Pamela D. Anderson
1527 Kenwood Road
Manning, South Carolina 29102
803-460-3131

February 24, 2015

Alicia Cornelius
Insurance Regulatory Analyst
Consumer Services Division
South Carolina Department of Insurance
Post Office Box 100105
Columbia, South Carolina 29202

Re: 154103

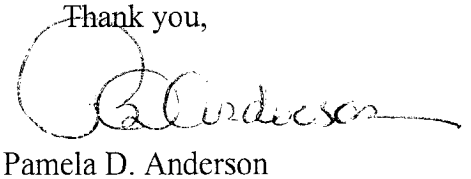
Dear Ms. Cornelius:

I received the letter with enclosures dated February 16, 2015 from Selena A. Suber of BlueCross BlueShield on Saturday, February 21, 2015. I received your letter enclosing hers dated February 20, 2015 yesterday, after I had responded to her letter and copied the Department.

Both my letter of February 10, 2015 and February 23, 2015 contain information that BlueCross BlueShield is attempting to deny coverage **based only <u>on a portion</u> of the USPSTF guidelines** because the complete recommendations do not limit screenings to only those ages 50-75. *Affordable Care Act* implementation information was included with both letters which confirms the USPSTF Grade A or B screenings include high-risk individuals (those with a family history) and are to be covered with no cost sharing imposed.

Please review both of these letters and all attachments and do not hesitate at all to contact me to further discuss this matter.

Thank you,



Pamela D. Anderson

/pda
enclosures as stated

bcc: US Department of Health & Human Services
The Hon. Kevin L. Johnson, Senator, SC District 36
SC Governor's Office of Ombudsman

SOUTH CAROLINA
DEPARTMENT OF INSURANCE

Division of Market and Consumer Services
Office of Consumer Services
1201 Main St, Suite 1000
Columbia, South Carolina 29201

Mailing Address:
P.O. Box 100105, Columbia, S.C. 29202-3105
Telephone: (803) 737-6180 or 1-800-768-3467

February 20, 2015

Pamela Anderson
1527 Kenwood Road
Manning, SC 29102

In Reply Refer To: 154103
Blue Cross Blue Shield of SC

Dear Ms. Anderson:

We received a reply from the company and a company of the reply mailed directly to you. The company maintains that the claim was denied in accordance with policy guidelines and per recommended USPSTF guidelines.

A copy of the guidelines was included with their reply to you. They further advise that you contacted their office prior to having the procedure and was advised that it would not be process as preventive but as a diagnostic procedure. According to recommended guidelines of the USPSTF the services are recommended as preventive for individual 50 and over.

They have also address your concerns regarding their communication with your medical provider and that it did not violate HIPAA privacy requirements.

If you have any questions, please let me know. Thank you for the opportunity to serve you.

Respectfully,

Alicia Cornelius

ALICIA CORNELIUS
Insurance Regulatory Analyst
Consumer Services Division

Enclosure

South Carolina

February 16, 2015

Ms. Pamela D. Anderson
1527 Kenwood Rd
Manning, SC 29102 7746

RE:		
	Insured:	Pamela D. Anderson
	Patient:	Pamela D. Anderson
	ID#:	ZCR838648228830
	Claim #:	5C21555700000

Dear Ms. Anderson:

This letter is in response to your appeal letter dated February 10, 2015 concerning services rendered January 19, 2014 by Sumter Gastroenterology LLC. We received your letter in our office February 11, 2014 as an attachment to the inquiry you sent to the Department of Insurance.

The claim referenced above was correctly denied in accordance with the BlueEssentials Gold 1 policy guidelines. This policy provides benefits for screening colonoscopies as defined in the USPSTF A and B Recommendations (see attachment). A Notice of Adverse Determination is included along with a copy of the Schedule of Benefits.

According to our records, you contacted us before the consultation and were advised the USPSTF guidelines only recommend screening colonoscopies at or above age 50. Because you do not meet this age criteria, the benefits would pay only after you have met your deductible and paid any applicable coinsurance. You requested a copy of the USPSTF A & B Recommendations; we apologize that these had not been provided to you prior to your complaint to DOI and are including them with this response.

The provider contacted us February 4, 2015 to determine benefits and eligibility. We advised the provider that if the procedure qualifies as a screening procedure under USPSTF guidelines, it is paid with 100% benefits; however, the USPSTF guidelines do not recommend screening colonoscopies prior to age 50. If a member receives a colonoscopy prior to age 50, benefits will be paid as though for a diagnostic procedure and the claim would process by applying the plan's deductible/coinsurance. Our communication with the provider related to your treatment and payment is not in violation of HIPAA privacy requirements. Federal regulations at 45 C.F.R. § 164.506 (c) allow communication between a covered entity/health care insurer and a health care provider for the purpose of treatment or payment.

This concludes all mandatory appeals under your health plan of benefits. Please contact me if you need any further assistance or have any questions in the future.

Sincerely,

Selena A. Suber

Selena A. Suber, Priority Counselor
Group and Individual Operations
Phone: 1-800-868-2500 extension 42569
Fax: 1-803-264-8335

Enclosures: USPSTF A and B Recommendations – US Preventive Services Task Force
Schedule of Benefits
Adverse Notice of Determination

USPSTF A and B Recommendations

Topic	Description	Grade	Release Date of Current Recommendation
Abdominal aortic aneurysm screening: men	The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked.	B	June 2014*
Alcohol misuse: screening and counseling	The USPSTF recommends that clinicians screen adults age 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.	B	May 2013*
Anemia screening: pregnant women	The USPSTF recommends routine screening for iron deficiency anemia in asymptomatic pregnant women.	B	May 2006
Aspirin to prevent cardiovascular disease: men	The USPSTF recommends the use of aspirin for men ages 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage.	A	March 2009
Aspirin to prevent cardiovascular disease: women	The USPSTF recommends the use of aspirin for women ages 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.	A	March 2009
Bacteriuria screening: pregnant women	The USPSTF recommends screening for asymptomatic bacteriuria with urine culture in pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.	A	July 2008
Blood pressure screening in adults	The USPSTF recommends screening for high blood pressure in adults age 18 years and older.	A	December 2007
BRCA risk assessment and genetic counseling/testing	The USPSTF recommends that primary care providers screen women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (*BRCA1* or *BRCA2*). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.	B	December 2013*
Breast cancer preventive medications	The USPSTF recommends that clinicians engage in shared, informed decisionmaking with women who are at increased risk for breast cancer about medications to reduce their risk. For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene.	B	September 2013*
Breast cancer screening	The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older.	B	September 2002†
Breastfeeding counseling	The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding.	B	October 2008
Cervical cancer screening	The USPSTF recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.	A	March 2012*
Chlamydia screening: women	The USPSTF recommends screening for chlamydia in sexually active women age 24 years or younger and in older women who are at increased risk for infection.	B	September 2014*
Cholesterol abnormalities screening: men 35 and older	The USPSTF strongly recommends screening men age 35 years and older for lipid disorders.	A	June 2008
Cholesterol abnormalities screening: men younger than 35	The USPSTF recommends screening men ages 20 to 35 years for lipid disorders if they are at increased risk for coronary heart disease.	B	June 2008
Cholesterol abnormalities screening: women 45 and older	The USPSTF strongly recommends screening women age 45 years and older for lipid disorders if they are at increased risk for coronary heart disease.	A	June 2008
Cholesterol abnormalities screening: women younger than 45	The USPSTF recommends screening women ages 20 to 45 years for lipid disorders if they are at increased risk for coronary heart disease.	B	June 2008
Colorectal cancer screening	The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.	A	October 2008
Dental caries prevention: infants and children up to age 5 years	The USPSTF recommends the application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption in primary care practices. The USPSTF recommends primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient.	B	May 2014*
Depression screening: adolescents	The USPSTF recommends screening adolescents (ages 12-18 years) for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.	B	March 2009
Depression screening: adults	The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.	B	December 2009
Diabetes screening	The USPSTF recommends screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.	B	June 2008
Falls prevention in older adults: exercise or physical therapy	The USPSTF recommends exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.	B	May 2012
Falls prevention in older adults: vitamin D	The USPSTF recommends vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.	B	May 2012
Folic acid supplementation	The USPSTF recommends that all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.	A	May 2009
Gestational diabetes mellitus screening	The USPSTF recommends screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation.	B	January 2014
Gonorrhea prophylactic medication: newborns	The USPSTF recommends prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmia neonatorum.	A	July 2011*
Gonorrhea screening: women	The USPSTF recommends screening for gonorrhea in sexually active women age 24 years or younger and in older women who are at increased risk for infection.	B	September 2014*
Healthy diet and physical activity counseling to prevent cardiovascular disease: adults with cardiovascular risk factors	The USPSTF recommends offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.	B	August 2014*
Hearing loss screening: newborns	The USPSTF recommends screening for hearing loss in all newborn infants.	B	July 2008
Hemoglobinopathies screening: newborns	The USPSTF recommends screening for sickle cell disease in newborns.	A	September 2007
Hepatitis B screening: nonpregnant adolescents and adults	The USPSTF recommends screening for hepatitis B virus infection in persons at high risk for infection.	B	May 2014
Hepatitis B screening: pregnant women	The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit.	A	June 2009
Hepatitis C virus infection screening: adults	The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.	B	June 2013

HIV screening: nonpregnant adolescents and adults	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.	A	April 2013*
HIV screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.	A	April 2013*
Hypothyrodism screening: newborns	The USPSTF recommends screening for congenital hypothyroidism in newborns.	A	March 2008
Intimate partner violence screening: women of childbearing age	The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.	B	January 2013
Iron supplementation in children	The USPSTF recommends routine iron supplementation for asymptomatic children ages 6 to 12 months who are at increased risk for iron deficiency anemia.	B	May 2006
Lung cancer screening	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.	B	December 2013
Obesity screening and counseling: adults	The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m^2 or higher to intensive, multicomponent behavioral interventions.	B	June 2012*
Obesity screening and counseling: children	The USPSTF recommends that clinicians screen children age 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.	B	January 2010
Osteoporosis screening: women	The USPSTF recommends screening for osteoporosis in women age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.	B	January 2012*
Phenylketonuria screening: newborns	The USPSTF recommends screening for phenylketonuria in newborns.	B	March 2008
Preeclampsia prevention: aspirin	The USPSTF recommends the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.	B	September 2014
Rh incompatibility screening: first pregnancy visit	The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.	A	February 2004
Rh incompatibility screening: 24–28 weeks' gestation	The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D) -negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.	B	February 2004
Sexually transmitted infections counseling	The USPSTF recommends intensive behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections.	B	September 2014*
Skin cancer behavioral counseling	The USPSTF recommends counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.	B	May 2012
Tobacco use counseling and interventions: nonpregnant adults	The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products.	A	April 2009
Tobacco use counseling: pregnant women	The USPSTF recommends that clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling to those who smoke.	A	April 2009
Tobacco use interventions: children and adolescents	The USPSTF recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.	B	August 2013
Syphilis screening: nonpregnant persons	The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection.	A	July 2004
Syphilis screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.	A	May 2009
Visual acuity screening in children	The USPSTF recommends vision screening for all children at least once between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors.	B	January 2011*

The Department of Health and Human Services, in implementing the Affordable Care Act under the standard it sets out in revised Section 2713(a)(5) of the Public Health Service Act, utilizes the 2002 recommendation on breast cancer screening of the U.S. Preventive Services Task Force. To see the USPSTF 2009 recommendation on breast cancer screening, go to http://www.uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/breast-cancer-screening.

Previous recommendation was an "A" or "B."

Current as of: October 2014

Internet Citation: *USPSTF A and B Recommendations.* U.S. Preventive Services Task Force. October 2014. http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

Schedule of Benefits for Business BlueEssentials[SM]
PPO Gold 1

Employer Name:	Client Number:
Client Effective Date:	Group Number:
Anniversary Date:	Coverage Effective Date:
Benefit Period:	

Copayment - You Pay	$15 copay/visit Primary Care Physician (PCP)* office visit $30 copay/visit Specialist* office visit $300 per Emergency Room (ER) visit *Copayments for Primary Care Physicians and Specialists are In-network only. Applies toward the Out-of-pocket Limit and stops when the Out-of-pocket Limit is reached.
Deductible - You pay	Network Providers - $1,200 for Single (individual) coverage or $2,350 for Family coverage each Benefit Period. With family coverage, once one person meets his/her Deductible, benefits will begin paying for that person. Out-of-Network Providers - There is no Deductible Deductible amount applies to the Out-of-pocket Limit.
Out-of-pocket Limit - You pay	Network Providers - $4,200 for Single (individual) coverage or $8,250 for Family coverage each Benefit Period. Out-of-Network Providers - There is no Out-of-Pocket Limit Covered Services will be paid at 100% from Network Providers after the Out-of-pocket Limit is met.
Benefit Period Maximum - We Pay (All Benefit Period Maximums are per Member per Benefit Period)	60 days for Skilled Nursing Facility 60 visits for Home Health Care 6 months per episode for Hospice Care 30 visits for Physical, Speech and Occupational Therapy Services combined - other than Inpatient

There is no Annual or Lifetime Dollar Limits on Essential Health Benefits.

All benefits payable on Covered Services are based on our Allowed Amounts. All Covered Services must be Medically Necessary. Please refer to the Certificate for services that require Preauthorization.

Schedule of Benefits for Business BlueEssentials℠
PPO Gold 1
(continued)

Services that are covered for you	What you must pay when you get these services	
	In-Network	Out-of-Network
Prescription Drugs - Per prescription or refill		
Retail Pharmacy - Limited to 31-day supply		
- Tier 0 Drugs	$0	50%
- Tier 1 Drugs and designated Over-the-counter Drugs	$10 Copayment	
- Generic Oral birth control	$0	
- Tier 2 Drugs including oral birth control	$35 Copayment	
- Tier 3 Drugs including oral birth control	$100 Copayment	
Mail-service Pharmacy - Limited to a 90-day supply		No Benefits
- Tier 0 Drugs	$0	
- Tier 1 Drugs and designated Over-the-counter Drugs	$14 Copayment	
- Generic Oral birth control	$0	
- Tier 2 Drugs including oral birth control	$95 Copayment	
- Tier 3 Drugs including oral birth control	$270 Copayment	
Specialty Drugs		
- Tier 4 Drugs are available at the Specialty Network Pharmacy Only	$200 Copayment	
Primary Care Physician or Specialist Services		
Office Visit Services - Office charges for the treament of an accident or injury; injections for allergy, tetanus and antibiotics; diagnostic lab and diagnostic X-ray services (such as chest X-rays and standard plain film X-rays), when performed in the Physician's office on the same date and billed by the Physician (excluding Maternity Care)	0% after Copayment	50%
All other services - Lab, X-ray, and the reading/interpretation of diagnostic lab and X-ray services; Surgery; endoscopies (such as proctoscopy and laparoscopy); second surgical opinion; consultation; anesthesia; dialysis treatment, chemotherapy and radiation therapy and Specialty Drugs (including the adminstration)	20% after Deductible	50%
Inpatient and Outpatient (other than office) Physician charges	20% after Deductible	50%

Schedule of Benefits for Business BlueEssentials℠
PPO Gold 1
(continued)

Services that are covered for you	What you must pay when you get these services	
	In-Network	Out-of-Network
Preventive Services		
The following are covered: • United States Preventive Preventive Services Task Force (USPSTF) recommended Grade A or B screenings • Immunizations as recommended by the Centers for Disease Control (CDC). • Screenings recommended for children and women by Health Resources and Services Administration (HRSA) • Preventive prostate screening/lab work according to the American Cancer Society • Preventive Mammography • Lactation support and counseling. Includes breast pump when purchased through a doctor's office, Pharmacy or DME supplier and is limited to one pump every 12 months • Female sterilization • The following contraceptive devices or services: generic injections, Mirena IUD, Nexplanon implant, Ortho Evra patch, Nuvaring, Ortho Flex, Ortho Coil, Ortho Flat, Wide-seal, Omniflex, Prentif and Femcap-vaginal	$0	No Benefits
Contraceptive devices not specifically listed above	20% after Deductible	50%
Laboratory Services		
Outpatient laboratory and pathology	20% after Deductible	50%
Radiology, ultrasound and nuclear medicine; inpatient laboratory and pathology; ECG, EEG and other electronic diagnostic medical procedures and physiological medical testing; Endoscopies (such as colonscopy, proctoscopy and laparoscopy); high technology diagnostic services such as, but not limited to, MRIs, MRAs, PET scans, CT scans, cardiac catheterizations, and procedures performed with contrast or dye	20% after Deductible	50%
Hospital Services		
Inpatient and Outpatient Hospital (other than Skilled Nursing Facilities or Rehabilitation Facilities)	20% after Deductible	50%
Emergency Services		
Emergency Room charges	20% after Copayment and Deductible	20% after Copayment and Deductible
Ambulance, Out-of-Area (including Physician services)	20% after Deductible	50%

Schedule of Benefits for Business BlueEssentials℠
PPO Gold 1
(continued)

Services that are covered for you	What you must pay when you get these services	
	In-Network	Out-of-Network
Maternity		
Pre- and post-natal care including Physician. Hospital services are the	20% after Deductible	50%
Newborn Care		
Post-natal care including Physician. Hospital services are the same as	20% after Deductible	50%
Pediatric Services		
Preventive Care - Grade A or B screenings as recommended by the United States Preventive Services Task Force (USPSTF) Immunizations - As recommended by the Centers for Disease Control (CDC) Routine Vision Services • Eye Exam - limited to one exam per Benefit Period • Eyeglasses - limited to once every two years for frames and once every year for lenses. Contacts only when medically necessary.	$0 $25 Copayment $50 Copayment	No Benefits No Benefits
Rehabilitative and Habilitative		
Durable Medical Equipment (DME) - purchase or rental - excludes repair of, replacement of and duplicate DME	20% after Deductible	50%
Physical, occupational, speech and repiratory therapy	20% after Deductible	50%
Rehabilitation including cardiac and pulmonary	20% after Deductible	50%
Skilled Nursing and Rehabilitation Facilities	20% after Deductible	50%
Medical Supplies	20% after Deductible	50%
Mental Health & Substance Use Disorder Services		
Inpatient and Physician's Services	Paid same as Hospital Services	50%
Outpatient and Physician's Services	Paid same as Hospital Services	50%
Residential Treatment Centers	20% after Deductible	50%
Physician's Office	Paid same as Primary Care Physician	50%
Other Services		
Dental Services Related to Accidental Injury - Only when such care is for treatment, Surgery or appliances caused by accidental bodily injury (except dental injuries occuring through the natural act of chewing). It's limited to care completed within six months of such accident and while the patient is still covered under this Policy.	20% after Deductible	50%
Home Health Care	20% after Deductible	50%
Hospice Care	20% after Deductible	50%
Out-of-Country Services including Facility and Physician	20% after Deductible	50%

Pamela D. Anderson
1527 Kenwood Road
Manning, South Carolina 29102
803-460-3131

February 23, 2015

Selena A. Suber, Priority Counselor
Group and Individual Operations
BlueCross BlueShield of South Carolina
Post Office Box 100300
Columbia, South Carolina 29202-3300

Via Facsimile 803-264-8335 & US Mail

Re: Pamela D. Anderson
ID Number ZCR838648228830
Claim Number 5C21555700000

Dear Ms. Suber:

This letter is in response to yours of February 16, 2015. I must say that I am gravely concerned inasmuch as your response to my letter dated February 10, 2015 (which you purport was received as a copy from the South Carolina Department of Insurance, but was mailed directly to BlueCross and included numerous documents), omitted several key facts.

My records indicate that when I contacted your company by telephone in January, I advised: (1) my mother was very recently diagnosed with Stage IV Colorectal Cancer after being completely asymptomatic until minor issues prompted her physician to refer her for a screening colonoscopy; (2) my mother's gastroenterologist urged her to notify her children to seek screening colonoscopies by the age of 40 due to the type and size of polyps and cancer revealed in the screening process; and, (3) My younger sister, an RN of age 40 at the time, had undergone a screening colonoscopy which revealed polyps of significant size and type to warrant frequent colonoscopy screenings; (4) during a routine visit to my primary care provider, when asked for updated family history, I provided this information and was referred to Sumter Gastroenterology for a screening; (5) during that phone conversation, when I questioned the blanket statement, "Colonoscopies are only covered at age 50", I was told, "Family history is no reason to have a colonoscopy"; and (6) since that time, my father underwent a screening colonoscopy which found significant polyps.

It was during that call that I requested evidence in writing that family history was no reason to have a screening colonoscopy. I was told that I would be provided with this information within 48 hours. I have subsequently requested this information repeatedly

and have not yet been provided with it; however, I included more than the mere quick reference chart from the USPSTF that you enclosed with your letter to me in my letter of February 10, 2015.

The entirety of the USPSTF recommendations with regard to colorectal cancer screening includes the following language: **"...for those with first-degree relatives who developed cancer at a younger age or those with multiple affected first-degree relatives, an earlier start to screening may be reasonable."**

My letter of February 10, 2015 included a set of FAQs issued jointly by DOL, HHS and the Treasury, as posted on websites providing information about the ACA and preventive services. I have again enclosed this information, which details the colorectal cancer screening guidelines of the USPSTF. I have also enclosed a copy of information from the CDC which quotes the USPSTF recommendations and clearly states: **People at higher risk of developing colorectal cancer should begin screening at a younger age, and may need to be tested more frequently.**

As a company that loudly and publicly promotes preventive colorectal cancer screening, I certainly do not want to believe that BlueCross BlueShield of South Carolina is wrongfully denying coverage or delaying proper payment of my claim. I also do not want to believe that my privacy was violated in the manner I believe it was. Your response nor any attempt to justify or misstate the violation omits several components, but sanctions for HIPPA violations are not my primary concern right now. I prefer to believe that, just as the information I originally requested in January has never been sent to me, somewhere along the lines of communication information has been misplaced or overlooked and that my claim for the needed, medically proven and nationally recognized screening will be processed without cost sharing and without further delay.

If I, any member of my family, my primary care provider, Sumter Gastroenterology, LLC, or Wesmark Ambulatory Surgical Center may provide you with any information, please do not hesitate to contact me.

Thank you for your consideration. I look forward to hearing from you soon,

Pamela D. Anderson

/pda
enclosures as stated
cc: Santee Cooper Urgent Care
Sumter Gastroenterology, LLC
Wesmark Ambulatory Surgical Center
SC Department of Insurance
US Department of Health & Human Services
The Hon. Kevin L. Johnson, Senator, SC District 36

CMS.gov
Centers for Medicare & Medicaid Services

Center for Consumer Info + Ins Oversight

The Center for Consumer Information & Insurance Oversight

Affordable Care Act Implementation FAQs - Set 12

Set out below are additional Frequently Asked Questions (FAQs) regarding implementation of various provisions of the Affordable Care Act. These FAQs have been prepared jointly by the Departments of Labor, Health and Human Services (HHS), and the Treasury (collectively, the Departments). Like previously issued FAQs, these FAQs answers questions from stakeholders to help people understand the new law and benefit from it, as intended.

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Limitations on Cost-Sharing under the Affordable Care Act

Coverage of Preventive Services

Limitations on Cost-Sharing under the Affordable Care Act

Public Health Service (PHS) Act section 2707(b), as added by the Affordable Care Act, provides that a group health plan shall ensure that any annual cost-sharing imposed under the plan does not exceed the limitations provided for under section 1302(c)(1) and (c)(2) of the Affordable Care Act. Section 1302(c)(1) limits out-of-pocket maximums and section 1302(c)(2) limits deductibles for employer-sponsored plans.

Q1:Who must comply with the deductible limitations under PHS Act section 2707(b)?

The HHS final regulation on standards related to essential health benefits implements the deductible provisions described in section 1302(c)(2) for non-grandfathered [1] health insurance coverage and qualified health plans offered in the small group market, including a provision implementing section 1302(c)(2)(C) so that such small group market health insurance coverage may exceed the annual deductible limit if it cannot reasonably reach a given level of coverage (metal tier) without exceeding the deductible limit.[2]

With respect to self-insured and large group health plans, as explained in the preamble to the HHS final regulations, the Departments intend to engage in future rulemaking to implement PHS Act section 2707(b). The Departments continue to believe that only plans and issuers in the small group market are required to comply with the deductible limit described in section 1302(c)(2). Public input is welcome in advance of a future rulemaking, which will implement that only plans and issuers in the small group market will be subject to the deductible limit. Please send comments by April 22, 2013 to e.ohpsca-2707.ebsa@dol.gov.

Until that rulemaking is promulgated and effective, the Departments have determined that a self-insured or large group health plan can rely on the Departments' stated intention to apply the deductible limits imposed by section 1302(c)**(2) of the Affordable Care Act only on plans and issuers in the small group market.**

Q2:Who must comply with the annual limitation on out-of-pocket maximums under PHS Act section 2707(b)?

As stated in the preamble to the HHS final regulation on standards related to essential health benefits, the Departments read PHS Act section 2707(b) as requiring all non-grandfathered group health plans to comply with the annual limitation on out-of-pocket maximums described in section 1302(c)(1) of the Affordable Care Act.[3]

The Departments recognize that plans may utilize multiple service providers to help administer benefits (such as one third-party administrator for major medical coverage, a separate pharmacy benefit manager, and a separate managed behavioral health organization). Separate plan service providers may impose different levels of out-of-pocket limitations and may utilize different methods for crediting participants' expenses against any out-of-pocket maximums. These processes will need to be coordinated under section 1302(c)(1), which may require new regular communications between service providers.

The Departments have determined that, only for the first plan year beginning on or after January 1, 2014, where a group health plan or group health insurance issuer utilizes more than one service provider to administer benefits that are subject to the annual limitation on out-of-pocket maximums under section 2707(a) or 2707(b), the Departments will consider the annual limitation on out-of-pocket maximums to be satisfied if both of the following conditions are satisfied:

(a) The plan complies with the requirements with respect to its major medical coverage (excluding, for example, prescription drug coverage and pediatric dental coverage); and

(b) To the extent the plan or any health insurance coverage includes an out-of-pocket maximum on coverage that does not consist solely of major medical coverage (for example, if a separate out-of-pocket maximum applies with respect to

prescription drug coverage), such out-of-pocket maximum does not exceed the dollar amounts set forth in section 1302 (c)(1).

The Departments note, however, that existing regulations implementing Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) [4] prohibit a group health plan (or health insurance coverage offered in connection with a group health plan) from applying a cumulative financial requirement or treatment limitation, such as an out-of-pocket maximum, to mental health or substance use disorder benefits that accumulates separately from any such cumulative financial requirement or treatment limitation established for medical/surgical benefits. Accordingly, under MHPAEA, plans and issuers are prohibited from imposing an annual out-of-pocket maximum on all medical/surgical benefits and a separate annual out-of-pocket maximum on all mental health and substance use disorder benefits.

Coverage of Preventive Services

PHS Act section 2713 and the interim final regulations[5] require non-grandfathered group health plans and health insurance coverage offered in the individual or group market to provide benefits for and prohibit the imposition of cost-sharing requirements with respect to, the following:

- Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved;
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved;
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA, to the extent not already included in certain recommendations of the USPSTF.[6]

If a recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of that service, the plan or issuer can use reasonable medical management techniques to determine any coverage limitations. [7]

These requirements do not apply to grandfathered health plans.[8]

Out-of-Network Services Generally

Q3: My plan does not have any in-network providers to provide a particular preventive service required under PHS Act section 2713. If I obtain this service out-of-network, can the plan impose cost-sharing?

No. While nothing in the interim final regulations generally requires a plan or issuer that has a network of providers to provide benefits for preventive services provided out-of-network, this provision is premised on enrollees being able to access the required preventive services from in-network providers. Thus, if a plan or issuer does not have in its network a provider who can provide the particular service, then the plan or issuer must cover the item or service when performed by an out-of-network provider and not impose cost-sharing with respect to the item or service.

United States Preventive Services Task Force (USPSTF)

Q4: The USPSTF recommends the use of aspirin for certain men and women when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm. Aspirin is generally available over-the-counter (OTC) to patients. Are group health plans and health insurance issuers now required to pay for OTC methods such as aspirin?

Aspirin and other OTC recommended items and services must be covered without cost-sharing only when prescribed by a health care provider.

Q5: If a colonoscopy is scheduled and performed as a screening procedure pursuant to the USPSTF recommendation, is it permissible for a plan or issuer to impose cost-sharing for the cost of a polyp removal during the colonoscopy?

No. Based on clinical practice and comments received from the American College of Gastroenterology, American Gastroenterological Association, American Society of Gastrointestinal Endoscopy, and the Society for Gastroenterology Nurses and Associates, polyp removal is an integral part of a colonoscopy. Accordingly, the plan or issuer may not impose cost-sharing with respect to a polyp removal during a colonoscopy performed as a screening procedure. On the other hand, a plan or issuer may impose cost-sharing for a treatment that is not a recommended preventive service, even if the treatment results from a recommended preventive service.

Q6: Does the recommendation for genetic counseling and evaluation for routine breast cancer susceptibility gene (BRCA) testing include the BRCA test itself?

Yes. HHS believes that the scope of the recommendation includes both genetic counseling and BRCA testing, if appropriate, for a woman as determined by her health care provider.

PHS Act section 2713 addresses coverage for evidence-based items or services with a rating of "A" or "B" in the current recommendations of the USPSTF, as well as coverage for preventive care and screenings as provided for in

comprehensive guidelines released by HRSA. The USPSTF recommends with a "B" rating that "women whose family history is associated with an increased risk for deleterious mutations in the BRCA1 or BRCA2 genes be referred for genetic counseling and evaluation for BRCA testing."

The HRSA Guidelines, released by HHS in August 2011, incorporate by reference relevant portions of an Institute of Medicine (IOM) Report, released on July 19, 2011. In some instances, the IOM Committee Report provides additional interpretation of USPSTF recommendations. For the USPSTF BRCA recommendation, the IOM Committee interpreted the recommendation to include "referral for genetic counseling and BRCA testing, if appropriate." Thus, genetic counseling and BRCA testing, if appropriate, must be made available as a preventive service without cost-sharing.

Q7: Some USPSTF recommendations apply to certain populations identified as high-risk. Some individuals, for example, are at increased risk for certain diseases because they have a family or personal history of the disease. It is not clear, however, how a plan or issuer would identify individuals who belong to a high-risk population. How can a plan or issuer determine when a service should or should not be covered without cost-sharing?

Identification of "high-risk" individuals is determined by clinical expertise. Decisions regarding whether an individual is part of a high-risk population, and should therefore receive a specific preventive item or service identified for those at high-risk, should be made by the attending provider. Therefore, if the attending provider determines that a patient belongs to a high-risk population and a USPSTF recommendation applies to that high-risk population, that service is required to be covered in accordance with the requirements of the interim final regulations (that is, without cost-sharing, subject to reasonable medical management).

Advisory Committee on Immunization Practices (ACIP)

Q8: Which ACIP recommendations are required to be covered without cost-sharing by non-grandfathered group health plans and health insurance coverage?

PHS Act section 2713 and the interim final regulations require coverage for immunizations for routine use in children, adolescents, and adults that have in effect a recommendation by the ACIP for routine use. The vaccines must be covered without cost-sharing requirements when the service is delivered by an in-network provider. The ACIP makes routine immunization recommendations for children, adolescents, and adults that are population-based (e.g., age-based), risk-based (e.g., underlying medical conditions, work-related, or other special circumstances that increase risk of illness), or are catch-up recommendations.

In some circumstances, the ACIP makes a recommendation that applies for certain individuals rather than an entire population. In these circumstances, health care providers should determine whether the vaccine should be administered, and if the vaccine is prescribed by a health care provider consistent with the ACIP recommendations, a plan or issuer is required to provide coverage for the vaccine without cost-sharing.

New ACIP recommendations will be required to be covered without cost-sharing starting with the plan year (in the individual market, policy year) that begins on or after the date that is one year after the date the recommendation is issued. An ACIP recommendation is considered to be issued on the date on which it is adopted by the Director of the Centers for Disease Control and Prevention (CDC), which is the earlier of: the date the recommendation is published in the Mortality and Morbidity Weekly Report, or the date the recommendation is reflected in the Immunization Schedules of the CDC. Therefore plans or issuers with respect to a plan can determine annually what vaccines recommended by ACIP must be covered by checking http://www.healthcare.gov/law/features/rights/preventive-care/index.html prior to the beginning of each plan year.

Women's Preventive Services

Q9: Do the recommendations for women's preventive services in the HRSA Guidelines promote multiple visits for separate services?

No. Section 2713 of the PHS Act and its implementing regulations allow plans and issuers to use reasonable medical management techniques to determine the frequency, method, treatment, or setting for a recommended preventive item or service, to the extent this information is not specified in a recommendation or guideline. Although the HRSA Guidelines list services individually, nothing in PHS Act section 2713 or the regulations requires that each service be provided in a separate visit. Efficient care delivery and the delivery of multiple prevention and screening services at a single visit is a reasonable medical management technique, permissible under the regulations. For example, HIV screening and counseling and Sexually Transmitted Infections counseling could occur as part of a single well-woman visit.

Q10: What is included in a "well-woman" visit?

The HRSA Guidelines recommend at least one annual well-woman preventive care visit for adult women to obtain the recommended preventive services that are age- and developmentally-appropriate, including preconception and prenatal care. The HRSA Guidelines recommend that well-woman visits include preventive services listed in the HRSA Guidelines, as well as others referenced in section 2713 of the PHS Act. HHS understands that additional well-woman visits, provided without cost-sharing, may be needed to obtain all necessary recommended preventive services, depending on a woman's health status, health needs, and other risk factors. If the clinician determines that a patient requires additional well-woman visits for this purpose, then the additional visits must be provided in accordance with the requirements of the interim final regulations (that is, without cost-sharing and subject to reasonable medical management).

Q11: What do health care providers need to know to conduct a screening and counseling for interpersonal and domestic violence, as recommended in the HRSA Guidelines?

Screening may consist of a few, brief, open-ended questions. Screening can be facilitated by the use of brochures, forms, or other assessment tools including chart prompts. One option is the five-question Abuse Assessment Screening tool available here: (http://www.cdc.gov/ncipc/pub-res/images/ipvandsvscreening.pdf, page 22). Counseling provides basic information, including how a patient's health concerns may relate to violence and referrals to local domestic violence support agencies when patients disclose abuse. Easy-to-use tools such as patient brochures, safety plans, and provider educational tools, as well as training materials, are available through the HHS-funded Domestic Violence Resource Network, including the National Resource Center on Domestic Violence (http://www.acf.hhs.gov/programs/fysb/programs/family-violence-prevention-services/programs/centers).

Q12: In the discussion of "Identified Gaps" within the Cervical Cancer section of the IOM report, the IOM recognized "co-testing with cytology and high-risk Human Papillomavirus (HPV) DNA testing among women 30 years of age and older as a strategy to increase screening intervals to every three years." When should the HPV DNA test be administered?

The HRSA Guidelines recommend high-risk HPV DNA testing for women with normal cytology results who are 30 years of age or older to occur no more frequently than every 3 years.

Q13: The HRSA Guidelines include a recommendation for annual HIV counseling and screening for all sexually active women. Is the term "screening" in this context defined as actual testing for HIV?

Yes. In this context, "screening" means testing.

Q14: The HRSA Guidelines include a recommendation for all Food and Drug Administration (FDA) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity, as prescribed by a health care provider. May a plan or issuer cover only oral contraceptives?

No. The HRSA Guidelines ensure women's access to the full range of FDA-approved contraceptive methods including, but not limited to, barrier methods, hormonal methods, and implanted devices, as well as patient education and counseling, as prescribed by a health care provider. Consistent with PHS Act section 2713 and its implementing regulations, plans and issuers may use reasonable medical management techniques to control costs and promote efficient delivery of care. For example, plans may cover a generic drug without cost-sharing and impose cost-sharing for equivalent branded drugs. However, in these instances, a plan or issuer must accommodate any individual for whom the generic drug (or a brand name drug) would be medically inappropriate, as determined by the individual's health care provider, by having a mechanism for waiving the otherwise applicable cost-sharing for the branded or non-preferred brand version. This generic substitution approach is permissible for other pharmacy products, as long as the accommodation described above exists.[9] If, however, a generic version is not available, or would not be medically appropriate for the patient as a prescribed brand name contraceptive method (as determined by the attending provider, in consultation with the patient), then a plan or issuer must provide coverage for the brand name drug in accordance with the requirements of the interim final regulations (that is, without cost-sharing, subject to reasonable medical management).

Q15: Do the HRSA Guidelines include contraceptive methods that are generally available over-the-counter (OTC), such as contraceptive sponges and spermicides?

Contraceptive methods that are generally available OTC are only included if the method is both FDA-approved and prescribed for a woman by her health care provider. The HRSA Guidelines do not include contraception for men.[10]

Q16: Do the HRSA Guidelinesinclude services related to follow-upand management of side effects, counseling for continued adherence, and for device removal?

Yes. Services related to follow-up and management of side effects, counseling for continued adherence, and device removal are included under the HRSA Guidelines and required to be covered in accordance with the requirements of the interim final regulations (that is, without cost-sharing, subject to reasonable medical management).

Q17: Are intrauterine devices and implants contraceptive methods under the HRSA Guidelines and therefore required to be covered without cost-sharing?

Yes, if approved by the FDA and prescribed for a woman by her health care provider, subject to reasonable medical management.

Q18: The USPSTF already recommends breastfeeding counseling. Why is this part of the HRSA Guidelines?

Under the topic of "Breastfeeding Counseling" the USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding. The HRSA Guidelines specifically incorporate comprehensive prenatal and postnatal lactation support, counseling, and equipment rental. Accordingly, the items and services described in the HRSA Guidelines are required to be covered in accordance with the requirements of the interim final regulations (that is, without cost-sharing, subject to reasonable medical management, which may include purchase instead of rental of equipment).

Q19: How are certified lactation consultants reimbursed for their services under the HRSA Guidelines?

Reimbursement policy is outside of the scope of the HRSA Guidelines and the Departments' regulations.

Q20: Under the HRSA Guidelines, how long after childbirth is a woman eligible for lactation counseling? Are breastfeeding equipment and supplies unlimited?

Coverage of comprehensive lactation support and counseling and costs of renting or purchasing breastfeeding equipment extends for the duration of breastfeeding. Nonetheless, consistent with PHS Act section 2713 and its implementing regulations, plans and issuers may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for a recommended preventive item or service, to the extent not specified in the recommendation or guideline.

[1] See The Departments interim final regulations relating to grandfather health plans (June 17, 2010) at 75 FR 34538 (June 17, 2010) and amended interim final regulations at 75 FR 70114 (November 17, 2010).
[2] Issued February 20, 2013 and available at: http://www.cms.gov/cciio/Resources/Regulations-and-Guidance/index.html#Plan Management
[3] See section 1251 of the Affordable Care Act, which limits the application of PHS Act section 2707 to non-grandfathered group health plans and health insurance coverage.
[4] See 26 CFR 54.9812-1(c)(3)(v), 29 CFR 2590.712(c)(3)(v), and 45 C.F.R. 146.136(c)(3)(v).
[5] 75 FR 41726 (July 19, 2010).
[6] "Women's Preventive Services: Required Health Plan Coverage Guidelines" (HRSA Guidelines) were adopted and released on August 1, 2012, based on recommendations developed by the Institute of Medicine (IOM) at the request of HHS. These recommended women's preventive services are required to be covered without cost-sharing, for plan years (or, in the individual market, policy years) beginning on or after August 1, 2012.
[7] See 26 CFR 54.9815-2713T(a)(4), 29 CFR 2590.715-2713(a)(4), 45 CFR 147.130(a)(4).
[8] Certain non-grandfathered, non-profit religious organizations are not required to cover the contraceptive services recommendation that is part of the HRSA guidelines. For information on these entities, see 77 FR 8725 and . See also proposed rules published on February 6, 2013, at 78 FR 8456.
[9] See http://www.healthcare.gov/news/factsheets/2011/08/womensprevention08012011a.html
[10] See 78 FR 8456, 8458, footnote 3, which provides that the HRSA guidelines "exclude services relating to a man's reproductive capacity, such as vasectomies and condoms."

South Carolina

GEDDINGS LAW FIRM PA

Coverage Period: 01/01/2015 - 12/31/2015

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

Coverage for: SINGLE FAMILY Plan Type: PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.SouthCarolinaBlues.com** or by calling **1-800-868-2500, Ext. 41010**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$1,200 single / $2,350 family for in network providers. $0 single / $0 family for out-of-network providers. Doesn't apply to preventive care, prescription drugs or in-network doctor's office visits. Copayments don't count toward the deductible.	You must pay all the costs up to the **deductible** 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**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes; $4,200 single / $8,250 family for in network providers. There is no out of pocket limit for out of network providers.	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.
What is not included in the out-of-pocket limit?	Premiums; charges in excess of the allowed amount; amounts exceeding any maximum payments for benefits; or any expense not allowed according to any provisions of this coverage.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. For a list of in-network providers, see www.SouthCarolinaBlues.com or call 1-800-810-2583	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**.
Do I need a referral to see a specialist?	No. You dont need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed in the Excluded Services and Other Covered Services section. See your policy or plan document for additional information about **excluded services**.

Questions: Call **1-800-868-2500, Ext. 41010** or visit us at **www.SouthCarolinaBlues.com**. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call **1-800-868-2500, Ext. 41010** to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible.**
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles, copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-Of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit	50% coinsurance	Copay doesn't include surgery, outpatient lab and X-ray services (except for standard plain film X rays), second surgical opinion, dialysis, chemotherapy, radiation therapy, specialty drugs, endoscopies and imaging.
	Specialist visit	$30 copay/visit	50% coinsurance	Copay doesn't include surgery, outpatient lab and X ray services (except for standard plain film X rays), second surgical opinion, dialysis, chemotherapy, radiation therapy, specialty drugs, endoscopies and imaging.
	Other practitioner office visit	$15 copay/visit	50% coinsurance	Copay doesn't include surgery, outpatient lab and X-ray services (except for standard plain film X-rays), second surgical opinion, dialysis, chemotherapy, radiation therapy, specialty drugs, endoscopies and imaging.
	Preventive care/screening/immunization	No charge	Not covered	No charge for mammograms at a participating provider.
If you have a test	Diagnostic test (x ray, blood work)	20% coinsurance	50% coinsurance	NONE
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	No benefit if not preapproved.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call **1-800-868-2500, Ext. 41010** or visit us at **www.SouthCarolinaBlues.com**. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call **1-800-868-2500, Ext. 41010** to request a copy. BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association.

Your Rights and Responsibilities

As a Member, you have certain rights. You also have some responsibilities. As part of our ongoing efforts to keep you informed, we've listed your rights and responsibilities below.

You have the right to:

- Be treated with respect and recognition of your dignity and right to privacy.
- Get the information you need to make thoughtful decisions before choosing a provider or treatment plan.
- Constructively share your opinion, concerns or complaints.
- Receive information from BlueCross regarding services provided or care received.

You have the responsibility to:

- Carefully read all health plan materials provided by BlueCross after we accept you as a member.
- Ask questions and make sure you understand the information given to you.
- Present your BlueCross ID card prior to receiving services or care.
- Inform BlueCross of any information that affects your coverage, including any other insurance you may have.
- Select a representative to act on your behalf in the event you're unable to represent yourself.
- Pay your cost share amounts, including your premium.
- Tell us if you move.

If two or more Physicians, other than as an assistant at Surgery or anesthesiologist, perform procedures in conjunction with one another, we'll prorate the Allowed Amount between them when so required by the Physician in charge of the case. This benefit is subject to the above paragraphs.

When more than one skin lesion is removed at one time, we provide full benefits for the largest lesion, 50 percent of the Allowed Amount is covered for the removal of the second largest lesion and 25 percent of the Allowed Amount is covered for removing any other lesions.

We designate certain surgical procedures that are normally exploratory in nature as "Independent Procedures." The Allowable Charge is covered when such a procedure is performed as a separate and single procedure. However, when an Independent Procedure is performed as an integral part of another surgical service, only the Allowable Charge for the major procedure will be covered.

b. Surgical Assistant –Services of one Physician who actively assists the operating Physician when an eligible Surgery is performed in a Hospital, and when such surgical assistant service isn't available by an intern, resident or house Physician. We'll provide a predetermined percent not more than 20 percent of the Allowable Charges, not to exceed the Physician's actual charge.

c. Anesthesia – Services provided by a Physician or a certified registered nurse anesthetist, other than the attending surgeon or his assistant.

5. Chemotherapy – The treatment of malignant disease by chemical or biological antineoplastic agents that have received full, unrestricted market approval from the FDA.

6. Dialysis Treatment – The treatment of acute renal failure or chronic irreversible renal insufficiency to include hemodialysis or retinol dialysis. Dialysis treatment includes home dialysis.

7. Radiation Therapy – The treatment of disease by X-ray, radium or radioactive isotopes.

Prescription Drugs – Benefits will be provided for Prescription Drugs. More detailed information is noted in the *Prescription Drug Coverage* section.

Preventive Screenings – Benefits will be provided as follows:

- The United States Preventive Services Task Force (USPSTF) recommended Grade A or B screenings.
- Screenings recommended for children and women by Health Resources and Services and Administration.
- Preventive prostate screenings and lab work according to the American Cancer Society (ACS) guidelines.
- Pediatric oral and vision care as recommended by the United States Preventive Services Task Force (USPSTF) Grade A or B screenings and Health Resources and Services Administration (HRSA).

These services are provided in-Network only.

Prosthetics – Benefits are provided for a prosthetic, other than a dental or cranial prosthetic, which meets minimum specifications for the body part it is replacing regardless of the functional activity level. The item must be a standard, non-luxury item as determined by us. Specialty items such as bionics or microprocessor components aren't covered. Benefits are provided only for the initial temporary and permanent prosthesis. No benefits are provided for repair, replacement or duplicates, nor for services related to the repair or replacement of such prosthetics, except when necessary due to a change in the Member's medical condition, and with prior authorization from us. Repair or replacement for routine wear and tear isn't a Covered Service.

South Carolina

Because it matters how you're treated.

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2014 Screening Colonoscopy Guidelines

August 19, 2014

This guideline clarifies billing instructions for colonoscopy procedures. As you discuss colonoscopy with BlueCross members, please keep these coverage distinctions in mind. We want your patients to make well-informed health care decisions and understand how much they will have to pay.

The American Gastroenterological Association (AGA) gives guidance on how to determine if a patient is referred for a screening colonoscopy or a diagnostic colonoscopy. The AGA is an independent company that offers colonoscopy guidelines on behalf of BlueCross. Whether a patient has gastrointestinal (GI) symptoms or not prior to the procedure governs how you will bill for the service.

Refer the patient with no GI symptoms for a screening colonoscopy for these reasons:

- Patient is age 50 with no high-risk factors
- Pattient has a personal history of colon cancer or colon polyps
- Patient has a family history (first-degree relative) of colon cancer or colon polyps

Refer the patient for a diagnostic colonoscopy because of these symptoms:

- Blood in stool/hemopositive stool
- Bleeding from rectum
- Iron deficiency anemia of unknown cause
- Change in bowel habits
- Persistent abdominal pain

Screening or Early Detection Colonoscopy

If the initial, pre-procedure intent is to perform a routine screening colonoscopy on an individual without GI symptoms:

- Use the preventive diagnosis code V76.51 (special screening for malignant neoplasms, intestine, colon) for the primary diagnosis. (This is because the initial intent of the procedure was screening or early detection.)

- Use secondary diagnosis codes for any conditions identified during the screening colonoscopy (For example, to remove a polyp).
- To whatever colonoscopy code most accurately describes the services performed, append modifier -33 (preventive or screening service).

If a patient who has a personal or family history of colon cancer or colon polyps returns for a follow-up screening and is without GI symptoms:

- Use the preventive diagnosis code V76.51 for the primary diagnosis code, as the intent of the procedure was screening.
- File the history of disease as the secondary diagnosis code (For example, V10.05 or V10.06, personal history of malignant neoplasm; V16.0, family history of malignant neoplasm; or V12.72, personal history of colonic polyps).

Be sure to use the appropriate diagnosis code for screening colonoscopy claims and add modifier -33 to the accurate CPT code that describes the service you performed. Remember, screening and/or early detection colonoscopy is correct coded only for individuals without GI symptoms, as is identified by the AGA.

Diagnostic Colonoscopy

If you perform a colonoscopy because the patient presents with GI symptoms:

- File the claim with the diagnosis that is the reason for the colonoscopy as the primary diagnosis. Do not append modifier -33 to the code that most accurately describes the service provided.

Members' Costs for Colonoscopies

When you discuss colonoscopy procedures with BlueCross members, please remember:

- A screening colonoscopy is a covered benefit. There is no cost share for members who have a preventive benefit plan.
- A diagnostic colonoscopy will apply applicable copayments, coinsurance and deductibles based on the member's plan.

Screening Colonoscopy Examples

Here are some examples for a screening colonoscopy. These illustrations apply to both the physician and outpatient facility.

1. A 50-year-old woman has preventive benefits. She presents with no GI symptoms and no family history. You perform a screening colonoscopy. You find and remove polyps.

- First, as the initial diagnosis code, submit V76.51 as the pre-procedure intent was a screening colonoscopy.
- Second, submit the appropriate diagnosis codes related to the polyp removal.

- Append modifier -33 to the colonoscopy code that most accurately describes the services you provided.
- There should be no cost sharing by the member.
- You should code any follow-up colonoscopy as we've explained, depending on if the member presents with GI symptoms or is asymptomatic.

2. A 64-year old man has preventive benefits. He was previously diagnosed with colon cancer and had surgery for the condition. The member has no GI complaints and current evaluation suggests he is disease free. He is five years out from his cancer resection.

- You should bill this as a screening colonoscopy. The screening diagnosis is the primary diagnosis and a history of disease is the secondary diagnosis code.
- The member's benefit would apply as a preventive screening. It would not be diagnostic.

3. A 55- year old man presents requesting a colonoscopy. Five years earlier, the member was diagnosis with polyps and inflammatory bowel disease (IBD) following a colonoscopy for GI symptoms. He is currently experiencing symptoms.

- Submit the claim with the codes that describes the diagnosis(es) present.
- Do not append modifier -33, as this is a diagnostic colonoscopy to evaluate an individual with GI symptoms.

For questions about these billing guidelines, please contact Provider Education at 803-264-4730 or by email at provider.education@bcbssc.com.

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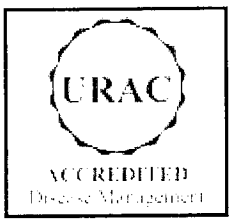
Constituent Tools:



Patients with sessile adenomas that are removed piecemeal[2]	2 to 6 months to verify complete removal		Once complete removal has been established, subsequent surveillance needs to be individualized based on the endoscopist's judgment. Completeness of removal should be based on both endoscopic and pathologic assessments.
Increased Risk—Patients with Colorectal Cancer			
Patients with colon and rectal cancer should undergo high-quality perioperative clearing [4]	3 to 6 months after cancer resection, if no unresectable metastases are found during surgery; alternatively, colonoscopy can be performed intraoperatively.	Colonoscopy	In the case of nonobstructing tumors, this can be done by preoperative colonoscopy. In the case of obstructing colon cancers, CTC with intravenous contrast or DCBE can be used to detect neoplasms in the proximal colon.
Patients undergoing curative resection for colon or rectal cancer[4,5]	1 year after the resection (or 1 year following the performance of the colonoscopy that was performed to clear the colon of synchronous disease)	Colonoscopy	This colonoscopy at 1 year is in addition to the perioperative colonoscopy for synchronous tumors. If the examination performed at 1 year is normal, then the interval before the next subsequent examination should be 3 years. If that colonoscopy is normal, then the interval before the next subsequent examination should be 5 years. Following the examination at 1 year, the intervals before subsequent examinations may be shortened if there is evidence of HNPCC or if adenoma findings warrant earlier colonoscopy. Periodic examination of the rectum for the purpose of identifying local recurrence, usually performed at 3- to 6-month intervals for the first 2 or 3 years, may be considered after low anterior resection of rectal cancer.
Increased Risk—Patients with a Family History			
Either colorectal cancer or adenomatous polyps in a first-degree relative before age 60 years or in 2 or more first-degree relatives at any age[2,4]	Age 40 years, or 10 years before the youngest case in the immediate family	Colonoscopy	Every 5 years
Either colorectal cancer or adenomatous polyps in a first-degree relative age 60 or older or in 2 second-degree relatives with colorectal cancer[2,4]	Age 40 years	Screening options at intervals recommended for average-risk individuals	Screening should be at an earlier age, but individuals may choose to be screened with any recommended form of testing.
High Risk			
Genetic diagnosis of FAP or suspected FAP without genetic testing evidence[2,3]	Age 10 to 12 years	Annual FSIG to determine if the individual is expressing the genetic abnormality and counseling to consider genetic testing	If the genetic test is positive, colectomy should be considered.
Genetic or clinical diagnosis of HNPCC or individuals at increased risk of HNPCC[2,4]	Age 20 to 25 years, or 10 years before the youngest case in the immediate family	Colonoscopy every 1 to 2 years and counseling to consider genetic testing	Genetic testing for HNPCC should be offered to first-degree relatives of persons with a known inherited MMR gene mutation. It should also be offered when the family mutation is not already known, but 1 of the first 3 of the modified Bethesda criteria is present
Inflammatory bowel disease,[2,4] chronic ulcerative colitis, and Crohn's colitis	Cancer risk begins to be significant 8 years after the onset of pancolitis or 12 to 15 years after the onset of left-sided colitis	Colonoscopy with biopsies for dysplasia	Every 1 to 2 years; these patients are best referred to a center with experience in the surveillance and management of inflammatory bowel disease.

CRC, colorectal cancer; CSPY, colonoscopy; CTC, computed tomographic colonography; DCBE, double-contrast barium enema; FAP, familial adenomatous polyposis; FSIG, flexible sigmoidoscopy; HNPCC, hereditary nonpolyposis colon cancer; MMR, mismatch repair.

There appears to be a clear need for institutionally based quality assurance programs to improve the quality of CRC screening. This guideline update emphasizes issues for quality assurance across colorectal screening modalities, spanning training requirements, optimal techniques to complete examination, screening intervals, and appropriate recommendations for follow-up. In contrast, cost-effectiveness is not specifically discussed in this document, based on the numerous complexities of adequately addressing this topic, including understanding real costs in different environments, differences in test performance and interpretation, and wide variability of screening intervals in different settings. It is hoped that compliance with improvements in quality assurance will both improve quality and promote cost-effectiveness.

Clearly, better definition of the target lesion of clinical importance is needed across modalities. As new technologies evolve that detect but do not remove polyps, multidisciplinary consensus is needed to best manage a patient programmatically for follow-up polypectomy versus surveillance intervals. Although there are some ongoing studies of the natural history of small polyps, evidence-based data will probably take 10 to 20 years to meaningfully translate into clinical practice