Dear Provider,

The Affordable Care Act (ACA) brings many health insurance changes to our patients. In addition to changes being implemented due to ACA, Prevea360 is also taking this opportunity to improve certain other processes, such as utilizing split copays and enhancing our HIPAA EDI Transactions. These changes and improvements are detailed in this booklet. Please review this information so you are aware what is changing relative to your participation within Prevea360's provider network.

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Plan and Benefit Changes

Quick Glance at the Changes

One of the biggest impacts for our patients' coverage is the introduction of Essential Health Benefits (EHB). Beginning in 2014, Health Care Reform requires new individual and small group plans to include a suite of benefits called EHB. A benchmark plan was established in each state to define the state's standard set of EHB. For states that did not establish their own benchmark plan, one was selected from an array of payor products. Wisconsin is one of the states that did not develop its own benchmark plan. As a result, United Healthcare's Choice Plus plan is Wisconsin's benchmark plan in 2014. Prevea360 updated their individual and small group coverage in order to align with the state benchmark plan.

Coverage changes to accommodate EHB for the new Affordable Care Act (ACA) plans will begin in January 2014. New individual and small group (employers with less than 50 employees) members whose plans begin on or after January 1, 2014 will have ACA-compliant plans.

It is important to note that individual and small group members have an option to keep their existing plans if their plans were effective on October 1, 2013, and have a scheduled policy renewal month between January 1 and October 1, 2014. Prevea360 will be communicating these plan options to its members. The coverage of EHB is not required for those individual and small groups renewing their existing plans. In addition, large group plans are not required to offer EHB. However, large groups must remove annual and lifetime dollar limits on any EHB that they offer.

All benefit changes in this packet pertain to the new individual and small group ACA-compliant plans, as well as large group plans that offer EHB.

Key Points:

- Prevea360 is implementing coverage changes for individual and small groups to align with EHB regulations.
- EHB affect those who have individual and small group insurance coverage regardless if they purchased coverage through the Federally Facilitated Marketplace (FFM or also referred to as the Federally Facilitated *Exchange*) or directly from Prevea360.
- Standard cost-sharing applies to all EHB, except preventive services (which follows a different regulation than that of EHBs).
- If individual and small groups move to an EHB-compliant plan, coverage changes will be effective for new plans that are effective on or after January 1, 2014. Members renewing their existing policies between January and October 2014 will be able to keep their current plan or move to an EHB-compliant plan.

The table below gives more details on Prevea360's coverage changes as a result of EHB, annual product, and benefit analysis. Note that annual dollar limits have been removed for all EHB categories. We have expanded on some of these topics in the following pages in order to give you more depth of knowledge regarding these changes.

Essential Health Benefit	Individual and Small Group Coverage Changes
Pediatric Eyewear	• One covered pair of eyeglasses (lenses & frames) per year • One replacement pair per year • Frame packages established w/contracted vendors

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	• Subject to deductible/coinsurance Medical Policy Notes: • No medical policy restriction • No prior authorization requirement
Hearing Aid Benefits	• Subject to deductible/coinsurance • Requires prior authorization for medical necessity • 1 hearing aid/ear per 36 months Medical Policy Notes: • Medical policy MP9444 Hearing Aids • Hearing Aid services are no longer a limited benefit • Hearing Aids, molds, examinations and related services are covered when a member meets the medical criteria outlined in the medical policy • Prior authorization requirements being finalized
Habilitative Services	• Addition of habilitative services • Definition: Services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings • Requires prior authorization for medical necessity and covered services Medical policy notes: • Medical Policy MP9443 Habilitative Services • Habilitation Services are for only those plans that have the benefit and are covered when a member meets the medical criteria outlined in the medical policy • Prior authorization is required for all services
Therapy Services/Home Health/Skilled Nursing Facility (SNF)	• Physical Therapy (PT)/Occupational Therapy (OT)/Speech Therapy (ST) – increase from 50 to 60 visits/yr • Home Health – increase from 40 to 60 visits/yr • SNF – decrease from 120 days to 30 days/yr • Deductible and coinsurance apply
Bariatric Services	• Bariatric services will no longer be covered
Infertility Services	• Infertility services will no longer be covered
Prescription Drugs	• Addition of prescription drug coverage on all individual and large groups • Moving to 4-tier prescription formulary • 2014 formulary may be found on deancare.com
Maternity Services	• Addition of maternity services on all individual and large groups
Pediatric Dental	• This benefit will not be covered in individual and small group plans
Preventive Services	• No change to contraceptive or sterilization benefits
Mental Health	• No Change
Rehabilitative Services	• No Change
Emergency Services	• No Change
Laboratory Devices	• No Change
Non-Cancer Clinical Trials (Not technically an EHB, but still a mandate)	Medical Policy Notes • Medical Policy MP9379 • Expanded coverage to include life-threatening illnesses as defined in the policy • Prior authorization is required to enroll in the trial and documentation of the trial protocols need to be on file with the health plan

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Split Copays

Overview

Effective January 2014, PREVEA360 will be offering split copays for individual and small group HMO/POS copay-style plans. (Note: this is only applicable to our new ACA-compliant plan offerings in 2014. Split copays will not apply to members who renew non ACA-compliant plans.) The primary drivers behind the new offering are to position Prevea360 competitively on the FFM and to align with the market, which has been offering split copay designs for many years. This encourages the use of primary care providers by our members, as the copay level assessed on a primary care office visit is at a lower level than the copay assessed on a specialty office visit. Please see the diagrams on the following pages for additional explanation

Scope of Change

Split copays will be managed within Prevea360's claims system.

Prior to January 1, 2014, our medical plans apply copays on the following (these are all professional services):

- Office Visits (including specialty care consultations)
- Urgent Care Clinic visits*
- Routine physicals (depending on the benefit offered; ACA-mandated preventive exams are not charged copays)
- Vision exams
- Chiropractic services
- PT/ST/OT services

*Urgent care will subject to application of specialty copay starting January 1, 2014.

Starting January 1, 2014 for new/renewing ACA-compliant plans, the applicable copay will be determined by whether a service is subject to office visit copay *and* by the billing provider's primary specialty as defined in Prevea360's claims system. If a Nurse Practitioner (NP) or Physician Assistant (PA) is seen for the visit, the visit charge would be driven off the specialty type of the extender or the supervising physician, depending upon how services are billed.

Primary Care Copay

- Family Medicine
- Family Medicine with OB
- General Medicine
- Internal Medicine
- Obstetrics Gynecology (OB/GYN)
- Certified Nurse Midwife (CNM)
- Pediatric Medicine
- Optometry
- Chiropractic

Split copays will be applied to medical plan copays, but not prescription drug or emergency room copays. Split copays apply to commercial HMO and POS products only. Generally, the copay differential will be twice the primary care amount for the specialty care amount. Copay levels will be $15/$30 (for some cost-sharing reduction FFM plans), $25 primary care/50 specialty care, $30 primary care/$60 specialty care, or $40 primary care/$80 specialty care.

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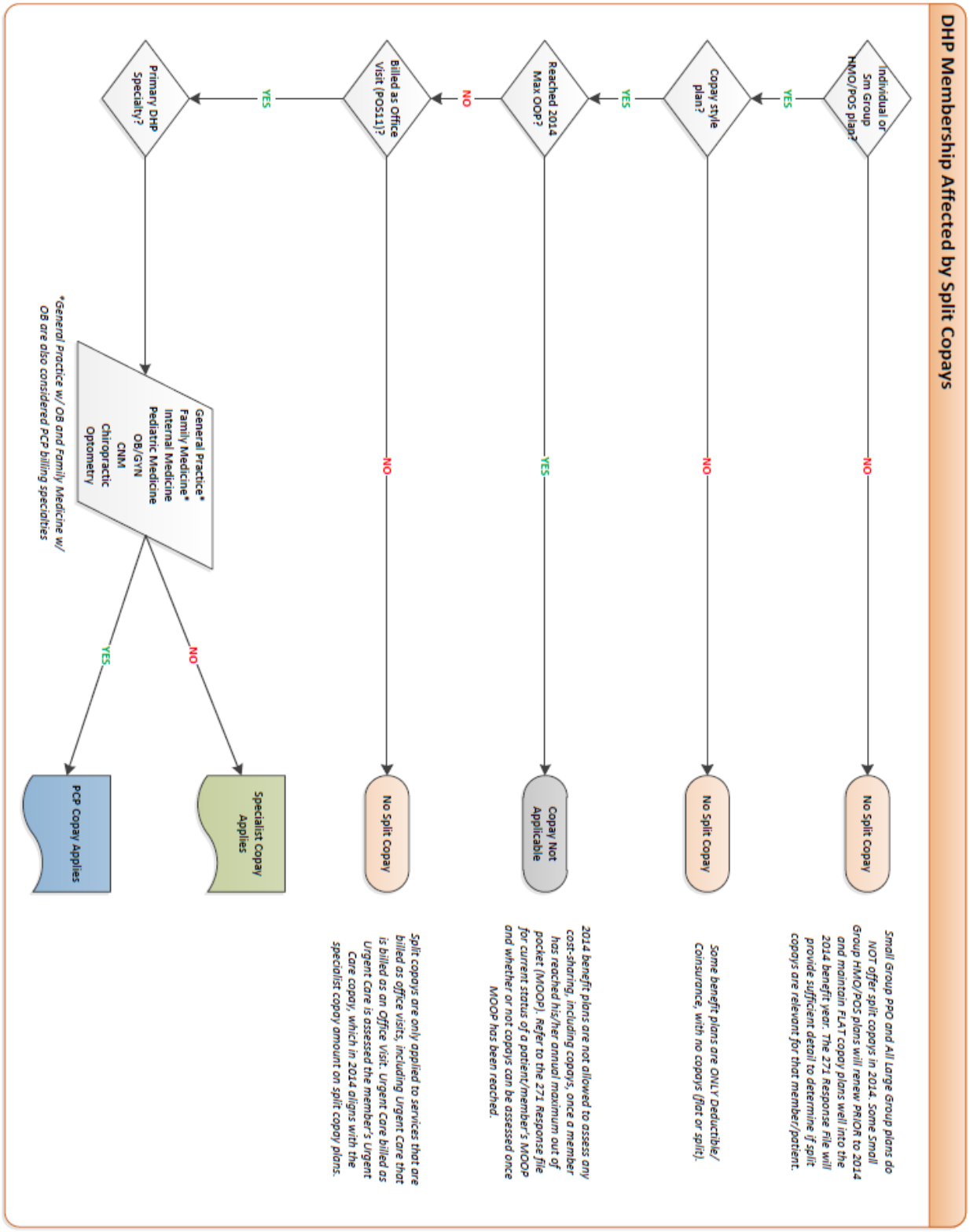
Diagrams



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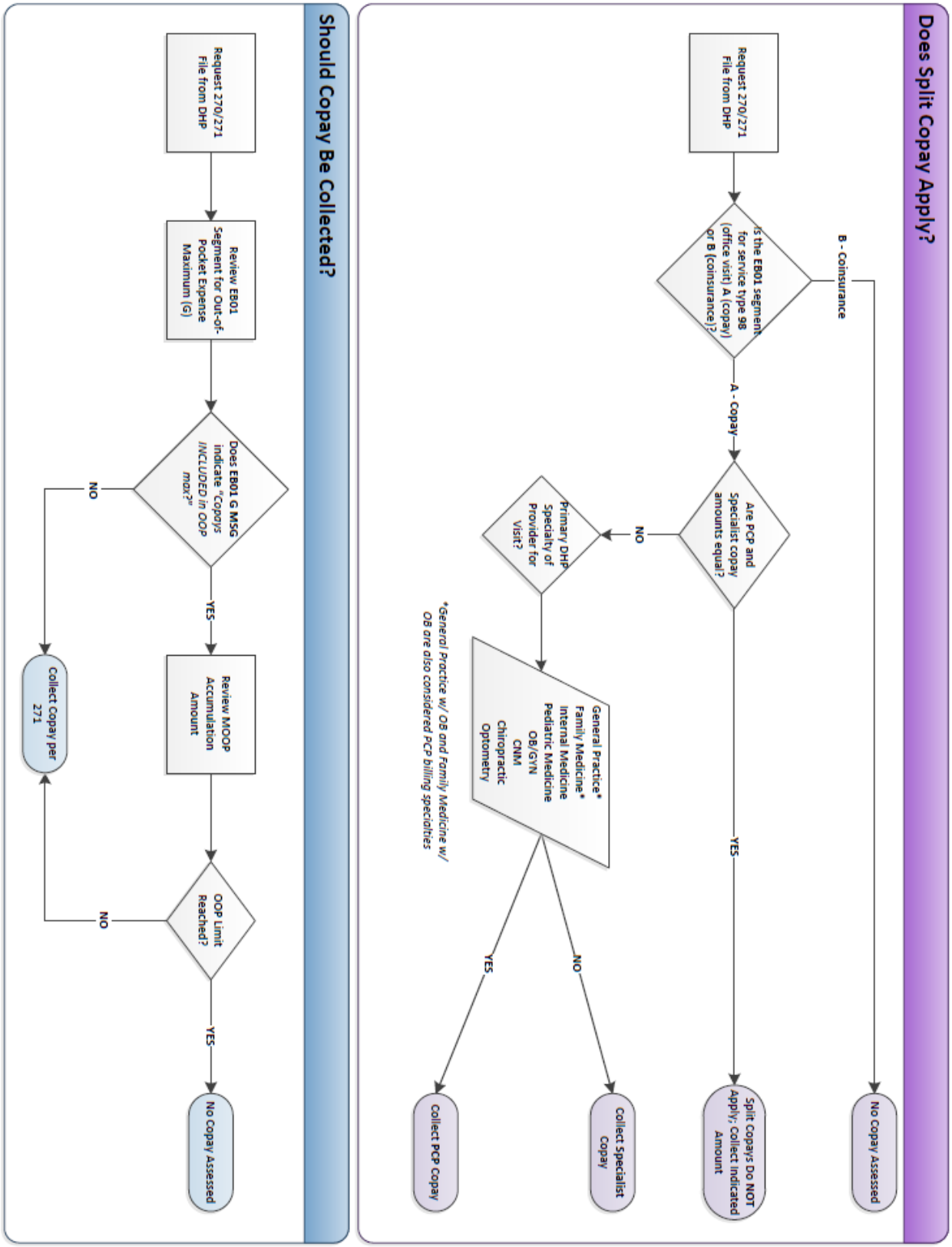

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Maximum Out-of-Pocket (MOOP) Changes

Overview

The Affordable Care Act (ACA) requires changes to PREVEA360's calculation of Maximum-Out-Of-Pocket (MOOP) for our members. Pre-ACA, only deductible and coinsurance member payments accrued toward MOOP. Beginning for new ACA compliant plans starting on or after January 1, 2014 for individual and small groups, MOOP includes the deductible and coinsurance as well as copayments (including prescription out of pocket costs).

On average, less than 20% of membership currently satisfies their MOOP. For many members, this change will not have a visible impact. For a few members, this will simply mean that copay will no longer need to be collected after the MOOP is achieved. If copays are collected at point of service after the MOOP has been satisfied, amounts paid over the MOOP will need to be refunded to the member or applied to other open account balances.

The allowance of more health expenses accumulating toward a member's MOOP may help members in budgeting health care and other expenses. Prevea360 customer service and claims staff will assist members and providers in understanding this important change, if needed.

Scope of Change

Copay may be part of the MOOP for some plans starting in 2014.

Provider Impact

The 270/271 eligibility inquiry transaction set will be Prevea360's source of information to determine MOOP, co-pays, deductibles, etc. EDI transaction guides may be obtained at http://www.prevea360.com/About-Prevea360-Health-Plan/Quality/HIPAA-Transactions.aspx. Please note that the 271 response is like a snapshot in time, which is based on the claims that have been processed as of the time of the 270 inquiry.

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Pediatric Vision Benefit Changes

Overview

As described earlier, the state of Wisconsin is using United Healthcare's Choice Plus plan for the 2014 benchmark plan. Our state benchmark plan does not cover pediatric vision, one of the mandated EHB. The federal government guided us towards the Federal Employee plan for a supplemental outline of pediatric vision benefits.

This benefit is applicable "on" and "off" the FFM for individual and small group plans. Large groups will have a buy-up option to elect this benefit. In accordance with this EHB, Prevea360 will cover one pair of eyeglasses (frames and lenses) and one replacement pair. For individual plans, this benefit is payable per calendar year. Small group plans will cover this benefit per calendar year or the group's contract year. For large group plans, benefits are payable per calendar year or the group's contract year if the benefit applies to that plan.

This benefit is specifically for obtaining eyeglass frames and lenses, and is available only to members under 19 years of age. Eye exams and optometry/ophthalmology services will continue to be covered under the member's regular medical services coverage.

Prevea360's Response

Due to the changes described above, Prevea360 has provider network agreements in place with certain providers to be able to provide pediatric vision hardware. We have contacted participating providers via letter regarding this topic so that they are aware of this new benefit

Impact on our Members

Eyeglass frames and lenses are not a preventive service. Therefore, the member's normal cost-sharing amounts; deductible, coinsurance, and/or copays may apply. However, the Pediatric eye exam is considered a preventive service and therefore Prevea360 will cover this eligible service without applying the member's cost share.

Covered Expenses

- Single vision, Conventional (lined) Bifocal, and Conventional (lined) Trifocal lenses
- Polycarbonate lenses (monocular or patients with prescriptions ≥ +/-6.00 diopters)
- Frame
- Scratch Resistant Coating
- Ultraviolet Protective Coating
- Lenses include choice of glass or plastic lenses; all lens powers (single vision, bifocal, trifocal).
- One replacement of eye glasses (frames and/or lenses) per year

Non-Covered Expenses

- Blended Segment Lenses
- Intermediate Vision Lenses
- Standard Progressives
- Premium Progressives (Varilux ®, etc.)
- Photochromic Glass lenses
- Plastic Photosensitive lenses (Transitions ®)
- Polarized lenses
- Standard Anti-Reflective (AR) Coating
- Premium AR Coating
- Contact lenses

Provider Impact

There are no medical policy requirements, and no prior authorization required for these vision services. Any claims submitted by a non-contracted pediatric vision hardware provider for glasses/lenses will be denied. As a contracted provider for eye exams, we will continue to pay your office for these services rendered to our members. If glasses/lenses are needed, the member should be redirected to a contracted hardware provider.

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To confirm a member's coverage eligibility, please either:

- Utilize our HIPAA 270/271 member eligibility transaction set. Prevea360's 271 response will display "Not Covered" in the EB03 segment in the AM (frames) and AO (lenses) rows if this benefit is *not* covered by the member's plan; or
- Call Prevea360's Customer Service Department at 877.230.7555

For a complete list of Prevea360 pediatric vision hardware contracted providers, please visit our website at www.prevea360.com.

1. Go to "Find a Doctor, Location, and choose find a provider.
2. In the "Specialties" field, select "Optical - Pediatric Eyeglasses
3. Select the network for which you are inquiring.
4. A listing of pediatric vision eyeglasses providers will display.

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Hearing Aids

Overview

Hearing aids are defined as an EHB. Therefore, when this benefit is offered, it must now be covered without annual dollar limits. Prevea360 has removed the payable benefit dollar limit on hearing aids. This benefit is subject to deductible and coinsurance. Initially, all hearing aids will require prior authorization. However, there is a plan in place to review this medical policy, and changes may be forthcoming. The medical policy (MP94444 Hearing Aids) with detailed information is posted online as of January 2.

Contraceptive Services for Women

Overview

While contraceptive services for women are now a mandated benefits requirement, religiously-affiliated non-profit organizations have been offered an accommodation to this requirement by the federal government. The accommodation allows religiously-affiliated non-profit organizations, ("eligible organizations"), to exclude contraceptive services as covered benefits under their group health plans. Instead, the issuer of the eligible organization's group health plan, i.e. Dean Health Plan (DHP) will pay for the contraceptive services using funds outside of those collected from the eligible organization. Eligible contraceptive services will be covered without charging the members cost share amounts (co-pays, deductibles, coinsurance). Contraceptive service coverage for members who are insured through eligible organizations will have two approaches for the coverage and payment of this benefit: one for Administrative Services Only (ASO) self-insured employer groups; and, another for fully-insured groups (no DHP groups are currently affected).

Contraceptive services for women are considered to be preventive health services and include:

- FDA-approved contraceptive drugs and devices
- outpatient consultations, examinations, procedures, and medical services that are necessary to prescribe, administer, maintain, or remove a contraceptive drugs and devices
- female sterilization
- contraceptive education and counseling

Under the ACA Federal Contraceptive Mandate, DHP, the issuer of the eligible organization's group health plan is required to pay for the services listed in the bullet points above. The ACA requires that these services are covered without cost share when they are prescribed by an in-network health care provider. Therefore, as long as the member accesses these services through an in-network provider, DHP will pay for the service without applying any cost share including co-pay, deductible, or coinsurance.

How will this affect you?

DHP's fully-insured groups' claims administration approach for contraceptive services will be seamless.

For DHP's self-insured groups, **when submitting claims for contraceptive services rendered for members who have ASO group health plans, providers will receive two Explanation of Payment forms (EOPs); one for denial of payment from the eligible organization's group health ASO plan, and the other with eligible contraceptive services claim payment from DHP.**

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The eligible organization's group health plan will deny the contraceptive services using EOP Remark Description Code 204 and will state the following "This service/equipment/drug is not covered under the patient's current benefit plan." We have attached a sample ASO self-insured employer group EOP for your reference.

Fully-Insured Approach:

- Provider claims for covered contraceptive services will be considered and paid using the DHP insured group's benefit plan;
- Members will use their DHP group health plan ID card to access medical services;
- DHP will determine its payment liability and will remit payment to the provider using either its standard EOP or new 835/electronic remittance advice (ERA) claims payment processes;
- DHP will only consider claims from in-network providers for eligible contraceptive services payment, and will not cover contraceptive services claims submitted by out-of-network providers.

Self-Insured Approach:

- Members use their ASO group health plan ID card to access medical services;
- Provider claims for contraceptive services will be denied under the eligible organization's ASO group plan and providers will be notified of this denial via the eligible organization's ASO plan EOP;
- DHP's member will receive an Explanation of Benefits (EOB) denying the claim for the contraceptive services under the ASO plan;
- The eligible contraceptive services claim will then be crossed-over within DHP's claims administration process for coverage determination under the DHP coverage plan for the eligible organization, i.e. the one under which eligible contraceptive services can be considered for payment. This step will not require any additional work or claim submission by the provider;
- DHP will calculate the payment due under its plan for the eligible contraceptive services;
- DHP will make payment to the submitting provider for the eligible contractive services, using DHP's plan of coverage, as required by the ACA;
- DHP will issue a second EOP to providers for this payment which will show the DHP plan and payment information;
- DHP will send a second EOB to the member detailing the benefits paid;
- Notification of this new benefits coverage and claims payment process for covered contraceptive services will be sent to members of eligible organizations;
- You may find additional information at http://www.deancare.com/ASO/members/aso-medical-management/

If you have any questions regarding how the ACA's new contraceptive services benefit has to be administered for eligible organizations with self-insured plans, please contact your Provider Network Liaison.

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3 Month Grace Period for Advanced Premium Tax Credit Members (Sold through the Marketplace)

Overview

In accordance with the ACA, issuers will be permitted to terminate coverage for individual and family members who fail to pay premiums. However, insurers must observe a three-month Advanced Premium Tax Credit (APTC) grace period before terminating coverage for **members receiving an Advance Premium Tax Credit (APTC) for insurance purchased using the new Federally Facilitated Marketplace (Exchange) and have already paid their share of one month's premium in full.** For enrollees who meet this initial requirement, the APTC grace period is triggered once the enrollee subsequently misses a premium payment. **For non-APTC members, Prevea360's normal grace period rules apply.**

An enrollee must make all outstanding premium payments to be removed from the APTC grace period. If an enrollee exhausts the APTC grace period without making all outstanding premium payments, the issuer must terminate coverage with notice to the enrollee. A member cannot extend the grace period by paying only a portion of the outstanding premium.

If coverage is terminated after the APTC grace period for non-payment of premiums, **coverage will be retroactively terminated back to the end of last day of the first month of the grace period**. If coverage is terminated due to non-payment of premium, the issuer must return APTCs for the second and third months to the Treasury Department.

During the first month of a grace period, the insurer must continue to process claims. Once the member enters the second month of a grace period, through the third month, claims will be pended by the insurer. The insurer will then adjudicate and pay them as appropriate if it receives payment within the APTC grace period. Or, if the member does not pay all back premiums, the insurer will deny all pending claims for services rendered during the second and third months of the grace period.

Pharmacy claims have different rules during the three-month APTC premium grace period. During members' second and third months of their APTC grace period, Prevea360 will process pharmacy claims as "discount only," i.e. Prevea360 will deny the claims, but will be able to pass its contractual discount on to the member, who must pay the whole amount. Member may file claims for reimbursement with our Pharmacy Benefit Manager (PBM) if they make outstanding premium payments before the end of the APTC grace period.

See the diagram at the end of this topic for a visual overview of this process.

Members Impact

If a member makes all outstanding premium payments before the end of the APTC grace period, enrollment in his or her current plan remains intact. However, if the enrollee exhausts the APTC grace period without making all outstanding premium payments, Prevea360 may terminate coverage with notice to the enrollee and deny any claims incurred in the second and third months of the grace period.
Prevea360 will notify enrollees who are receiving APTCs and who have failed to make a premium payment that they are delinquent in payment, and will include information about the grace period and consequences of losing coverage. Members are sent a bill at the beginning of each month for the next month, which includes the entire outstanding balance. A delinquency letter will be sent on the 20th of each month a member is in a premium payment delinquency status.

Impact on our Providers

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As described above, PREVEA360 will process claims incurred during the first month of the APTC grace period per normal procedure, but will pend claims for services rendered during the second and third month of a member's grace period. If the member makes all outstanding payments by the last day of the third month of the APTC grace period, Prevea360 will process all pending claims. If the member fails to make all outstanding premium payments by the end of the APTC grace period, Prevea360 will deny claims for services rendered during the member's second or third month of his or her APTC grace period.

Providers may submit a 270 Health Care Eligibility electronic request to confirm status of members who may be in an APTC grace period. Status can change quickly for an APTC grace period member, for as soon as a full payment is received within the APTC grace period, a member will be removed from the grace period status. If a member is in the second or third month of his or her grace period, the 271 response will indicate that the member is "pending investigation" in EB01 with a value of 5.

CMS states that providers shall be notified as soon as practicable when a provider submits a claim incurred during the APTC grace period member on a member. Therefore, billing providers can expect notification from Prevea360 when a claim is submitted for services rendered during a member's grace period. The earliest that a FFM member could fall into a three-month grace period is February 1, 2014. If a provider chooses to treat a member that is in his or her grace period, network contract requirements and state law must be followed. So, the provider can only bill the member for the contracted copayments, and assumes the risks of non-payment of eligible claims in the event the member fails to pay his or her required premiums before the APTC grace period ends.

Prevea360 will send notification to billing providers as follows: Notification is triggered upon claim submission for a member in an APTC grace period. It is possible that providers will receive multiple letters per member, depending on the number of claims submitted for a member.

- The first opportunity of notification occurs when a provider has treated a member during the first month of his or her grace period and the member has not paid the premium by the 25th day (or business day before) of the first month, and will provide information about the claim and the member for reference. The notification serves the purpose to inform the provider that an APTC member has missed a premium payment, and is therefore in the first month of an APTC grace period. It will also state that Prevea360 will process claims that are submitted for dates of service within the first month of the grace period.
- A different letter will be sent to providers within 5 days of each submitted claim for services rendered during the second or third month of a member's grace period. This letter will notify the provider that the claim is pended, and will give information about the claim and the member for reference. The notification will also state that the claim will be denied if the member's coverage is terminated at the exhaustion of the grace period.

See the diagram on the next page.

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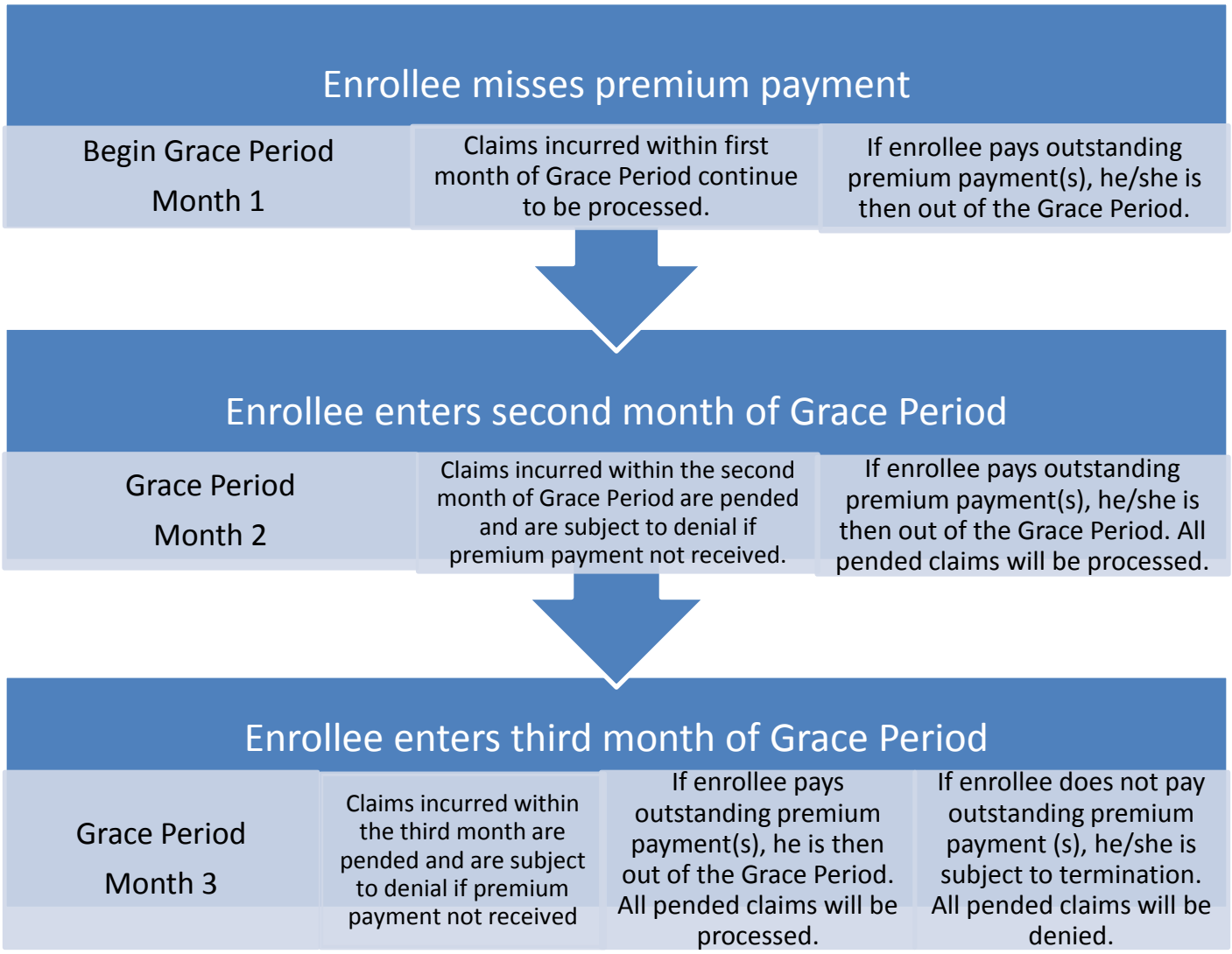
Diagram of APTC Grace Period:



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EDI Transaction Changes

835/ERA and EFT changes

Overview

Definitions:

- EFT: Electronic Funds Transfer - Any transfer of funds that is initiated through electronic means. For Prevea360's purposes, EFT means that providers using this functionality will be paid electronically.
- ERA: Electronic Remittance Advice - Electronic transactions which provide claim payment information in the HIPAA mandated ACSX12 005010X221A1 format. These files are used by practices, facilities, and billing companies to post claim payments into their systems automatically. An ERA replaces a paper Explanation of Payment (EOP).
- 835 EDI Transaction: Used interchangeably with ERA.

Scope of Change

- Updated 835/ERA transactions available as of January 31, 2014
- EFT and 835/ERA transactions available through Emdeon as of January 31, 2014
- Enrollment information for these transactions has been provided to those PREVEA360 network providers who currently receive 835/ERA.

Provider Impact

Emdeon ePayment replaces paper-based claims payments with EFT payments that are directly deposited into the provider's bank account. Providers can also search, view and print human-readable images of the ERA using Emdeon Payment Manager, an online application available for Emdeon ePayment users. Providers can also download HIPAA-formatted 835 ERA files.

EFT and the updated 835/ERA transactions are available to all providers through Emdeon. PREVEA360's Companion Guide for 835 EDI transactions may be accessed at http://www.prevea360.com/About-Prevea360-Health-Plan/Quality/HIPAA-Transactions.aspx. Providers will either need to enroll with Emdeon, or contact their vendors/clearinghouses to enroll with Emdeon, to obtain 835/ERA EDI transactions. We encourage our providers to enroll for both EFT and 835/ERA transactions. Enrollment may take seven to twenty-one days. If you have multiple NPIs that will receive payment under the same Tax Identification Number (TIN) and for which EFTs should be split into different bank accounts, you should be certain that each of those NPIs and their corresponding bank account information has been entered as part of your enrollment with Emdeon.

Frequently-Asked Questions

What are the benefits of switching from paper-based to electronic claims payments?

- The reimbursement cycle can be accelerated since providers can receive EFT payments more quickly than check payments sent through the mail.
- Payments can be distributed more securely by virtually eliminating check payments lost in the mail.

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- Cash flow can be accelerated since manual processes such as sorting and opening mail, reconciling paper-based claims payments, creating deposit tickets and making trips to the bank are bypassed.

Will providers be charged any service fees for enrolling with or using Emdeon ePayment?

No.

If providers use a billing service, clearinghouse or other entity to submit claims and collect receivables, can they still enroll with Emdeon ePayment?

Yes. Providers can enroll with Emdeon ePayment while continuing to use a billing service, clearinghouse or other entity to submit claims and collect receivables.

How do providers receive more information about Emdeon ePayment?

Providers can visit www.emdeon.com/epayment to learn more about Emdeon ePayment or to request additional information.

Do providers have to complete a separate EFT agreement for all health plan payers?

By enrolling with Emdeon ePayment, providers have the opportunity to select from the entire list of enrolled payers without having to enroll multiple times. Some payors may require additional information to switch from paper to electronic claim payments.

Can Emdeon ePayment support payment distribution to multiple bank accounts under the same Provider Tax ID?

Yes, though this varies by payor. Emdeon ePayment can support payment distribution to multiple bank accounts under the same Provider Tax ID for claim payments issued by payors who support this format.

Will providers continue to receive paper remittance statements once enrollment with Emdeon ePayment is complete?

By enrolling with Emdeon ePayment, the provider is authorizing electronic deposit instead of continuing to receive a live check and paper EOP. Upon successful enrollment, there is a payor-defined transitional period during which EFT's will be deposited into the desired account(s) while delivery of the paper remittances is continued. **Prevea360 will continue to produce a paper EOP for 3 payment cycles in addition to providing the 835/ERA/EFT transactions**. At the end of this transitional period, the delivery of printed EOPs advices will cease. Providers can temporarily change the paper cut-off preferences by calling Emdeon Enrollment Support at 866.506.2830 or emailing EFTEnrollment@emdeon.com.

Will the provider be able to access the associated remittance advice?

Providers can easily search, view and print readable images of the 835/ERA using Emdeon Payment Manager, an online application available for Emdeon ePayment users. Using the basic version of Emdeon Payment Manager, providers can also download HIPAA-formatted 835 ERA files for any of Emdeon's participating EFT Payers.

How do providers initially enroll for the EFT program?

Providers have two options for enrolling. Providers can either enroll online or download a form and mail or fax the completed form to Emdeon to complete enrollment.

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How can providers enroll online?

To get started, providers can simply complete the online registration form. After the information is verified, a Welcome Kit is emailed to the provider with the account information and instructions for completing enrollment including setting payor preferences and adding bank accounts.

What number should providers call for help with Emdeon ePayment?

Providers may call 866.506.2830 for assistance.

How may providers confirm that their Emdeon ePayment enrollment is complete?

A small deposit will be processed to the provider's account to verify the provider's bank routing and account number. Upon confirmation of the deposit amount:

- If the provider is an existing Payment Manager user, their services will be enabled under the assigned account.
- If the provider is new to Payment Manager, they will be given a username and password for their new account. Please allow 5 to 10 business days to verify provider bank accounts and ensure all the security measures are taken.

Once the enrollment form is faxed/mailed or completed online, how long will it be until the provider receives an EFT payment?

The exact length of time will vary, though on average, providers can expect to receive their first EFT payment 10 – 15 business days after completing Emdeon ePayment enrollment.

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Prevea360 is underwritten by Dean Health Plan, Inc.

270/ 271 Health Care Eligibility/Benefit Inquiry and Response

Overview

- EDI Health Care Eligibility/Benefit Inquiry (270) electronic transaction is used to inquire about the health care eligibility and benefits associated with a subscriber or dependent. Providers submit 270 eligibility requests through the connection at Prevea360's clearinghouse.
- EDI Health Care Eligibility/Benefit Response (271) electronic transaction is the response to a 270 inquiry about health care eligibility and benefits associated with a member or dependent. Prevea360 places the 271 eligibility response on Prevea360's clearinghouse connection.

EDI transactions benefit members and providers through improved efficiencies. Providers may access the fully compliant EDI transactions through Emdeon Provider WebConnect. We are updating member out-of-pocket cost accumulator information, adding split copay information, and the member's group ID to these transactions.

Impact on our Members and Providers

By using EDI 270/271 transactions, we achieve the following benefits for both members and providers:

- Reduced collection and billing costs,
- Decreased bad debt,
- Improved cash flow,
- Increased productivity and efficiency, and
- Fewer rejected claims.

The 270 and 271 EDI transactions are both real-time requests. Real-time is defined as one 270 eligibility request with a single eligibility response in the 271. Any transactions with multiple claims contained in the response will be serviced through the originating communication channels but will be reported as batch responses, meaning that providers can submit several transactions at one time, and Prevea360 must return a single response within 20 seconds.

To sign up for the WebConnect tool contact Emdeon at http://www.emdeon.com/webconnectforgov/. You may also call Emdeon's Sales department at (877-363-3666 press 1 for sales and then press 2 for provider).

Prevea360's Companion Guide for EDI HIPAA transactions may be accessed at: http://www.prevea360.com/About-Prevea360-Health-Plan/Quality/HIPAA-Transactions.aspx.

For more information, contact Prevea360's EDI Team at:
Phone: (608) 827-4320 | Toll-free Phone: (800) 356-7344 Ext.: 4320
Fax: (608) 836-6335 | Email: Email: dhpedi@deancare.com.

276/ 277 Health Care Claim Status Request & Response

Overview

Providers may use the 276 EDI HIPAA transactions to verify the status of a claim that was submitted to a payor. The 276 transaction includes

- Provider identification
- Patient identification
- Subscriber information
- Date of service
- Charges

The provider will receive a 277 EDI HIPAA response of the 276 transaction claim status, generally indicating if it is in process, either pending or finalized. If the claim is finalized, the 277 transaction will indicate if the claim was rejected, denied, approved for payment, or paid. Further information on the claim's adjudication can be found on the 835/ERA.

Scope of Change

There are providers that currently look up claims (and eligibility) on NaviNet. In 2014 they will be able to continue this; however that solution does not provide the Health Care Reform compliant information. Providers will have the ability to utilize a different interface to enter a claim status (or eligibility) request and receive a response. This additional solution will be fully compliant. Providers may access the fully compliant EDI transactions through Emdeon Provider WebConnect.

Impact on our Members and Providers

By using EDI 276 and 277 transactions, we achieve the following benefits for both our members and providers:

- HIPAA Compliant EDI transactions
- Real time transactions/responses to more quickly obtain needed claim status information
- Fewer phone calls and less time spent by staff attempting to determine claim status

The 276 and 277 EDI transactions are both real-time requests. Real-time is defined as one 276 claim status inquiry with an information status response in the 277. Any transactions with multiple claims contained in the response will be serviced through the originating communication channels but will be reported as batch responses, meaning that providers can submit several transactions at one time, and Prevea360 must return a single response within 20 seconds.

To sign up for the WebConnect tool contact Emdeon at http://www.emdeon.com/webconnectforgov/. You may also call Emdeon's Sales department at (877-363-3666 press 1 for sales and then press 2 for provider).

Prevea360's Companion Guide for EDI HIPAA transactions may be accessed at: http://www.prevea360.com/About-Prevea360-Health-Plan/Quality/HIPAA-Transactions.aspx.

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Glossary

Health Care Reform Glossary

To help you through the health care reform maze, here is a list of health care reform related terms and details on how they may impact your health insurance coverage. Note: definitions with an asterisk (*) at the end came directly from CMS, and may be found at https://www.healthcare.gov/glossary/ .

Acronym	Spelled out	Definition
ACA	Affordable Care Act	The Affordable Care Act, health reform legislation enacted by Congress on March 22 2010 and upheld by U.S. Supreme Court on June 26, 2012.
ACO	Accountable Care Organization	A group of health care providers who give coordinated care, chronic disease management, and thereby improve the quality of care patients get. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings.*
APTC	Advanced Premium Tax Credit	The Affordable Care Act provides a new tax credit to help you afford health coverage purchased through the Marketplace. Advance payments of the tax credit can be used right away to lower your monthly premium costs. If you qualify, you may choose how much advance credit payments to apply to your premiums each month, up to a maximum amount. If the amount of advance credit payments you get for the year is less than the tax credit you're due, you'll get the difference as a refundable credit when you file your federal income tax return. If your advance payments for the year are more than the amount of your credit, you must repay the excess advance payments with your tax return. Also called premium tax credit.*
AV	Actuarial Value	The percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of 70%, on average, you would be responsible for 30% of the costs of all covered benefits. However, you could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on your actual health care needs and the terms of your insurance policy.*
CAC	Certified Application Counselors	An individual (affiliated with a designated organization) who is trained and able to help consumers, small businesses, and their employees as they look for health coverage options through the Marketplace, including helping them complete eligibility and enrollment forms. Their services are free to consumers.*
CMS	Center for Medicare and Medicaid Services	The federal agency that runs the Medicare, Medicaid, and Children's Health Insurance Programs, and the federally facilitated Marketplace. For more information, visit cms.gov.
CO-OP	Consumer Oriented and Operated Plan	A non-profit organization in which the same people who own the company are insured by the company. Cooperatives can be formed at a national, state, or local level and can include doctors,

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		hospitals, and businesses as member-owners. Co-ops will offer insurance through the Marketplace.*
CSR	Cost Sharing Reduction	A discount that lowers the amount you have to pay out-of-pocket for deductibles, coinsurance, and copayments. You can get this reduction if you get health insurance through the Marketplace, your income is below a certain level, and you choose a health plan from the Silver plan category (See Health Plan Categories). If you're a member of a federally recognized tribe, you may qualify for additional cost-sharing benefits.*
EHB	Essential Health Benefits	A set of health care service categories that must be covered by certain plans, starting in 2014. The Affordable Care Act ensures health plans offered in the individual and small group markets, both inside and outside of the Health Insurance Marketplace, offer a comprehensive package of items and services, known as essential health benefits. Essential health benefits must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Insurance policies must cover these benefits in order to be certified and offered in the Health Insurance Marketplace, and all Medicaid state plans must cover these services by 2014.*
ESRP	Employer Shared Responsibility Payment	The Affordable Care Act requires certain employers with at least 50 full-time employees (or equivalents) to offer health insurance coverage to its full-time employees (and their dependents) that meets certain minimum standards set by the Affordable Care Act or to make a tax payment called the ESRP.*
FFE/ FFM	Federally Facilitated Exchange, aka, Federally Facilitated Marketplace	A resource where individuals, families, and small businesses can learn about their health coverage options; compare health insurance plans based on costs, benefits, and other important features; choose a plan; and enroll in coverage. The Marketplace also provides information on programs that help people with low to moderate income and resources pay for coverage. This includes ways to save on the monthly premiums and out-of-pocket costs of coverage available through the Marketplace, and information about other programs, including Medicaid and the Children's Health Insurance Program (CHIP). The Marketplace encourages competition among private health plans, and is accessible through websites, call centers, and in-person assistance. In some states, the Marketplace is run by the state. In

		others it is run by the federal government.* Wisconsin has deferred to the federal government to build its state-specific health insurance exchange/marketplace for individuals and small businesses.
FPL	Federal Poverty Level	A measure of income level issued annually by the Department of Health and Human Services. Federal poverty levels are used to determine your eligibility for certain programs and benefits. (The amounts below are based on 2013 numbers and are likely to be slightly higher in 2014.). The lower end of each eligibility range is the federal poverty level for that household. • $11,490 to $45,960 for individuals • $15,510 to $62,040 for a family of 2 • $19,530 to $78,120 for a family of 3 • $23,550 to $94,200 for a family of 4 • $27,570 to $110,280 for a family of 5 • $31,590 to $126,360 for a family of 6 • $35,610 to $142,440 for a family of 7 • $39,630 to $158,520 for a family of 8*
FTE	Full Time Employee	An employee who works an average of at least 30 hours per week (so part-time would be less than 30 hours per week).*
HPREVEA360	High Deductible Health Plan	A plan that features higher deductibles than traditional insurance plans. High deductible health plans (HPREVEA360s) can be combined with a health savings account or a health reimbursement arrangement to allow you to pay for qualified out-of-pocket medical expenses on a pre-tax basis.*
HIRSP	Health Insurance Risk Sharing Plan	Wisconsin's insurance program designed to provide health insurance to residents who are considered medically uninsurable and are unable to buy coverage in the individual market. HIRSP sunsets December 31, 2013.
MAGI	Modified Adjusted Gross Income	The figure used to determine eligibility for lower costs in the Marketplace and for Medicaid and CHIP. Generally, modified adjusted gross income is your adjusted gross income plus any tax-exempt Social Security, interest, or foreign income you have.*
MLR	Medical loss ratio	A basic financial measurement used in the Affordable Care Act to encourage health plans to provide value to enrollees. If an insurer uses 80 cents out of every premium dollar to pay its customers' medical claims and activities that improve the quality of care, the company has a medical loss ratio of 80%. A medical loss ratio of 80% indicates that the insurer is using the remaining 20 cents of each premium dollar to pay overhead expenses, such as marketing, profits, salaries, administrative costs, and agent commissions. The Affordable Care Act sets minimum medical loss ratios for different markets, as do some state laws.*
MOOP	Maximum Out-of-Pocket	The maximum amount members have to pay for covered services in a plan year. All coinsurance, copays and deductibles track toward MOOP under the ACA.
Navigator	Navigator	Navigators are outlined in the ACA as helpers for people to

		enroll in coverage through the Exchange, and refer or assist with Medicaid enrollment. Navigators are funded through Exchanges, and regulations from the Department (HHS) are clear that anyone who gets payments from insurance companies cannot be a Navigator. Navigators also must meet cultural competency standards and go through training and certification.
OCI	Wisconsin Office of the Commissioner of Insurance	State of Wisconsin insurance regulator with oversight of Navigator and CAC entities.
PPACA	Patient Protection and Affordable Care Act of 2010	Formal name for health care reform legislation enacted by Congress on March 22, 2010 and upheld by U.S. Supreme Court June 26, 2012. See Affordable Care Act (ACA).
QHP	Qualified Health Plan	Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.*
SBC	Summary of Benefits and Coverage	An easy-to-read summary that lets you make apples-to-apples comparisons of costs and coverage between health plans. You can compare options based on price, benefits, and other features that may be important to you. You'll get the "Summary of Benefits and Coverage" (SBC) when you shop for coverage on your own or through your job, renew or change coverage, or request an SBC from the health insurance company.*SBCs must be provided beginning on the first day of the first open enrollment period that begins on or after Sept. 23, 2012: • from group health plans to participants and beneficiaries when enrolling or re-enrolling; • from group health plans to new and special enrollees signing up ***not*** during open enrollment period; • from insurers to group health plans; and • from insurers to buyers of individual policies.
SHOP	Small Business Health Options Program	Marketplace for health plans sold to small businesses up to 50 employers in 2014. Assists eligible small employers when enrolling their employees in qualified health plans offered in the small-group market.

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