BlueCross BlueShield of South Carolina and
BlueChoice® HealthPlan of South Carolina

Independent licensees of the Blue Cross Blue Shield Association.

Consolidated Appropriations Act (CAA)

Frequently Asked Questions

Surprise Billing

1. **What is surprise billing?**
   Surprising billing is when a patient receives an unexpected bill from a health care provider or facility. This can happen when the patient unknowingly obtains medical care from a provider or facility outside of their health plan's network. Surprise billing happens in both emergency and non-emergency care.
2. **How does the No Surprises Act prevent surprise billing?**
   The No Surprises Act helps to prevent the following:
   - Bans surprise billing for emergency services. Emergency services, regardless of where they are provided, must be treated on an in-network basis without requirements for prior authorization.
   - Bans high out-of-network cost-sharing for emergency and non-emergency services. Patient cost-sharing cannot be higher than if such services were provided by an in-network provider, and any coinsurance or deductible must be based on in-network provider rates.
   - Bans out-of-network charges for ancillary care at an in-network facility in all circumstances.
   - Bans other out-of-network charges without advance notice. Health care providers and facilities must provide patients with a plain-language consumer notice explaining that patient consent is required to receive care on an out-of-network basis before that provider can bill at the higher out-of-network rate.

Independent Dispute Resolution (IDR)

3. **What is the purpose of independent dispute resolutions?**
   The independent dispute resolution process may be used to determine out-of-network rates for certain emergency services, nonemergency items, and services furnished by nonparticipating providers at participating health care facilities, and for air ambulance services furnished by nonparticipating provider of air ambulance services where an All-Payer Model Agreement or specified state law does not apply.

   Note: IDR occurs between the provider and the health plan; the patient/member is not involved.
4. **Where is the independent dispute resolution form located?**
   The independent dispute resolution form is located on www.SouthCarolinaBlues.com and www.BlueChoiceSC.com at the following links:

   BlueCross –

https://www.southcarolinablues.com/web/public/resources/4626e99b-f523-42dc-be41-2f59d2abed40/Open+Negotiation+Notice+form_20211209_Final.pdf?MOD=AJPERES&CVID=nSAVtgB

BlueChoice® HealthPlan – https://www.bluechoicesc.com/sites/default/files/documents/Open%20Negotiation%20Notice%20form_20211209_Final.pdf

5. **How should the independent dispute resolution form be submitted?**
   The independent dispute resolution form can be mailed in to:
   - AX – 620
     I-20 @ Alpine Road
     Columbia, SC 29219

   Or it can be emailed to OPN_IDR_Requests@bcbssc.com.
6. **What is the overall independent dispute resolution process?**
   For more information on the independent dispute resolution process, please visit https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act.

Member Identification Cards

7. **What are the new requirements for member identification cards?**
   As part of the No Surprises Act, member identification cards are to include the following components to improve transparency around in-network and out-of-network costs:
   - All plan deductibles, both in-network and out-of-network
   - Out-of-pocket maximum, both in-network and out-of-network
   - A phone number and web address for consumer information, including information on in-network providers
8. **Will all members receive a new identification card?**
   New identification cards will only be issued to members that normally receive a new identification card, such as during open enrollment or if ordering a new card.

   Existing members will not be issued a new identification card unless there is another change that would require a new card, such as an alpha prefix change or group number change.

   All members can access their updated identification card via My Health Toolkit.

Advanced Explanation of Benefits

IMPORTANT NOTICE: The information below summarizes the requirements under the CAA; however, the Federal government has delayed enforcement until guidance is issued. BlueCross and BlueChoice® have paused their implementation of these requirements until this guidance is issued.

9. **What must be included in the advanced explanation of benefits?**
   To meet the advanced explanation of benefits requirements under the No Surprises Act, health plans must submit documentation to the patient to include the following information:
   - Whether the provider or facility is in-network or out-of-network

- The contracted rate for the service if it is in-network
- A description of where to find information regarding in-network providers or facilities if the service is out-of-network
- A good faith estimate from the provider or facility based on applicable medical billing codes
- An estimate of the amount payable under the plan
- An estimate of the patient's cost-sharing responsibility
- An estimate of any accrued amounts that patient has already met regarding out-of-pocket maximums and deductibles
- Whether the proposed service is subject to medical management practices such as prior authorization, concurrent review, or fail-first protocols
- A disclaimer informing the patient that all the listed costs are only estimates
- Any other information deemed appropriate by plan administrators

10. **When does an advanced explanation of benefits need to be submitted?**
    The timing for providing an advanced explanation of benefits depends on when the patient schedules a service or requests an estimate.
    If the patient schedules a service three to nine days before the intended date of service, the plan must submit an advanced explanation of benefits within one business day after receiving notification from the provider or facility.

    If the patient schedules a service 10 days or more before the intended date of service, the plan must submit an advanced explanation of benefits within three business days of notification.

    Advanced explanation of benefits can be submitted to the patient electronically or by mail.

Provider Validation Updates

11. **How often will providers need to validate their information in the provider directory?**
    As part of the No Surprises Act, providers will be required to verify their demographic data at least every 90 days. This applies to both individual physicians and facilities.
12. **How can providers validate their demographic data?**
    Validations should be completed through M.D. Checkup, which can be accessed through My Insurance Manager℠. Validations will be determined based on the number of days since the last validation was made.
13. **What happens if a provider misses the validation date?**
    If more than 90 days has passed since the provider's last validation, we are required to suppress them from our provider directory.