



BlueCross BlueShield of South Carolina and
BlueChoice HealthPlan of South Carolina

Independent licensees of the Blue Cross and Blue Shield Association

The BlueCard[®] Program Provider Manual

March 2015

Table of Contents

Table of Contents.....	2
1. Introduction: The BlueCard Program Makes Filing Claims Easy	3
2. What is the BlueCard Program?.....	3
2.1 Definition.....	3
2.2 BlueCard Program Advantages to Providers.....	3
2.3 Products Included in BlueCard.....	4
2.4 Products Excluded from the BlueCard Program.....	4
3. How to Identify Members	6
3.1 Member ID Cards.....	6
3.2 International Members.....	7
3.4 Consumer-Directed Health Care and Health Care Debit Cards.....	8
3.5 Coverage and Eligibility Verification.....	9
3.6 Electronic Provider Access	10
3.7 Utilization Review	11
4. Claim Filing.....	13
4.1 How Claims Flow through BlueCard.....	13
4.2 Ancillary Claims.....	14
4.3 Coordination of Benefits (COB) Claims	16
4.4 Traditional Medicare-Related Claims.....	17
4.5 Medicare Advantage (MA) Claims.....	18
4.6 Medical Records.....	20
4.7 Adjustments	21
4.8 Appeals.....	21
4.9 Claim Payment.....	21
4.10 Claim Status Inquiry.....	21
4.11 Calls from Members and Others with Claim Questions.....	22
4.12 Key Contacts.....	22
5. Frequently Asked Questions	22
6. BlueCard Program Quick Tips.....	26
7. Glossary of BlueCard Program Terms.....	27

1. Introduction: The BlueCard Program Makes Filing Claims Easy

As a participating provider of BlueCross BlueShield of South Carolina, you may render services to patients who are National Account members of other Blue Plans, and who travel or live in South Carolina.

This manual describes the advantages of the program and provides information to make filing claims easy. This manual offers helpful information about:

- Identifying members
- Verifying eligibility
- Getting precertifications/pre-authorizations
- Filing claims
- Who to contact with questions

2. What is the BlueCard Program?

2.1 Definition

The BlueCard program enables Blue Plan members to get health care service benefits and savings while traveling or living in another Blue Plan's service area. The program links participating health care providers across the country and internationally through a single electronic network for claims processing and reimbursement.

The BlueCard program lets you submit claims for Blue Plan members directly to your local BlueCross BlueShield of South Carolina Plan.

We will be your point of contact for education, contracting, claims payment/adjustments and problem resolution.

2.2 BlueCard Program Advantages to Providers

The BlueCard Program lets you conveniently submit claims for members from other Blue Plans, including international Blue Plans, directly to BlueCross BlueShield of South Carolina. We will be your only point of contact for all your claims-related questions.

BlueCross BlueShield of South Carolina continues to experience growth in out-of-area membership because of our partnership with you. That is why we are committed to working with you to ensure your patients will have a positive experience at each visit. .

2.3 Products Included in BlueCard

A variety of products and claim types are eligible for delivery via BlueCard, however, not all Blue Plans offer all of these products to their members. Currently, BlueCross BlueShield of South Carolina offers products in these categories:

- Traditional (indemnity insurance)
- Preferred provider organization (PPO)
- Health maintenance organization (HMO)
- Medicare Advantage (MA)*

*MA is a separate program from BlueCard. Since you might see members of other Blue Plans who have MA coverage, however, there is a section about MA claims processing in this manual.

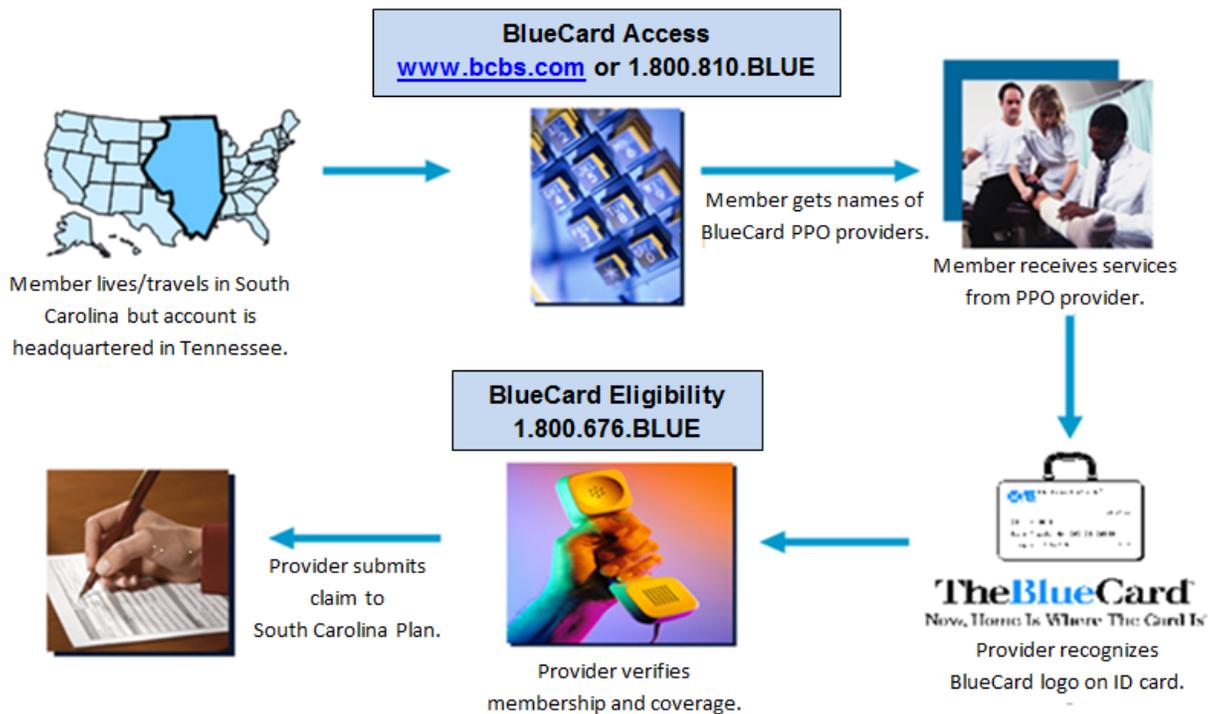
2.4 Products Excluded from the BlueCard Program

We exclude these claims from the BlueCard Program:

- Stand-alone dental
- The Federal Employee Program (FEP)

Please follow the BlueCross BlueShield of South Carolina billing guidelines.

How the BlueCard Program Works



In this example, suppose a member has PPO coverage through BlueCross BlueShield of Tennessee. There are two scenarios for which the member might need to see a provider in another Plan's service area. In this example, it's South Carolina.

- 1) If the member was traveling in South Carolina or
- 2) If the member resided in South Carolina and had employer-provided coverage through BlueCross BlueShield of Tennessee.

In either scenario, providers and members can get the names and contact information for BlueCard PPO providers in South Carolina by calling the BlueCard Access® Line at 800-810-BLUE(2583) or on the Internet by using the BlueCard National Doctor and Hospital Finder available at www.bcbs.com or at www.SouthCarolinaBlues.com. Simply key in the member's alpha prefix and other required information to identify participating providers.

NOTE: You will receive a return message for members with no out-of-area benefits indicating that only in-area benefits are available, unless seeking urgent or emergent care.

As a South Carolina BlueCard PPO provider, when a member makes an appointment, you should verify the member's eligibility and coverage information via the BlueCard Eligibility® Line at 800-676-BLUE(2583). You can also get this information via a Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic eligibility transaction if you have established electronic connections for such transactions with us.

After rendering services, you will file the claim locally with BlueCross BlueShield of South Carolina. We will forward the claim to BlueCross BlueShield of Tennessee. The Tennessee Plan will adjudicate the claim according to the member's benefits and your provider arrangement with us.

When the claim is finalized, the Tennessee Plan will issue an Explanation of Benefits (EOB) to the member. We will issue the explanation of payment or remittance advice and pay you.

3. How to Identify Members

3.1 Member ID Cards

When members of Blue Plans arrive at your office or facility, be sure to ask them for their current Blue Plan membership identification cards.

The ID cards may have:

- PPO in a suitcase logo
- PPOB in a suitcase logo
- A blank suitcase logo

Sample ID Card:

 BlueCross BlueShield of Geography		Blue Product	ALPHA Employer Group
Member Name Member ID XYZ123456789		Dependents Dependent One Dependent Two Dependent Three	
Group No. 023457 BIN 997554 Benefit Plan HIOPT Effective Date 00/00/00 Plan Code 123	Plan PPO Office Visit \$15 Specialist Copay \$15 Emergency \$75 Deductible \$50		
		 	

The PPO in a suitcase logo indicates that the member is enrolled in either a PPO or exclusive provider organization (EPO) product. In either case, you will be reimbursed according to BlueCross BlueShield of South Carolina's PPO provider contract. Please note that EPO products may have limited out-of-area benefits.

The PPOB in a suitcase logo indicates the member has selected a PPO or EPO exchange product from a Blue Plan. The member has access to the BlueCard PPO Network. You will be reimbursed for covered services in accordance with your PPO contract with BlueCross BlueShield of South Carolina.

The empty suitcase logo indicates the member is enrolled in either a traditional or HMO product. You will be reimbursed in accordance with the BlueCross BlueShield of South Carolina PPO contract for covered professional services and in accordance with the participating provider agreement (PAR) for hospital services.

Some Blue ID cards do not have a suitcase logo on them. Such ID cards include Medicaid, State Children's Health Insurance Programs (SCHIP) (if administered as part of a state's Medicaid program), and Medicare complementary and supplemental products, also known as Medigap. Government-determined reimbursement levels apply to these products. BlueCross BlueShield of South Carolina routes all of these claims for out-of-area members to the member's Blue Plan. We also send most of the Medicare complementary or Medigap claims directly from the Medicare intermediary to the member's Plan via the established electronic crossover process.

The three-character alpha prefix at the beginning of the member's identification number is the key element we use to identify and correctly route claims. The alpha prefix identifies the Blue Plan or National Account to which the member belongs. We need it to confirm a patient's membership and coverage.

The alpha prefix is also critical for the electronic routing of specific HIPAA transactions to the appropriate Blue Plan. To ensure accurate claim processing, it is important to capture all ID card data. If you do not capture the information correctly, you may experience a delay with claim processing. Please make copies of the front and back of the ID card, and share this key information with your billing staff.

Examples of member ID numbers:

ABC1234567

Alpha
Prefix

ABC1234H567

Alpha
Prefix

ABC12345678901234

Alpha
Prefix

As a provider servicing out-of-area members, you may find these tips helpful:

- A correct member ID number includes the alpha prefix (first three positions) and all subsequent characters, up to 17 positions total. This means that you may see cards with ID numbers between six and 14 numbers/letters following the alpha prefix.
- Ask the member for the most current ID card at every visit. Since new ID cards may be issued to members throughout the year, this will ensure you have the most up-to-date information in the member's file.
- Verify with the member that the ID number on the card is not his or her Social Security Number. If it is, call the BlueCard Eligibility line at 800-676-BLUE(2583) to verify the ID number.
- Make copies of the front and back of the member's ID card and pass this key information on to your billing staff.
- Report member ID numbers exactly as shown on the ID card. Do not change or alter them. Do not add or omit any characters from the member ID numbers.

3.2 International Members

Occasionally, you may see identification cards from members of international Licensees. Currently those Licensees include Blue Cross Blue Shield (BCBS) of U.S. Virgin Islands, BlueCross & BlueShield of Uruguay and Blue Cross and Blue Shield of Panama. If in doubt, always check with BlueCross BlueShield of South Carolina as the list of international Licensees can change. ID cards from these Licensees will also contain three-character alpha prefixes and may or may not have one of the benefit product logos referenced in these sections. Please treat these members the same as you would domestic Blue Plan members (e.g., do not collect any payment from the member beyond cost-sharing amounts, such as deductible, coinsurance and copayment). File their claims to BlueCross BlueShield of South Carolina.

Sample ID Card from an International Licensee:



Canadian ID Cards

You may occasionally see ID cards for people with Canadian Blue Cross Plan coverage. Claims for Canadian Blue Cross Plan members are not processed through the BlueCard Program.

Please follow the instructions of the Blue Cross Plans in Canada on the ID cards when servicing their members. The Blue Cross Plans in Canada are:

Alberta Blue Cross	Atlantic Blue Cross Care	Saskatchewan Blue Cross
Manitoba Blue Cross	Quebec Blue Cross	Pacific Blue Cross

NOTE: The Canadian Association of Blue Cross Plans and its member Plans are separate and distinct from the Blue Cross and Blue Shield Association (BCBSA) and its member Plans in the United States.

3.4 Consumer-Directed Health Care and Health Care Debit Cards

“Consumer-Directed Health Care (CDHC)” is a term that refers to a movement in the health care industry to empower members, reduce employer costs and change consumer health care purchasing behavior.

Health plans that offer CDHCs provide members with additional information to make informed and appropriate health care decisions through the use of member support tools, provider and network information and financial incentives.

Members who have CDHC plans often have health care debit cards that allow them to pay for out-of-pocket costs using funds from their health reimbursement arrangement (HRA), health savings account (HSA) or flexible spending account (FSA). All three are types of tax-favored accounts the member’s employer offers to pay for eligible expenses the health plan doesn’t cover.

Some cards are stand-alone debit cards that cover eligible out-of-pocket costs, while others also serve as a health plan member ID card. These debit cards can help you simplify your administration process and can potentially help:

- Reduce bad debt
- Reduce paperwork for billing statements
- Minimize bookkeeping and patient account functions for handling cash and checks
- Avoid unnecessary claim payment delays

In some cases, the card will display the Blue Cross and Blue Shield trademarks, along with the logo from a major debit card, such as MasterCard® or Visa®.

Sample Stand-alone Health Care Debit Card:



Sample of Combined Health Care Debit Card and Member ID Card:



The cards include a magnetic strip allowing you to swipe the card to collect the member's cost-sharing amount (i.e., copayment). With health care debit cards, members can pay for copayments and other out-of-pocket expenses by swiping the card through any debit card swipe terminal. The funds will be deducted automatically from the member's appropriate HRA, HSA or FSA account.

If your office currently accepts credit card payments, there is no additional cost or equipment necessary. The cost to you is the same as what you pay to swipe any other signature debit card.

Helpful tips:

- Using the member's current member ID number, including alpha prefix, carefully determines the member's financial responsibility before processing payment. Check eligibility and benefits electronically through www.SouthCarolinaBlues.com or by calling 800-676-BLUE(2583).
- Bill BlueCross BlueShield of South Carolina for all services, regardless of whether or not you've collected the member responsibility at the time of service for proper benefit determination, and to update the member's claim history.
- Please do not use the card to process full payments up front. If you have any questions about the member's benefits, please contact 800-676-BLUE(2583). For information about the health care debit card processing instructions or payment issues, please contact the toll-free debit card administrator's number on the card.

3.5 Coverage and Eligibility Verification

For BlueCross BlueShield of South Carolina members, verify the patient's eligibility and coverage at My Insurance ManagerSM or by calling 800-868-2510.

For other Blue Plan members, submit an electronic inquiry or call BlueCard Eligibility at 800-676-BLUE(2583) to verify the patient's eligibility and coverage:

- Electronic — Submit a HIPAA 270 transaction (eligibility) via www.SouthCarolinaBlues.com.
You can receive real-time responses to your eligibility requests for out-of-area members between 6 a.m. and midnight, Central Time, Monday through Saturday.
- Phone — Call BlueCard Eligibility at 800-676-BLUE(2583).
 - Please have the member's identification number ready, including the alpha prefix.
 - English- and Spanish-speaking phone operators are available to assist you.
 - Blue Plans are located throughout the country and may operate on a different time schedule than BlueCross BlueShield of South Carolina. You may be transferred to a voice response system linked to customer enrollment and benefits outside that Plan's regular business hours.
 - The BlueCard Eligibility line is for eligibility, benefit and pre-certification/referral authorization inquiries only. Do not use it for claim status.
- Electronic Health ID Cards
 - Some Blue Plans have implemented electronic health ID cards to facilitate a seamless coverage and eligibility verification process.
 - Electronic health ID cards enable electronic transfer of core subscriber/member data from the ID card to the provider's system.
 - A Blue electronic health ID card has a magnetic stripe on the back of the ID card, similar to what you can find on the back of a credit or debit card. The subscriber/member electronic data is embedded on the third track of the three-track magnetic stripe.
 - Core subscriber/member data elements embedded on the third track of the magnetic stripe include the subscriber's/member's name, ID, date of birth and PlanID.
 - The PlanID data element identifies the health plan that issued the ID card. PlanID will help you facilitate health transactions among various payers in the marketplace.
 - You will need a **track-3 card reader** in order to read the data on track three of the magnetic stripe. (The majority of card readers in provider offices only read tracks one and two of the magnetic stripe. Tracks one and two are proprietary to the financial industry.)

3.6 Electronic Provider Access

BlueCross BlueShield of South Carolina and other Blue Plans launched a tool called Electronic Provider Access (EPA). This tool gives you the ability to access out-of-area members' Blue Plan's (Home Plan's) provider portals to conduct electronic pre-service review through a secure routing mechanism. The term "pre-service review" refers to pre-notification, precertification, pre-authorization and prior approval among other pre-claim processes. Once in the Home Plan's provider portal, you will have the same access to electronic pre-service review capabilities as the Home Plan's local providers.

The availability of EPA will vary depending on the capabilities of each Home Plan. Some Home Plans will be fully implemented and have electronic pre-service review for many services. Others will not yet have

implemented electronic pre-service review capabilities. This section describes how to use EPA and what to expect when attempting to contact Home Plans at different stages of implementation.

Using the EPA Tool

The first step is to go to www.SouthCarolinaBlues.com. You will then select the menu options Education Center, Precertification and then the BlueCard precertification tool.

Next, enter the alpha prefix from the member's ID card. The alpha prefix is the first three alpha characters that precede the member ID.

You can first check whether the Home Plan requires pre-certification by either:

1. Sending a service-specific request through BlueExchange®.
2. Accessing the Home Plan's pre-certification requirements pages by using the medical policy router. Go to www.SouthCarolinaBlues.com. You will then select Providers, Education Center, Precertification and then BlueCard Precertification Medical Policies Tool.

Entering the member's alpha prefix from the ID card will automatically route you to the Home Plan's EPA landing page. This page will welcome you to the Home Plan's portal and indicate that you have left BlueCross BlueShield of South Carolina's portal. The landing page will allow you to connect to the available electronic pre-service review processes. Because the screens and functionality of Home Plan pre-service review processes vary widely, Home Plans may include instructional documents or e-learning tools on the Home Plan landing page to provide instruction on how to conduct an electronic pre-service review. The page will also include instructions for conducting pre-service review for services where the electronic function is not available.

The Home Plan landing page will look similar across Home Plans, but will be customized to the particular Home Plan based on the electronic pre-service review services they offer.

3.7 Utilization Review

As a BlueCross provider, you are responsible for getting pre-certification/ preauthorization for inpatient and/or outpatient services from a member's Blue Plan. Effective July 1, 2014, participating providers are responsible for getting pre-service review for inpatient facility services when the account or member contract (provider financial responsibility) requires it. In addition, members are held harmless when pre-service review is required and not received for inpatient facility services (unless an account receives an approved exception).

You must also follow specified timeframes for pre-service review notifications:

1. 48 hours to notify the member's Plan of a change in pre-service review
2. 72 hours for emergency/urgent pre-service review notification

You can find general information on pre-certification/preauthorization information on the Out-of-Area Member Medical Policy and Pre-Authorization/Pre-Certification Router at www.SouthCarolinaBlues.com using the three-letter prefix found on the member ID card.

You can also contact the member's Plan on the member's behalf. Here's how:

For Blue Plan members:

- Calling BlueCard Eligibility at 800-676-BLUE(2583) — ask to be transferred to the Utilization Review area.
- When pre-certification/preauthorization for a specific member is handled separately from eligibility verifications at the member's Blue Plan, your call will be routed directly to the area that handles pre-certification/pre-authorization. You will choose from four options, depending on the type of service for which you are calling:
 - Medical/surgical
 - Behavioral health
 - Diagnostic imaging/radiology
 - Durable/home medical equipment (D/HME)

If you are inquiring about eligibility and pre-certification/pre-authorization through 800-676-BLUE(2583), your eligibility inquiry will be addressed first. Then you will be transferred, as appropriate, to the pre-certification/preauthorization area.

- Submit an electronic HIPAA 278 transaction (referral/authorization) via www.SouthCarolinaBlues.com.

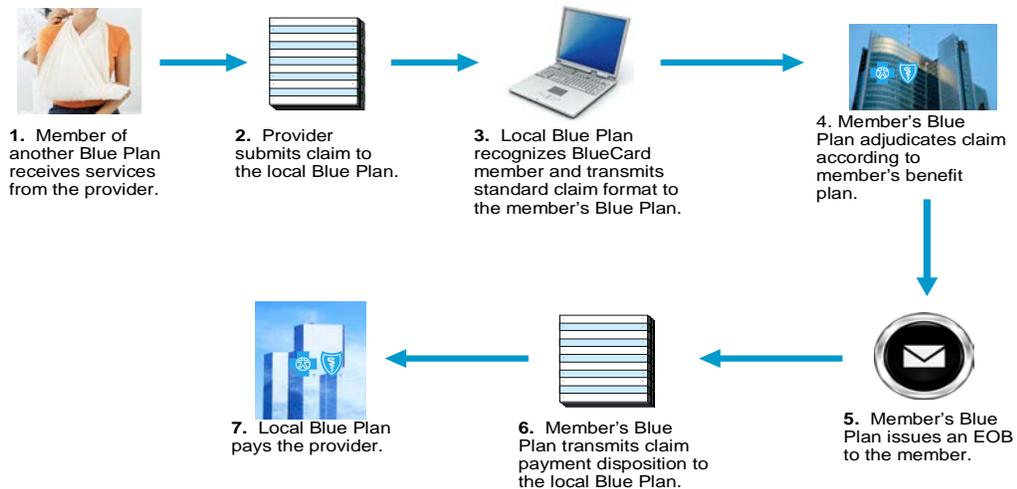
The member's Blue Plan may contact you directly regarding clinical information and medical records prior to treatment or for concurrent review or disease management for a specific member.

When getting pre-certification/preauthorization, please provide as much information as possible to minimize potential claims issues. We encourage you to follow-up immediately with a member's Blue Plan to communicate any changes in treatment or setting to ensure the existing authorization is modified or a new one is received, if needed. Failure to get approval for the additional days can result in claims processing delays and potential payment denials.

4. Claim Filing

4.1 How Claims Flow through BlueCard

This is an example of how claims flow through BlueCard.



After the member of another Blue Plan receives services from you, you should file the claim with BlueCross BlueShield of South Carolina. We will work with the member's plan to process the claim and the member's plan will send an EOB to the member. We will send you an explanation of payment or the remittance advice and issue the payment to you under the terms of our contract with you and based on the member's benefits and coverage.

You should always submit your claims to BlueCross BlueShield of South Carolina.

Following these helpful tips will improve your claims experience:

- Ask members for their current member ID cards and regularly get new photocopies of them (front and back). Having the current card enables you to submit claims with the appropriate member information (including alpha prefix) and avoid unnecessary claims payment delays.
- Check eligibility and benefits electronically by calling 800-676-BLUE(2583). Be sure to provide the member's alpha prefix.
- Verify the member's benefit cost-sharing amount before accepting full payment up-front.
- Indicate any payment you collected from the patient on the claim. (On the 837 electronic claim submission form, check field AMT01=F5 patient paid amount; on the CMS1500 locator **29** amount paid; on UB04 locator **54** prior payment; on UB04 locator **53** prior payment.)
- Submit all Blue claims to BlueCross BlueShield of South Carolina. Be sure to include the member's complete identification number when you submit the claim. This includes the three-character alpha prefix. Submit claims with only valid alpha prefixes. We cannot process claims with incorrect or missing alpha prefixes and member identification numbers.

- In cases in which there is more than one payer and a Blue Plan is a primary payer, submit other party liability (OPL) information with the claim. Upon receipt, we will electronically route the claim to the member's Blue Plan. The member's plan then processes the claim and approves payment. BlueCross BlueShield of South Carolina will reimburse you for services.
- Do not send duplicate claims. Sending another claim, or having your billing agency resubmit claims automatically, actually slows down the claims payment process and creates confusion for the member.
- Check claims status via My Insurance Manager at www.SouthCarolinaBlues.com.

4.2 Ancillary Claims

Ancillary providers include independent clinical laboratories (lab), (D/HME) and supplies, and specialty pharmacy providers. This is how you should file these types of claims:

- Lab
 - The Plan in whose state the specimen was drawn based on the location of the referring provider.
- D/HME
 - The Plan in whose state the equipment was shipped to or purchased at a retail store.
- Specialty pharmacy
 - The Plan in whose state the ordering physician is located.

This table demonstrates how to identify the local Plan, as defined for ancillary services:

Provider Type	How to File (Required Fields)	Where to File	Example
Lab (any type of non-hospital-based laboratory) Types of service include, but are not limited, to: Blood and urine samples and analysis, etc.	Referring Provider: <ul style="list-style-type: none"> - Field 17 on CMS 1500 Health Insurance Claim Form or - Loop 2310A (claim level) on the 837 Professional Electronic Submission 	File the claim to the Plan in which state the specimen was drawn . Where the specimen was drawn will be determined by which state the referring provider is located.	Blood is drawn in lab located in Alabama . Blood analysis is done in South Carolina . File to: BlueCross BlueShield of Alabama . You must file claims for the analysis of a lab to the Plan in which state the specimen was drawn .
D/HME Types of service include, but are not limited, to: Hospital beds, oxygen tanks, crutches, etc.	Patient's Address: <ul style="list-style-type: none"> - Field 5 on CMS 1500 Health Insurance Claim Form or - Loop 2010CA on the 837 Professional Electronic Submission 	File the claim to the Plan in which state the equipment was shipped to or purchased in a retail store .	A. Wheelchair is purchased at a retail store in South Carolina . File to: BlueCross BlueShield of South Carolina .

Provider Type	How to File (Required Fields)	Where to File	Example
	<p>Ordering Provider:</p> <ul style="list-style-type: none"> - Field 17 on CMS 1500 Health Insurance Claim Form or - Loop 2420E (line level) on the 837 Professional Electronic Submission <p>Place of Service:</p> <ul style="list-style-type: none"> - Field 24B on CMS 1500 Health Insurance Claim Form or - Loop 2300, CLM05-1 on the 837 Professional Electronic Submissions <p>Service Facility Location Information:</p> <ul style="list-style-type: none"> - Field 32 on CMS 1500 Health Insurance Form or - Loop 2310C (claim level) on the 837 Professional Electronic Submission 		<p>HIPAA Place of Service: 99</p> <p>B. Wheelchair is purchased on the Internet from an online retail supplier in Ohio and shipped to South Carolina.</p> <p>File to: BlueCross BlueShield of South Carolina.</p> <p>HIPAA Place of Service: 12</p>
<p>Specialty Pharmacy</p> <p>Types of service include non-routine, biological therapeutics a health care professional orders as a covered medical benefit the member's Plan's Specialty Pharmacy formulary defines. Including, but not limited, to, injectable, infusion therapies, etc.</p>	<p>Referring Provider:</p> <ul style="list-style-type: none"> - Field 17B on CMS 1500 Health Insurance Claim Form or - Loop 2310A (claim level) on the 837 Professional Electronic Submission. 	<p>File the claim to the Plan in the state where the ordering provider is located.</p>	<p>Patient is seen by a physician in Ohio who orders a specialty pharmacy injectable for the patient. Patient will receive the injections in South Carolina where the member lives for six months of the year.</p> <p>File to: Blue Cross Blue Shield of Ohio</p>

These rules apply regardless of your contracting status with the Blue Plan where you file the claim.

- Before providing any ancillary service, please verify a member's eligibility and benefits by calling the number on the member's ID card or call 800-676-BLUE(2583).
- If you use an outside vendor to provide services (e.g., you send a blood specimen for special analysis that the lab where the specimen was drawn cannot do), please use an in-network ancillary provider. This will reduce the possibility that the member will be liable for more costs.

- Members are financially liable for ancillary services their benefit plans do not cover. It is your responsibility to request payment directly from the member for non-covered services.

If you have any questions about where to file your claim, please contact Provider Education at provider.education@bcbsc.com.

4.3 Coordination of Benefits (COB) Claims

COB refers to how we ensure members receive full benefits and prevent double payment for services when a member has coverage from two or more sources. The member's contract language explains the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.

If you discover the member has more than one health plan coverage:

- Submit the claim with the other carrier's name and address to us. If you do not include the COB information with the claim, the member's Blue Plan will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment.
- Submit the claim to us after receiving payment from the primary payer. Be sure to include the explanation of payment from the primary carrier. If you do not include the COB information with the claim, the member's Blue Plan will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment.

Carefully review the payment information from all payers involved on the remittance advice before billing the patient for any potential liability. The information listed on our remittance advice as "patient liability" may be different from the actual amount the patient owes due to the combination of the primary insurer payment and your negotiated amount with us.

For professional claims, if the member does not have other insurance, it is imperative that you check either "YES" or "NO" on the electronic HIPAA 837 claims submission transaction or CMS 1500 claim form, in box 11D. Leaving the box unmarked may cause the member's Plan to stop the claim to investigate for COB.

COB Questionnaire

To streamline our claims processing and reduce the number of denials related to COB, a COB questionnaire is available to you at www.SouthCarolinaBlues.com, Providers, Forms and then Other Forms. It will help you and your patients avoid potential claim issues and delays.

If you see a Blue Plan member who may have other health insurance coverage (e.g., Medicare), give a copy of the questionnaire to him or her during his or her visit. Ensure that he or she fills out the form completely out and at a minimum includes the policyholder's name and identification number, including the three-character alpha prefix, and the member's signature. Once the form is complete, send it to BlueCross BlueShield of South Carolina as soon as possible. We will work with the member's Plan to get the COB information updated. Collecting COB information from members before you file their claims eliminates the need to gather this information later, thereby reducing processing and payment delays.

Pay and Chase

Many Blue Plans are what we refer to as "pay and chase". For these Plans, if the Blue Plan has no COB information on file or if the member is due to update his or her COB information, the claim will process as primary and a COB questionnaire will be sent to the member. The Blue Plan's file will be updated if the returned COB questionnaire indicates:

- No other health insurance exists.
- Another insurance carrier is secondary.
- Another insurance carrier is primary. In this case, claims history would be reviewed and refunds would be requested as necessary.

If a response to the questionnaire is not received, claims will continue to pay primary until contrary information is received. The member will continue to receive COB questionnaires until a response is received.

4.4 Traditional Medicare-Related Claims

When Medicare is primary payer, submit claims to your local Medicare intermediary.

Most Blue claims are set up to automatically cross over to the member's Blue Plan after the Medicare intermediary adjudicates them. When submitting the claim, it is essential that you enter the correct Blue Plan name as the secondary carrier. This may be different from the local Blue Plan. Check the member's ID card for the correct Blue Plan name.

Include the alpha prefix as part of the member identification number. The member's ID will include the alpha prefix in the first three positions. The alpha prefix is critical for confirming membership and coverage, and key to facilitating prompt payments.

When you receive the remittance advice from the Medicare intermediary, look to see if it automatically forwarded the claim (crossed over) to the Blue Plan:

- If the remittance advice indicates the claim was crossed over, Medicare has forwarded the claim on your behalf to the appropriate Blue Plan and the claim is in process. **DO NOT** resubmit that claim to BlueCross BlueShield of South Carolina.
- If the remittance advice indicates that the claim was not crossed over, submit the claim to BlueCross BlueShield of South Carolina with the Medicare remittance advice.
- In some cases, the member identification card may contain a Coordination of Benefits Agreement (COBA) ID number. If so, be certain to include that number on your claim.
- For claim status inquiries, go to My Insurance Manager or call 800-868-2510.

Claims submitted to the Medicare intermediary will be crossed over to the Blue Plan only after they have been processed. This process may take up to 14 business days. This means that the Medicare intermediary will be releasing the claim to the Blue Plan for processing about the same time you receive the Medicare remittance advice. As a result, it may take an additional 14 to 30 business days for you to receive payment from the Blue Plan.

If you submitted the claim to the Medicare intermediary/carrier and haven't received a response to your initial claim submission, don't automatically submit another claim. You should:

- Review the automated resubmission cycle on your claim system.
- Wait 30 days.
- Check the claim's status before resubmitting.

Sending another claim, or having your billing agency resubmit claims automatically, actually slows down the claim payment process and creates confusion for the member.

4.5 Medicare Advantage (MA) Claims

MA is the program alternative to standard Medicare Part A and Part B fee-for-service (FFS) coverage. The general reference is “traditional Medicare.”

MA offers Medicare beneficiaries several product options (similar to those available in the commercial market), including HMO, PPO, point of service (POS) and private fee-for-service (PFFS) plans.

All MA plans must offer beneficiaries at least the standard Medicare Part A and B benefits, but many offer additional covered services as well (e.g., enhanced vision and dental benefits).

In addition to these products, MA organizations may also offer a special needs plan (SNP), which can limit enrollment to subgroups of the Medicare population in order to focus on ensuring that their special needs are met as effectively as possible. MA plans may allow in- and out-of-network benefits, depending on the type of product selected. You should confirm the level of coverage — by calling 800-676-BLUE(2583) or submitting an electronic inquiry — for all MA members prior to providing service, since the level of benefits and coverage rules may vary depending on the MA plan.

All health care providers who submit bills to an MA plan for reimbursement, whether in network or out of network, must be Medicare-certified providers. This means you should have a Medicare provider number for the type of service rendered. In-network providers of the MA plan that are participating with Medicare are eligible for reimbursement accordingly. Non-contracting providers that are non-participating with Medicare are allowed to bill beneficiaries up-front up to 15 percent over the Medicare-allowable charge. The out-of-network/non-participating provider will be reimbursed at 95 percent of the Medicare allowance for the service.

4.5.1 Types of MA Plans

MA HMO

An MA HMO is a Medicare managed care option in which members typically receive a set of predetermined and prepaid services a network of physicians and hospitals provides. Generally (except in urgent or emergency care situations), BlueCard only covers medical services when in-network providers provide them. The level of benefits and the coverage rules may vary by MA plan.

MA POS

An MA POS program is an option available through some Medicare HMO programs. It allows members to determine — at the POS — whether they want to receive certain designated services within the HMO system or seek such services outside the HMO’s provider network (usually at greater cost to the member). The MA POS plan may specify which services will be available outside of the HMO’s provider network.

MA PPO

An MA PPO is a plan that has a network of providers, but unlike traditional HMO products, it allows members who enroll access to services provided outside the contracted network of providers. Required member cost sharing may be greater when members receive covered services out of network. MA PPO

plans may be offered on a local or regional (frequently multi-state) basis. Special payment and other rules apply to regional PPOs.

Medicare Blue members have in-network access to Blue MA PPO providers.

You can recognize an MA PPO member when his or her BlueCross BlueShield member ID card has this logo:



MA PFFS

An MA PFFS plan is a plan in which the member can go to any Medicare-approved doctor or hospital that accepts the plan's terms and conditions of participation. Acceptance is "deemed" to occur when the provider is aware, in advance of furnishing services, that the member is enrolled in a PFFS product and when the provider has reasonable access to the terms and conditions of participation.

The MA organization, rather than the Medicare program, pays for services rendered to such members. Members are responsible for cost sharing, as specified in the plan, and balance billing may be permitted in limited instances in which the provider is a network provider and the plan expressly allows for balance billing.

MA PFFS varies from other Blue products you might currently participate in:

- You can see and treat any MA PFFS member without having a contract with BlueCross BlueShield of South Carolina.
- If you do provide services, you will do so under the terms and conditions of that member's Blue Plan.
- MA PFFS terms and conditions might vary for each Blue Plan. We advise that you review them before serving MA PFFS members.
- Please refer to the back of the member's ID card for information on accessing the plan's terms and conditions. You may choose to render services to an MA PFFS member on an episode-of-care (claim-by-claim) basis.
- For your convenience, you will find MA PFFS terms and conditions for all Blue Plans at www.SouthCarolinaBlues.com providing the member's three-letter alpha prefix.
 - Submit your MA PFFS claims to BlueCross BlueShield of South Carolina.

MA Medical Savings Account (MSA)

An MA MSA is a Medicare health plan option made up of two parts. One part is a Medicare MSA health insurance policy with a high deductible. The other part is a special savings account where Medicare deposits money to help members pay their medical bills.

4.5.2 Reimbursement for MA PPO, HMO, POS and PFFS

Based upon the Centers for Medicare and Medicaid Services (CMS) regulations, if you are a provider who accepts Medicare assignment and you render services to an MA member for whom you have no obligation to provide services under your contract with a Blue Plan, you will generally be considered a non-contracted provider and be reimbursed the equivalent of the current Medicare-allowed amount for all covered services (i.e., the amount you would collect if the beneficiary was enrolled in traditional Medicare).

Special payment rules apply to hospitals and certain other entities (e.g., skilled nursing facilities) that are non-contracted providers.

Make sure you understand the applicable MA reimbursement rules.

Providers that are paid on a reasonable cost basis under traditional Medicare should send their CMS Interim Payment Rate letter with their MA claims. The plan will need this letter to calculate the Medicare-allowed amount.

Other than the applicable member cost-sharing amounts, a Blue Plan or its branded affiliate makes reimbursement directly. In general, you can collect only the applicable cost-sharing (e.g., copayment) amounts from the member at the time of service, and cannot otherwise charge or balance bill the member.

NOTE: Enrollee payment responsibilities can include more than copayments (e.g., deductibles).

Please review the remittance notice concerning MA plan payment, member's payment responsibility and balance billing limitations.

4.6 Medical Records

Blue Plans have made many improvements to the medical records process to make it more efficient and are able to send and receive medical records electronically with other Blue Plans. This method significantly reduces the time it takes to transmit supporting documentation for our out-of-area claims, reduces the need to request records multiple times and significantly reduces lost or misrouted records.

There are various circumstances for which a provider may get requests for medical records for out-of-area members:

- As part of the pre-authorization process, if you receive requests for medical records from other Blue Plans prior to rendering services, you will be instructed to submit the records directly to the member's Plan that requested them. This is the only circumstance in which you would not submit them to BlueCross BlueShield of South Carolina.
- As part of claim review and adjudication — these requests will come from BlueCross BlueShield of South Carolina in the form of a letter, fax, email or electronic communication requesting specific medical records and including instructions for submission.

BlueCard Medical Record Process for Claim Review

When medical records are needed, your office should receive an initial communication generally in the form of a letter requesting the needed information. Your office will also receive a remittance indicating the Plan is denying the claim pending receipt and review of records.

Occasionally, the medical records you submit might cross in the mail with the remittance advice for the claim indicating a need for medical records. A remittance advice is not a duplicate request for medical records. If you submitted medical records previously, but received a remittance advice indicating records were still needed, go to My Insurance Manager or call 800-868-2510 to ensure the Plan has received and is processing your original submission. This will prevent you from sending duplicate records unnecessarily.

Upon receipt of the information, the Plan will review the claim to determine the benefits.

Helpful Ways You Can Assist in Timely Processing of Medical Records

If the records are requested following submission of the claim, forward all requested medical records to BlueCross BlueShield of South Carolina. Follow the submission instructions given on the request using the specified physical or email address, or fax number. The address or fax number for medical records may be different than the address you use to submit claims. Include the cover letter you received with the request when submitting the medical records. This is necessary to make sure we route the records properly once we receive them.

Please submit the information to us as soon as possible to avoid further delay. Only send the information specifically requested. Frequently, complete medical records are not necessary.

Please do not proactively send medical records with the claim. Unsolicited claim attachments may cause claim payment delays.

4.7 Adjustments

Contact BlueCross BlueShield of South Carolina if an adjustment is required. We will work with the member's Blue Plan for adjustments. Your workflow, however, should not be different.

4.8 Appeals

BlueCross BlueShield of South Carolina handles appeals for all claims. We will coordinate the appeal process with the member's Blue Plan, if needed.

4.9 Claim Payment

If you have not received payment for a claim, do not resubmit the claim because we will deny it as a duplicate. This will cause member confusion because of multiple EOBs received.

If you do not receive your payment or a response about your payment, go to My Insurance Manager or contact us at 800-868-2510 to check the status of your claim.

In some cases, a member's Blue Plan may pend a claim because medical review or additional information is necessary. When resolution of a pended claim requires additional information from you, BlueCross BlueShield of South Carolina may either ask you for the information or give the member's Plan permission to contact you directly.

4.10 Claim Status Inquiry

BlueCross BlueShield of South Carolina is your single point of contact for all claim inquiries.

You can check claim status by using:

- My Insurance Manager
- Phone — call BlueCross BlueShield of South Carolina at 800-868-2510
- Electronically — send a HIPAA transaction 276 (claim status inquiry) via our website.

4.11 Calls from Members and Others with Claim Questions

If other Blue Plan members contact you, assist them as much as possible. If they have additional questions, advise them to contact their Blue Plan. Refer them to their ID cards for a Customer Service number.

The member's Plan should not contact you directly about claims issues. If the member's Plan contacts you and asks you to submit the claim to it, refer the Plan to BlueCross BlueShield of South Carolina.

4.12 Key Contacts

For more information:

- Visit www.SouthCarolinaBlues.com.
- My Insurance Manager
- Call BlueCross BlueShield of South Carolina at 800-868-2510.
- Contact Provider Education at provider.education@cbssc.com.

5. Frequently Asked Questions

What is the BlueCard program?

The BlueCard program enables Blue Plan members to get health care service benefits and savings while traveling or living in another Blue Plan's service area. The program links participating health care providers across the country and internationally, through a single electronic network for claims processing and reimbursement. The BlueCard program lets you submit claims for Blue Plan members directly to BlueCross BlueShield of South Carolina. BlueCross will be your point of contact for education, contracting, claims payment/adjustments and problem resolution.

What products do BlueCross BlueShield of South Carolina include in the BlueCard program?

These products/claims are included in the BlueCard program:

- Traditional (indemnity insurance)
- PPO
- HMO

What products are excluded from the BlueCard program?

These products/claims are excluded from the BlueCard program:

- Stand-alone dental
- FEP

What is the BlueCard traditional program?

It is a national program that offers members traveling or living outside of their Blue Plan's area traditional or indemnity level of benefits when they get services from a physician or hospital outside of their Blue Plan's service area.

What is the BlueCard PPO program?

It is a national program that offers members traveling or living outside of their Blue Plan's area the PPO level of benefits when they get services from a physician or hospital designated as a BlueCard PPO provider.

Are HMO patients served through the BlueCard program?

Yes, occasionally, Blue HMO members affiliated with other Blue Plans will seek care at your office or facility. You should handle claims for these members the same way you do for BlueCross BlueShield of South Carolina members, Blue traditional and PPO patients from other Blue Plans by submitting them to the BlueCross BlueShield of South Carolina.

How do I identify BlueCard members?

When members from Blue Plans arrive at your office or facility, be sure to ask them for their current Blue Plan membership identification cards. The main identifier for out-of-area members is the alpha prefix. The ID cards may also have these logos:

- PPO in a suitcase
- PPOB in a suitcase
- Blank suitcase

What is an alpha prefix?

The three-character alpha prefix at the beginning of the member's identification number is the key element used to identify and correctly route claims. The alpha prefix identifies the Blue Plan or national account to which the member belongs. It is critical for confirming a patient's membership and coverage.

What do I do if a member has an identification card without an alpha prefix?

Some members may carry outdated identification cards or have a card that may not have an alpha prefix. Ask the member for the current identification card or call the eligibility number on the card to determine if a new card with an alpha prefix has been issued.

How do I identify international members?

Occasionally, you may see identification cards from members residing abroad or foreign Blue Plan members. These ID cards will contain three-character alpha prefixes. Please treat these members the same as domestic Blue Plan members.

How do I verify membership and coverage?

For BlueCross BlueShield of South Carolina members, go to My Insurance Manager.

For other Blue Plan members, call BlueCard Eligibility at 800-676-BLUE(2583) or use the EPA tool.

Electronic — Submit a HIPAA 270 transaction (eligibility) to BlueCross BlueShield South Carolina via www.SouthCarolinaBlues.com.

What is the member cost-sharing level and copayments?

A member cost-sharing level and copayment is based on the member's health plan. You can collect the copayment amounts from the member at the time of service. To determine the cost-sharing and/or copayment amounts, you should call BlueCard Eligibility at 800-676-BLUE(2583).

How do I get utilization review?

As a BlueCross provider, you are responsible for getting pre-certification/preauthorization for inpatient and/or outpatient services from a member's Blue Plan, as required by the account or member contract (provider financial responsibility).

You can do so by:

- Phone — Call the utilization management/pre-certification number on the member's ID card. If the utilization management number is not listed on the member's ID card, call BlueCard Eligibility at 800-676-BLUE (2583) and ask to be transferred to the utilization review area.
- Electronic — Submit a HIPAA 278 transaction (referral/authorization) via www.SouthCarolinaBlues.com.

Where and how do I submit BlueCard claims?

You should always submit claims to BlueCross BlueShield of South Carolina. Be sure to include the member's complete identification number when you submit the claim. The complete identification number includes the three-character alpha prefix. Do not make up alpha prefixes. We cannot process claims with incorrect or missing alpha prefixes and/or member identification numbers.

How do I submit claims for international Blue members?

The claim submission process for international Blue Plan members is the same as for domestic Blue Plan members. You should submit the claim directly to BlueCross BlueShield of South Carolina.

How do I submit COB claims?

If after verifying eligibility by calling 800-676-BLUE(2583), you discover the member has secondary coverage and BlueCross BlueShield of South Carolina is the primary payer, submit the claim with COB information to BlueCross BlueShield of South Carolina.

How do I submit traditional Medicare-related claims?

When Medicare is primary, submit claims to your local Medicare intermediary. All Blue claims are set up to automatically cross over (or forward) to the member's Blue Plan after the Medicare intermediary adjudicates them. Be sure to include the alpha prefix.

How do I handle calls from members with questions about their claims?

If members contact you with questions about how the insurance paid their claims, assist them as much as possible. If they have additional questions, refer them to their Blue Plans and the Customer Service number on their member ID cards.

How do I identify MA members?

Members will not have a standard Medicare card. Instead, a Blue logo will be visible on the ID card. These examples illustrate how the different products associated with the MA program will be designated on the front of the member ID cards:

<p><i>Member ID cards for MA products will display one of the benefit product logos shown here:</i></p>		HMO
		MSA
		PFFS
		POS
		Network Sharing PPO

Do I have to provide services to MA PPO members from other Blue Plans?

If you are a contracted MA PPO provider with BlueCross BlueShield of South Carolina, you must provide the same access to care as you do for Blue MA PPO members. You can expect to receive the same contracted rates for such services.

If you are not an MA PPO-contracted provider, you may see MA members from other Blue Plans but you are not required to do so. Should you decide to provide services to Blue MA members, you will be reimbursed for covered services at the Medicare- allowed amount based on where the services were rendered and under the member's out-of-network benefits. For urgent or emergency care, you will be reimbursed at the in-network benefit level.

What if my practice is closed to new local Blue MA PPO members?

If your practice is closed to new local Blue MA PPO members, you do not have to provide care for Blue MA PPO out-of-area members. The same contractual arrangements apply to these out-of-area network-sharing members as your local MA PPO members.

What is BCBS MA PPO Network Sharing?

Network sharing allows MA PPO members from MA PPO Blue Plans to get in-network benefits when traveling or living in the service areas of the MA PPO Plans as long as the member sees a contracted MA PPO provider. MA PPO shared networks are available in 34 states and one territory:

Alabama	Arkansas	California	Colorado
Connecticut	Florida	Georgia	Hawaii
Idaho	Indiana	Kentucky	Maine
Massachusetts	Michigan	Missouri	Montana*
North Carolina	Nevada	New Hampshire	New Jersey
New Mexico*	New York	Ohio	Oklahoma*
Oregon	Pennsylvania	Puerto Rico	South Carolina
Tennessee	Texas	Utah	Virginia
Washington	Wisconsin	West Virginia	

*participating effective January 1, 2014

Where can I find more information?

For more information:

- Visit the BlueCross BlueShield of South Carolina website at www.SouthCarolinaBlues.com.
- Contact Provider Education at provider.education@bcbssc.com.

6. BlueCard Program Quick Tips

The BlueCard program provides a valuable service that lets you file all claims for members from other Blue Plans with BlueCross BlueShield of South Carolina.

Here are some key points to remember:

- Make a copy of the front and back of the member's ID card.
- Look for the three-character alpha prefix that precedes the member's ID number on the ID card.
- Call BlueCard Eligibility at 800-676-BLUE(2583) to verify the patient's membership and coverage or submit an electronic HIPAA 270 transaction (eligibility) to BlueCross BlueShield of South Carolina.
- Submit the claim to BlueCross BlueShield of South Carolina. Always include the patient's complete identification number, which includes the three-character alpha prefix.
- For claims inquiries, visit My Insurance Manager or call 800-334-BLUE(2583).

BlueCard Contacts and Resources	
BlueCard Eligibility	1-800-676-BLUE (2583)
BlueCard Access Line (Provider Search)	1-800-810-BLUE (2583) www.SouthCarolinaBlues.com Select <i>Find a Provider</i>
BlueCard Authorization	www.SouthCarolinaBlues.com Select <i>My Insurance Manager</i>
BlueCard Claim Status	www.SouthCarolinaBlues.com Select <i>My Insurance Manager</i>
BlueCard Program Provider Manual	www.SouthCarolinaBlues.com
Provider Education	Email: Provider.Education@bcbssc.com 1-800-288-2227, ext. 44730

7. Glossary of BlueCard Program Terms

Administrative Services Only (ASO)

ASO accounts are self-funded. The local Plan administers claims on behalf of the account, but does not fully underwrite the claims. ASO accounts may have benefit or claims processing requirements that may differ from non-ASO accounts. There may be specific requirements that affect medical benefits, submission of medical records, COB or timely filing limitations.

BlueCross BlueShield of South Carolina receives and prices all local claims, handles all interactions with providers with the exception of utilization management interactions, and makes payment to the local provider.

Alpha Prefix

Three characters preceding the subscriber identification number on the Blue Plan ID cards. The alpha prefix identifies the member's Blue Plan or national account and is required for routing claims.

bcbs.com

Blue Cross and Blue Shield Association's website, which contains useful information for providers.

BlueCard Access 800-810-BLUE (2583)

A toll-free 800 number for you and members to use to locate health care providers in another Blue Plan's area. This number is useful when you need to refer the patient to a physician or health care facility in another location.

BlueCard Eligibility 800-676-BLUE (2583)

A toll-free 800 number for you to verify membership and coverage information, and get pre-certification for patients from other Blue Plans.

BlueCard PPO

A national program that offers members traveling or living outside of their Blue Plan's area the PPO level of benefits when they get services from a physician or hospital designated as a BlueCard PPO provider.

BlueCard PPO member

Carries an ID card with this identifier on it. Only members with this identifier can access the benefits of the BlueCard PPO.



BlueCard Doctor & Hospital Finder Website

A website you can use to locate health care providers in another Blue Plan's area <http://www.bcbs.com/healthtravel/finder.html>. This is useful when you need to refer the patient to a physician or health care facility in another location. If you find that any information about you, as a provider, is incorrect on the website, please contact provider.education@bcbsc.com.

BlueCard Worldwide®

A medical assistance program that provides Blue members traveling or living outside the United States, Puerto Rico and U.S. Virgin Islands with access to doctors and hospitals around the world.

Consumer-Directed Health Care Plans (CDHP)/CDHC

CDHC is a broad umbrella term that refers to a movement in the health care industry to empower members, reduce employer costs and change consumer health care purchasing behavior. CDHC provides the member with additional information to make an informed and appropriate health care decision through the use of member support tools, provider and network information, and financial incentives.

Coinsurance

A provision in a member's coverage that limits the amount of coverage by the benefit plan to a certain percentage. The member pays any additional costs out of pocket.

Coordination of Benefits (COB)

Ensures that members receive full benefits and prevents double payment for services when a member has coverage from two or more sources. The member's contract language gives the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.

Copayment

A specified charge that a member incurs for a specified service at the time the service is rendered.

Deductible

A flat amount the member incurs before the insurer will make any benefit payments.

Exclusive Provider Organization (EPO)

An EPO is a health benefits program in which the member receives no benefits for care received outside the network except emergency care and does not include a primary care physician selection. EPO benefit coverage may be delivered via BlueCard PPO and is restricted to services BlueCard PPO providers provide.

Hold Harmless

An agreement with a health care provider not to bill the member for any difference between billed charges for covered services (excluding coinsurance) and the amount the health care provider has contractually agreed upon with a Blue Plan as full payment for these services.

Medicaid

A program designed to assist low-income families in providing health care for themselves and their children. It also covers certain individuals who fall below the federal poverty level. Other people who are eligible for Medicaid include low-income children under age 6 and low-income, pregnant women. Overall federal guidelines govern Medicaid in terms of eligibility, procedures, payment level, etc., but states have a broad range of options within those guidelines to customize the program to their requirements and/or can apply for specific waivers. The CMS must approve state

Medicaid programs. The State Department of Health (or similar state agency) oversees their daily operations.

Medicare Advantage (MA)

MA is the program alternative to standard Medicare Part A and Part B FFS coverage; generally referred to as “traditional Medicare.”

MA offers Medicare beneficiaries several product options (similar to those available in the commercial market), including HMO, PPO, POS and PFFS plans.

Medicare Crossover

Medicare established the Crossover program to allow Medicare to transfer Medicare Summary Notice (MSN) information directly to a payer with Medicare’s supplemental insurance company.

Medicare Supplemental (Medigap)

Pays for expenses Medicare doesn’t cover. Medigap is a term for a health insurance policy private insurance companies sell to fill the “gaps” in original Medicare plan coverage. Medigap policies help pay some of the health care costs that the original Medicare plan doesn’t cover.

Federal and state laws regulate and standardize Medigap policies. There may be up to 12 different standardized Medigap policies (Medigap plans A through L). Each plan, A through L, has a different set of basic and extra benefits. The benefits in any Medigap plan A through L are the same for any insurance company. Each insurance company decides which Medigap policies it wants to sell.

Most of the Medigap claims are submitted electronically directly from the Medicare intermediary to the member’s Home Plan via Medicare Crossover process.

Medigap does not include MA products, which are a separate program under the Centers for Medicare & Medicaid Services (CMS). Members who have an MA plan do not typically have a Medigap policy because under MA these policies do not pay any deductibles, copayments or other cost sharing.

National Account

An employer group with employee and/or retiree locations in more than one Blue Plan’s service area.

Other Party Liability (OPL)

Cost containment programs that ensure Blue Plans meet their responsibilities efficiently without assuming the monetary obligations of others and without allowing members to profit from illness or accident. OPL includes COB, Medicare, workers’ compensation, subrogation and no-fault auto insurance.

Plan

Refers to any Blue Plan.

Point of Service (POS)

A POS is a health benefit program in which the member receives the highest level of benefits when the member gets services from his or her primary care provider/group and/or complies with referral authorization requirements for care. Benefits are still provided when the member receives care from any eligible provider without referral authorization, according to the terms of the contract.

Preferred Provider Organization (PPO)

A PPO is a health benefit program that provides a significant incentive to members when they get services from a designated PPO provider. The benefit program does not require a gatekeeper (primary care physician) or referral to access PPO providers.

Preferred Provider Organization Basic (PPOB)

A health benefit program that provides a significant financial incentive to members when they get services from any physician or hospital designated as a PPO provider and that does not require a primary care physician gatekeeper/referral to access PPO providers. Similar to BlueCard PPO/EPO, this network includes providers specializing in numerous types of care, as well as other provider types, such as Essential Community and Indian Health Service providers where they are available.

State Children's Health Insurance Program (SCHIP)

SCHIP is a public program the [United States Department of Health and Human Services](#) administers. It provides [matching funds](#) to states for [health insurance](#) to families with children. The program covers uninsured children in families with incomes that are modest but too high to qualify for [Medicaid](#). It gives states flexibility in designing their SCHIP eligibility requirements and policies within broad federal guidelines.

Traditional Coverage

Traditional coverage is a health benefit plan that provides basic and/or supplemental hospital and medical/surgical benefits (e.g., basic, major medical and add-on riders) designed to cover various services. Such products generally include cost-sharing features, such as deductibles, coinsurance or copayments.