Health Insurance Marketplaces
BlueCross BlueShield of South Carolina and BlueChoice HealthPlan
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
Essential Health Benefits

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
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.
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.
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
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.
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).
The Enrollment Process

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 HealthPlan Networks)
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.
BlueEssentials Individual Plans

- 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.

• 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!
• You can also review our 2014 BlueEssentials covered drug list on the website.

• Caremark manages all specialty pharmacy drugs. Caremark is an independent company that manages specialty drugs on behalf of BlueCross and BlueChoice®.

  • 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, then from the Apply Now page choose MyChoice Advantage, Plan Designs.

- View benefits and features:
  http://bluechoicesc.com/UserFiles/bluechoice/Documents/Everybody/BlueChoice_MyAdvantage_Brochure.PDF
• 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 Individual Plans

• 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.

<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</td>
<td>You must pay all the costs up to the <strong>deductible</strong> 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 <strong>deductibles</strong> for specific services, but see the chart starting 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 <strong>out-of-pocket limit</strong> 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 <strong>out-of-pocket limit</strong>.</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 <strong>excluded services</strong>.</td>
</tr>
</tbody>
</table>

Questions: Call 1-800-868-2528 or visit us at 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/esa/pdf/SBCUniformGlossary.pdf or call to request a copy. BlueChoice HealthPlan is an independent licensee of the Blue Cross and Blue Shield Association.
Check out the new MyChoice Advantage provider network on [www.BlueChoiceSC.com](http://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 is an independent company that manages specialty drugs on behalf of BlueChoice.
  • 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
Utilization Management

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
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. NIA is an independent company that manages authorizations for radiological services on behalf of BlueCross and BlueChoice.
Cosmetic Procedures

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

• Examples include:
  • Blepharoplasty
  • Vein surgery
  • Sclerotherapy
  • Reduction mammoplasty
  • Brow lifts
  • Rhinoplasty
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 voice response unit (VRU)
### When Verifying Eligibility

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

<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>
</table>
| 1. Response will include both in- (covered) and out-of-network (non-covered) benefit. | 1. 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 | |
| 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.” | | |

| 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></td>
<td>1. Claims will pay.</td>
</tr>
<tr>
<td>2. There is no change to the claim status response.</td>
<td></td>
<td>2. There is no change to the claim status response.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Two to three months delinquency</th>
<th></th>
<th>Claim status response will voice a deferred/still processing status and the remit verbiage.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Response will display a PENDING status.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Will show HIPAA codes Category P5, Status 734 and/or Status 1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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...”</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Communications on Member Delinquency

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

<table>
<thead>
<tr>
<th>When Viewing Remittance Advice (hard copy and 835)</th>
<th>My Remit Manager</th>
</tr>
</thead>
</table>
| **One month delinquency** (same response as non-delinquent member) | 1. Claims will pay.  
2. There is no change to the remittance advice. |
| **Two to three months delinquency** | 1. Will show HIPAA codes CARC 177, RARC N617 and/or RARC N618.  
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.” |
• We welcome the chance to give individual training to your office about our health insurance marketplace plans.
• Please contact Provider Relations and Education by telephone at 803-264-4730 or by email at provider.education@bcbscc.com.