Humulin**
- **Breo Ellipta**
- **Rayos**
- **Kazano, Nesina, Oseni**
- **Tecfidera**

**Insulin:** Novolog, Novolin

**COPD:** Advair, Symbicort

**Corticosteroids:** Immediate-release prednisone

**Diabetes (DPP4):** Januvia, Janumet, Onglyza, Kombiglyze

**Multiple Sclerosis:** Ampyra, Copaxone, Rebif

*Current users will be grandfathered (not be subject to prior authorization) for life*
Quantity Management and Step Therapy Updates

Quantity Management:

- **Sumavel**, a needleless injectable migraine medication, will be limited to **one box per month**

Step Therapy Additions:

- **Fabior** is being added to the current Step Therapy criteria for acne

<table>
<thead>
<tr>
<th>First Choice Drugs</th>
<th>Used to treat</th>
<th>Second Choice Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>generic topical tretinoin</td>
<td>Acne</td>
<td>Atralin, Avita, Differin, <strong>Fabior</strong>, Retin-A, Retin-A Micro, Tazorac, Tretin-X, Veltin or Ziana</td>
</tr>
</tbody>
</table>

You must first try one of these drugs or your doctor must request an exception for you … before you can get coverage for these drugs.
<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>USED TO TREAT</th>
<th>PA ADDED?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexxar</td>
<td>Non-Hodgkins lymphoma</td>
<td>No</td>
</tr>
<tr>
<td>Gilotrif</td>
<td>Non-small cell lung cancer</td>
<td>No</td>
</tr>
<tr>
<td>Mekinist</td>
<td>Melanoma</td>
<td>No</td>
</tr>
<tr>
<td>Rixubis</td>
<td>Hemophilia B</td>
<td>No</td>
</tr>
<tr>
<td>Simponi Aria</td>
<td>Rheumatoid arthritis</td>
<td>No</td>
</tr>
<tr>
<td>Tafinlar</td>
<td>Melanoma</td>
<td>No</td>
</tr>
<tr>
<td>Valchlor</td>
<td>Cutaneous T-cell lymphoma</td>
<td>No</td>
</tr>
<tr>
<td>Xofigo</td>
<td>Prostate cancer</td>
<td>No</td>
</tr>
</tbody>
</table>
BlueChoice HealthPlan Medicaid

- Has its own formulary and drug management programs
- WellPoint administers the pharmacy benefit. WellPoint is an independent company that administers the pharmacy benefit on behalf of BlueChoice HealthPlan Medicaid.
New ACA Products

- Caremark will be the PBM for both non-specialty and specialty drug coverage
- There is a Covered Drug List and drug management programs that are unique to these products
• Preferred Drug List Changes

• Utilization Management Program Changes
  • Prior Authorization
  • Step Therapy

• Specialty Pharmacy
Drug Updates

These are drugs moving to tier 3, with their Preferred status alternatives.

- **Byetta** → **Bydureon, Victoza**
- **Crestor, Vytorin** → **Atorvastatin**
Prior Authorization List Changes

Effective January 1, 2014 for most members:

• Adding 15 drugs to current prior authorization list

• **New users** must request and receive prior authorization approval to have these drugs covered in 2014

• **Some current users** must request prior authorization approval to continue using them in 2014

• Visit [www.BlueChoiceSC.com](http://www.BlueChoiceSC.com) and see the Prescription Drug Information page for details
New Prior Authorization Drugs (effective January 1, 2014)

High Blood Pressure: candesartan, candesartan/hydrochlorothiazide, eprosartan, irbesartan, irbesartan/hydrochlorothiazide, losartan, losartan/hydrochlorothiazide, valsartan/hydrochlorothiazide, Benicar, Benicar HCT, Diovan

High Cholesterol (High Potency): atorvastatin

*Members taking Crestor 40mg or Vytorin 10/80mg will be grandfathered and not subject to the PA. They will have a tier change.

High Cholesterol: astorvastatin, fluvastatin, lovastatin, pravastatin, simvastatin

Diabetes (insulin): Novolog, Novolin

Diabetes (DPP-4): Januvia, Janumet, Janumet XR, Kombiglyze, Onglyza

Corticosteroids: immediate-release prednisone

COPD: Advair, Symbicort

Apidra

Kazano, Nesina, Oseni

Rayos

Brevo Ellipta

Crestor, Vytorin*

Lescol, Lescol XL, Lipitor, Mevacor, Pravachol, Zocor

Diovan HCT
New Prior Authorization Drugs (effective January 1, 2014)

- Tracleer, Letairis, Revatio, Sildenafil, Adcirca*
- Incivek, Victrelis**

*Grandfathered for life
**Current users will be grandfathered and not be subject to prior authorization until January 1, 2015

Prior authorization is being removed from iron replacement drugs and Boniva IV.
Beginning January 1, 2014, **Fabior** is being added to the current Step Therapy criteria for acne. You must first try one of these drugs or your doctor must request an exception for you …

<table>
<thead>
<tr>
<th>First Choice Drugs</th>
<th>Used to treat</th>
<th>Second Choice Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>generic topical tretinoin</td>
<td>Acne</td>
<td>Atralin, Avita, Differin, <strong>Fabior</strong>, Retin-A, Retin-A Micro, Tazorac, Tretin-X, Veltin or Ziana</td>
</tr>
</tbody>
</table>

... before you can get coverage for these.
### Specialty Drug List Update

#### Adding Drugs to the List

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>USED TO TREAT</th>
<th>PA ADDED?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bexxar</td>
<td>Non-Hodgkins lymphoma</td>
<td>No</td>
</tr>
<tr>
<td>Gilotrif</td>
<td>Non-small cell lung cancer</td>
<td>No</td>
</tr>
<tr>
<td>Mekinist</td>
<td>Melanoma</td>
<td>No</td>
</tr>
<tr>
<td>Rixubis</td>
<td>Hemophilia B</td>
<td>No</td>
</tr>
<tr>
<td>Simponi Aria</td>
<td>Rheumatoid arthritis</td>
<td>No</td>
</tr>
<tr>
<td>Tafinlar</td>
<td>Melanoma</td>
<td>No</td>
</tr>
<tr>
<td>Valchlor</td>
<td>Cutaneous T-cell lymphoma</td>
<td>No</td>
</tr>
<tr>
<td>Xofigo</td>
<td>Prostate cancer</td>
<td>No</td>
</tr>
</tbody>
</table>
Educational Outreach

• We sent member-specific mailings in November
  • Targeted members impacted by tier changes* and Utilization Management program changes

• We sent notifications to South Carolina physicians about the insulin change in November

*We do not routinely notify members about tier changes when a brand drug moves to tier 3 due to a generic launch.
Patient Protection and Affordable Care Act (PPACA)
Starting in 2014, non-grandfathered health plans in the individual and small group markets, within the Health Insurance Marketplace (exchanges), must offer a core package of items and services called “essential health benefits.”
Benefits must include services in 10 categories:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
Benefits must include services in 10 categories:

6. Prescription drugs
7. Habilitative and rehabilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care
Grandfathered vs. Non-Grandfathered

Current guidelines state everyone’s insurance must meet certain criteria:

• Grandfathered plans can maintain their current status as long as their benefits do not change substantially.

• Individuals are now allowed to keep their current coverage until 2015.
DME Breast Pumps Update

- Breast pump standard now includes electric pump
- A dual manual (E0602) or a standard, dual electric breast pump (E0603) is MEDICALLY APPROPRIATE for purchase for all women who choose to breast-feed.
- Rental of a heavy-duty, hospital grade electric breast pump (E0604) and purchase of necessary supplies is MEDICALLY APPROPRIATE during the time a mother and infant are separated because the infant remains hospitalized upon the mother's discharge.
For More Information

• Visit our website and under Providers, see the Health Care Reform section.
• We will continue to add or update information as we get new regulations or further guidance from the federal government.
• Also visit www.ahealthysc.tv.
Health Insurance Marketplace
What Is a Health Insurance Marketplace?

Qualified health plans offer uniform benefit packages:

- Gold – 80%
- Silver – 70%
- Bronze – 60%
- Catastrophic coverage
What Is a Health Insurance Marketplace?

There are two types of marketplaces – Exchanges – that are designed for individuals and small groups to shop for health insurance.

• Public, or the Federally Facilitated Marketplace (FFM)
• Private marketplace
  • Individuals = uninsured, underinsured, eligible for federal subsidy or cost-share reduction
  • Small businesses = 50 or fewer employees
Benefit Overview

All preventive benefits at 100 percent on designated services as outlined by the U.S. Preventive Services Task Force (USPSTF)

- Includes prostate screenings, pediatric oral and vision care, health resources and health services administration

There are no benefits for out-of-network providers.

- Benefits are for in-network providers only unless it is a true emergency.

Women’s preventive benefits at 100 percent.

- On designated services
Benefit Overview

**Pediatric vision and dental**

- Children are covered beginning at 0 years of age through the end of the benefit period of their 19th birthday.

**Prescription drug benefits**

- Copays, deductibles/coinsurance and a combination of all are integrated.

**Benefit periods**

- All individual plans will be calendar year.
Benefit Overview

Medical Maximum Out of Pocket (MOOP)

- Medical, pediatric vision and dental, and drug copays/deductibles/coinsurance all feed the MOOP.
- When the MOOP is met, benefits are covered at 100 percent.
- Copays/deductibles/coinsurance all cease when the MOOP is met.

Preauthorization

- If a preauthorization is not received, individual plans will deny all benefits on inpatient admissions.

BlueCard® Processing

- All individual plans have BlueCard coverage.
Federal Subsidy – A Closer Look

Individuals can save money in the marketplaces if they qualify in one of these ways:

• Premium Subsidy
  • If the amount of advance premium payments received for the year is less than the tax credit due when his or her federal income taxes are filed, the member gets the difference.
  • It depends on income and family size.
Individuals can save money in the marketplaces if they qualify in one of these ways:

• **Cost-sharing Subsidy**
  
  • People who earn less than 250 percent of the federal poverty line will get additional assistance.
  
  • Cost sharing will limit the plan's maximum out-of-pocket costs. For some, it will also reduce other cost-sharing amounts (i.e. deductibles, coinsurance or copays) they would otherwise have to pay.
  
  • Depending on income, the savings amount differs for each family size (up to eight).
1. The individual will select a plan and complete an online application.

2. The marketplace will forward the enrollment application to BlueEssentials or MyChoice Advantage plan for processing.

3. The plan receives the enrollment information and sends out a bill for the first month’s premium.
4. Once the premium is received, the plan will process the enrollment and send out the membership materials.

5. Members with individual policies must see providers in the BlueEssentials or MyChoice Advantage health insurance exchange provider networks.

NOTE! There are no out-of-network benefits except for emergencies.
Our Products on the FFM/Exchanges

**BlueEssentials Plan**

**MyChoice Advantage Plan**

**Individual Coverage**
Under 65

**Small Group Coverage** (Traditional PPO and BlueChoice Networks)
Sample BlueEssentials ID Card (Individual Plans)

Alpha Prefixes

- ZCU – Individual private
- ZCF – Individual FFM
- ZCQ – Individual FFM

These plans use the BlueEssentials Network.
Sample Exchange PPO ID Cards (Small Groups)

Alpha Prefixes

- ZCV – Small Group Private
- ZCR – Small Group FFM

These plans use the PPO network.
• The BlueEssentials plans are divided into two categories: the metallic plans (Gold, Silver, Bronze) and the catastrophic plan.

• Anyone can buy a metallic plan, but only certain people qualify for Blue Essentials Catastrophic 1.
• Young adults and people who cannot afford coverage can purchase a catastrophic plan.
• Catastrophic plans are offered to people who:
  • Received certification from the marketplace stating they are exempt from the individual mandate because they do not have an affordable coverage option or they qualify for a hardship exemption.
Benefits and Features


• View benefits and features:
  https://www.southcarolinablues.com/web/nonsecure/sc/resources/d02a3769-2c82-437a-9dea-d9f5906dc05e/BlueEssentialBrochure.pdf
This is the BlueEssentials Silver I plan, an example of the many plans available to view on our website.
Check out the new BlueEssentials provider network on our website www.SouthCarolinaBlues.com.

You can also find providers in the BlueEssentials Doctor and Hospital Finder.

Non-network Provider = No Benefits!
Covered Drug List

- You can also review our 2014 BlueEssentials covered drug list on the website.
- Caremark manages all specialty pharmacy drugs.
  - Caremark handles questions about preauthorization for step therapy and formulary exceptions.
Sample MyChoice Advantage ID Card (Individual Plans)

Alpha Prefixes

- ZCX – Individual FFM
- ZCJ – Individual Private
Alpha Prefixes

- ZCL – Small Group Private
- ZCG – Small Group FFM

These plans use the BlueChoice Network.
Benefits and Features

To view the benefits and features of each MyChoice Advantage Plan go to [www.BlueChoiceSC.com](http://www.BlueChoiceSC.com), then from the Apply Now page choose MyChoice Advantage, Plan Designs.

• If your patients need to buy health coverage for themselves or their family members, MyChoice Advantage has the right plan designs.
• They may also qualify for financial assistance from the government to help pay premiums.
MyChoice Advantage includes:

• Deductibles ranging from $400 to $6350
• State-wide doctor and hospital network
• No referral for specialist needed
• Plans with low office copays
• Plans with low drug deductibles
• Preventive services - $0 copay
This is the MyChoice Advantage Silver 400 plan, an example of the many plans available to view on our website.

### MyChoice Advantage / Silver 400

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period:** 01/01/2014 – 12/31/2014

**Coverage for:** Individual | **Plan Type:** HMO

---

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$400 person. Doesn’t apply to preventive care. Co-pays don’t count toward the deductible.</td>
<td>You must pay all the costs up to the deductable amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No</td>
<td>You don’t have to meet deductibles for specific services, but see the chart on page 2 for other costs for services this plan covers.</td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>Yes, $6,350 person</td>
<td>The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billed charges, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>Yes. For a list of participating providers, see <a href="http://www.BlueChoiceSC.com">www.BlueChoiceSC.com</a> or call 1-800-868-2528</td>
<td>If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.</td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>No. You don’t need a referral to see a specialist.</td>
<td>You can see the specialist you choose without permission from this plan.</td>
</tr>
<tr>
<td>Are there services this plan doesn’t cover?</td>
<td>Yes</td>
<td>Some of the services this plan doesn’t cover are listed on page 4. See your policy or plan document for additional information about excluded services.</td>
</tr>
</tbody>
</table>

---

Questions: Call 1-800-868-2528 or visit us at [www.BlueChoiceSC.com](http://www.BlueChoiceSC.com). If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at [http://dol.gov/ebia/pdf/SBCUniformGlossary.pdf](http://dol.gov/ebia/pdf/SBCUniformGlossary.pdf) or call to request a copy. BlueChoice HealthPlan is an independent licensee of the Blue Cross and Blue Shield Association.
Provider Directory

Check out the new MyChoice Advantage provider network on www.BlueChoiceSC.com.

You can also find providers in the MyChoice Advantage Doctor and Hospital Finder.

Non-network Provider = No Benefits!
Covered Drug List

• You can also review our 2014 MyChoice Advantage covered drug list on the website.
• Caremark manages all specialty pharmacy drugs.
  • Caremark handles questions regarding preauthorization for step therapy and formulary exceptions.
Utilization Management

• We only cover emergency visits for out-of-network providers.

• The health insurance marketplace provider network is a different network than the Preferred Blue or BlueChoice networks. A provider in either of those networks may not be in the BlueEssentials or the MyChoice Advantage networks.
Utilization Management

• We will provide transition of care plans for new members who enroll in these products.
• A transition of care request form must be completed for this benefit. You can find it on our website.
Utilization Management

• You must get preauthorization (also called prior authorization, prior approval or precertification) for certain categories of benefits.
• Failure to get preauthorization may result in us denying benefits.
• Preauthorization is not a guarantee that we will cover the service.
• Benefits are subject to patient eligibility.
• Verify benefits and eligibility through My Insurance Manager from the BlueChoice website Provider section.
Utilization Management

Type of service or treatment that must be preauthorized include:

- Hospital admission, including maternity notifications
- Skilled nursing facility (SNF) admission
- Continuation of a hospital stay (remaining in the hospital or SNF for a period longer than was originally approved) for a medical condition
- Outpatient chemotherapy or radiation therapy
Type of service or treatment that must be preauthorized include:

- Outpatient hysterectomy or septoplasty
- Home health care or hospice services
- Durable medical equipment when the purchase price or rental is $500 or more
- Admissions for habilitation, rehabilitation and/or human organ and/or tissue transplants
- Treatment for hemophilia
- Mental health and substance use disorders
Utilization Management

Type of service or treatment that must be preauthorized include:

• Certain prescription drugs and specialty drugs
  • Caremark handles preauthorization for these treatments

• Advanced radiological services
  • National Imaging Associates (NIA) handles preauthorization for these services.
Cosmetic Procedures

• Any procedure that is considered cosmetic is a non-covered service

• Examples include:
  • Blepharoplasty
  • Vein surgery
  • Sclerotherapy
  • Reduction mammoplasty
  • Brow lifts
  • Rhinoplasty
Network Hospitals

South Carolina hospitals in BlueEssentials (EPO) and MyChoice Advantage (HMO) Exclusive Provider Networks – for Health Insurance Marketplace (HIX)
Three-month grace period for individual policies with subsidies

- First month of delinquency – BlueCross pays claims/notifies provider
- Second/third month of delinquency – BlueCross will hold claims until premiums paid

Provider will receive message when verifying benefits via My Insurance Manager or VRU
## When Verifying Eligibility

Providers will have member active coverage response and benefits returned, with plan name/product description relayed.

<table>
<thead>
<tr>
<th>My Insurance Manager</th>
<th>Provider Services VRU</th>
</tr>
</thead>
</table>
| **One month delinquency** (same response as non-delinquent member) | 1. Response will include both in- (covered) and out-of-network (non-covered) benefit.  
2. Message states, “Please note that this member has an HCR Exchange policy. In-network benefits only apply when services are rendered by a provider who is in the [Blue Essentials] network. Services by providers not in the [Blue Essentials] network are not covered.” | Response will return the correct benefits based on the network status of the caller  
• Covered response for in-network provider  
• Non-covered response for out-of-network provider |

| Two to three months delinquency | Inactive – Pending eligibility update  
No benefits on the response | Response will state:  
1. Benefit period begin date  
2. Date through which premium has been paid |
## Communications on Member Delinquency

### When Checking Claim Status

<table>
<thead>
<tr>
<th>One month delinquency (same response as non-delinquent member)</th>
<th>My Insurance Manager</th>
<th>Provider Services VRU</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Claims will pay.</td>
<td>1. Claims will pay.</td>
<td></td>
</tr>
<tr>
<td>2. There is no change to the claim status response.</td>
<td>2. There is no change to the claim status response.</td>
<td></td>
</tr>
</tbody>
</table>

| Two to three months delinquency                                | 1. Response will display a PENDING status. |
|                                                              | 2. Will show HIPAA codes Category P5, Status 734 and/or Status 1. |
|                                                              | 3. Includes a link to this message: |
|                                                              | “We are unable to provide benefits at this time because our records indicate that this patient receives an advance premium tax credit and is in the second or third month of the premium delinquency grace period. Should coverage terminate because the patient fails to pay premiums, we will deny payment of claims incurred during the second and third months of the grace period.” |
|                                                              | Claim status response will voice a deferred/still processing status and the remit verbiage. |
## Communications on Member Delinquency

**When Viewing Remittance Advice (hard copy and 835)**

<table>
<thead>
<tr>
<th>My Remit Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>One month delinquency</strong>&lt;br&gt;(same response as non-delinquent member)</td>
</tr>
<tr>
<td>1. Claims will pay.&lt;br&gt;2. There is no change to the remittance advice.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Two to three months delinquency</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Will show HIPAA codes CARC 177, RARC N617 and/or RARC N618.&lt;br&gt;2. Includes this remit message: “We are unable to provide benefits at this time because our records indicate that this patient receives an advance premium tax credit and is in the second or third month of the premium delinquency grace period. Should coverage terminate because the patient fails to pay premiums, we will deny payment of claims incurred during the second and third months of the grace period and the patient will be liable. Once premiums have been paid, current claims will be processed according to plan benefits.”</td>
</tr>
</tbody>
</table>

*Claims will deny after 90 days if member does not pay premium.*
Thank You!

We appreciate our provider community for working together to improve the lives of our members.

Look for 2014 Educational Opportunities:
★ Regional Workshops
★ Clinic Days
★ Webinars