Provider Fact Sheet
The new Health Insurance Marketplace

*Important information about new Ohio health plans*

**INTRODUCTION**

Health care reform law will continue to bring many changes in 2014. The Affordable Care Act (ACA) calls for the development of new health plans, effective beginning January 1, 2014. All new individual and small group plans must include the Essential Health Benefits required by ACA.

Anthem Blue Cross and Blue Shield (Anthem) is offering new products that are sold on the Health Insurance Marketplace (commonly referred to as the Exchange) as well as new products not purchased on the Exchange, i.e., they are bought directly from Anthem Blue Cross and Blue Shield, a broker, etc.

In Ohio, new provider networks support individual and small group plans sold on the Exchange, as well as new individual plans not sold on the Exchange.

However, the Blue Access PPO network supports new small group plans not sold on the Exchange. *This means if you are a participating provider in Anthem’s Blue Access PPO network, you are an in-network provider for our new small group plans purchased off Exchange.*

You can identify these new plans by the alpha prefixes:

<table>
<thead>
<tr>
<th>Alpha Prefix</th>
<th>Product</th>
<th>Network Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>JWR</td>
<td>Individual (Exchange)</td>
<td>Pathway X Tiered Hospital</td>
</tr>
<tr>
<td>JWS</td>
<td>Small Group (Exchange)</td>
<td>Pathway X Tiered Hospital</td>
</tr>
<tr>
<td>JWT</td>
<td>Individual (OFF Exchange)</td>
<td>Pathway Tiered Hospital</td>
</tr>
<tr>
<td>JWQ</td>
<td>Small Group (OFF Exchange)</td>
<td>Blue Access PPO</td>
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(For more information on the new networks, see our article, *New provider networks will support health plans sold on and off the Health Insurance Marketplace*, posted online at [www.anthem.com>Providers](http://www.anthem.com>Providers) (enter Ohio)> Health Insurance Exchange.)

The following Q&A contains additional detail about the new plans supported by the Pathway Tiered Hospital and Pathway X Tiered Hospital networks. *Please read these details carefully.* If you have additional questions, please contact your local network management office.

**NEW HEALTH PLANS AND BENEFITS**

**Q. In general, what will the benefits for the new health plans look like (copayments, member out of pocket, etc)?**

**A.** Member benefits will vary based on options that are available for the member. In general, health plans purchased on the Exchange will have a slightly higher out of pocket, lean pharmacy benefits, and a more focused provider network. Small group benefit plans will vary based on how
the benefit is purchased, but there may be select drug lists. All individual and small group health plans will include Essential Health Benefits (or EHBs).

Large group benefit plans are not subject to many of the new requirements for individual and small group plans. They will look very much as they do today.

Providers should continue to verify eligibility and benefits for all members. Benefit information for these new health plans will be available on the Availity® Web Portal at www.Availity.com.

Q. What are Essential Health Benefits?
A. Essential Health Benefits (or EHBs) are benefits that must be covered for all individual or small group health plans purchased on or off the exchange upon renewal on or after 01/01/14. These benefits are defined by the health care reform law and include at least the following 10 categories of care:

1. Ambulance patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventative and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

Q. I have heard that many health plans will have “metal levels” - platinum, gold, silver and bronze. What do these mean?
A. Metal levels mean that a health plan was purchased on the Exchange and indicate the “richness” of the benefits associated with a product or health plan. For plans purchased on the Exchange, the product name on the ID card will include a metal level. For example, a member ID card for a plan purchased on the Exchange may reflect Anthem Bronze Direct Access as the name of the member’s health plan.

Q. Will the new health plans purchased on and off the Exchange have out-of-network benefits?
A. The new health plans offer out-of-network benefits.

Q. Are members required to have a primary care physician (PCP) and referrals to specialists?
A. No.

Q. How will you help members understand their new policy and benefits?
A. After a new plan is selected, members will receive either a Welcome Kit by mail or information by email. Welcome Kits provide members with benefit information and coverage details to help them understand their copays, deductibles, and coinsurance responsibilities. These kits also include information about health and wellness programs, and online tools to help members find in-network providers. When members prefer electronic communications, they receive an email with details about how to access all of this information and more through our member website.

Q. Where can I find updates and more information about these new health plans?
A. Anthem will share updates with providers via the Network Update newsletter and the provider home page at www.anthem.com. Additionally, we will use our email service, Network eUPDATE, to communicate critical updates about the Health Insurance Marketplace. If you are not yet signed up to receive Network eUPDATEs, we encourage you to enroll now so you will receive all information shared about the Exchange. To sign up, visit anthem.com>Providers (select Ohio).
On the home page, look for these words: **Click here to sign up for Anthem’s Network eUPDATE (formerly Rapid Update).**

## MEMBER ID CARDS

**Q. What will member ID card look like?**

**A.** Member ID cards will have a similar format to current Anthem member ID cards. New information included on the member ID card will include the network name, new prefixes, and drug list names. Other important information will include contact phone numbers, plan names, and metal levels (if applicable). The following sample represents the general look of the new member ID cards.

*Please note, this is a sample ID card. The policy and benefit information indicated does not necessarily represent benefit information for new member health plans. Policy and benefit information on actual member ID cards will vary by plan.*

**Q. Will there be new prefixes for the member ID cards?**

**A.** Yes. There will be new prefixes for the new individual and small group health plans. Please see the chart on page 1 for details.

**Q. Will eligibility and benefit information for these members be found on the Availity Web Portal?**

**A.** Yes. Providers will be able to verify eligibility and member benefits via the Availity Web Portal.
Q. What is the Provider Service phone number for these members?
A.

<table>
<thead>
<tr>
<th>Prefix Assigned</th>
<th>Provider Network</th>
<th>Type of Plan</th>
<th>Provider Service</th>
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<tbody>
<tr>
<td>JWR</td>
<td>Pathway X Tiered Hospital</td>
<td>Individual On-Exchange</td>
<td>(855) 748-1808</td>
</tr>
<tr>
<td>JWS</td>
<td>Pathway X Tiered Hospital</td>
<td>Small Group On-Exchange</td>
<td>(855) 748-1809</td>
</tr>
<tr>
<td>JWT</td>
<td>Pathway Tiered Hospital</td>
<td>Individual Off-Exchange</td>
<td>(855) 330-1106</td>
</tr>
<tr>
<td>JWQ</td>
<td>Blue Access PPO</td>
<td>Small Group Off-Exchange</td>
<td>(855) 330-1107</td>
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**PROVIDER NETWORK**

We’ve created provider networks to service the new individual and small group health plans purchased on the Exchange and individual plans purchased off the Exchange. These networks are more focused, but will continue to offer quality care for our members.

Q: What is the name of the provider network that will support individual and small group plans purchased on the Exchange?
A. The Pathway X Tiered Hospital network will support individual and small group plans purchased on the Exchange.

Q. What is the name of the provider network that will support individual plans purchased off the Exchange?
A. The Pathway Tiered Hospital network will support individual new plans purchased off the Exchange.

Q. Which providers are participating in these networks?
A. A subset of Anthem’s participating doctors, hospitals and other health care professionals are participating in the Pathway X Tiered Hospital and Pathway Tiered Hospital networks. The networks include a broad base of ancillary providers.

Q. How do I know if I am participating in one or more of the networks?
A. Providers have received, or will receive, a letter and/or an amendment to their Anthem contract confirming that they are part of the Pathway X Tiered Hospital and Pathway Tiered Hospital networks. Providers not participating in the Pathway X Tiered Hospital and Pathway Tiered Hospital networks will still remain participating providers in Anthem’s other provider networks, as applicable, under their existing provider agreements.

You can confirm your participation status by using our online Find a Doctor tool at www.anthem.com>Providers(enter Ohio)>Find a Doctor. Our tool allows you to search by specific provider name, zip code, provider specialty, or search for a list of local providers participating in a specific network and geographic area.

Q. Will more providers be brought into the Pathway X Tiered Hospital and Pathway Tiered Hospital networks?
A. We will continue to evaluate the needs of our membership and expand the network as appropriate in the future. Please note that your participation status in other Anthem provider networks remains unchanged.

Q. As a non-participating provider, what should I know if a member in one of the new plans presents at my office?
A. Your office will need to be able to identify members who are covered by a plan supported by the Pathway X Tiered Hospital and Pathway Tiered Hospital networks. You can easily identify these members by the Network Name field on the member ID card, which will indicate one of the
network names noted above. As with other Anthem products, services rendered by non-contracted providers will be processed as out-of-network. Providers should continue to verify eligibility and benefits for all members.

**Q: What if a member in one of the new plans has a medical emergency and is taken to a non-participating facility?**

**A.** Emergency care services are covered under the new plans. For example, if a member is covered by one of the plans supported by the Pathway X Tiered Hospital or Pathway Tiered Hospital network and is seen by a provider not participating in one of these networks, the charges (due to the seriousness of the illness or injury), will be covered as in-network benefits. However, if the visit is not a medical emergency, the claim will process as out-of-network.

**Q. What should providers know about referral processes/patterns?**

**A.** When referring members to another provider, it is important to refer them to other doctors, hospitals, or other providers participating in the network supporting the member’s plan. Please note the Pathway X Tiered Hospital and Pathway Tiered Hospital networks may include fewer specialists, hospitals, or other health care providers than other Anthem provider networks.

Referring providers will be able to identify other in-network providers by accessing the *Find a Doctor* tool.
PROCESSES – CLAIMS, PREAUTHORIZATIONS, AND REMITS

Q. Will claim edits (such as bundling rules or incidental services) be the same for new health plans?
A. Yes, claim edits will be the same for the new health plans.

Q. Will the preauthorization/precertification requirements be the same for new health plans?
A. Yes. Anthem’s existing preauthorization/precertification requirements will apply to the new policies both on and off the Exchange.

Q. Will claims for these new health plans reflect on my current remit? Will my remits look the same?
A. Yes.

THREE MONTH GRACE PERIOD

Q. What happens to a provider’s claims if an individual member with subsidized coverage purchased on the Exchange does not pay their portion of the premium?
A. The Affordable Care Act (ACA) mandates a three month grace period for individual members who purchase their health plan on the Exchange, are eligible for a premium subsidy from the government, and are delinquent in paying their portion of premiums. This three month grace period applies after the individual has paid at least one month’s premium within the benefit year.

In cases where the member has not paid their premium, Anthem will take the following steps, as defined by the legislation:

- Anthem will process claims for services received during the first month.
- Anthem will pend claims for services received during the second and third months of the grace period, until the full premium is received. Providers will receive a notification on their remittance indicating that the claim cannot be paid until the premium is received, and informing providers of the possibility of denied claims if the premium is not received by the end of the three month grace period.
- After the third month, if the member’s premium is not received, the member’s health plan will be terminated and the claims for services received during the second and third month will be denied. The member will be responsible for payment of services received during this time.

Q. Will claims for dates of service within the first month of the three month grace period be retracted if the member’s premium is not paid and the health plan is terminated?
A. No, Anthem will not retract payment of claims with dates of service within the first month of the grace period due to non-payment of premium.

Q. If a member is cancelled after their three month grace period, when can they re-enroll in another individual exchange health plan?
A. These members can re-enroll (if still eligible) in an individual health plan on the Exchange during the next open enrollment period. Open enrollment periods begin in October of each year.

Q. If a provider contacts Provider Services by phone to verify eligibility and benefits, will the provider be notified if the member is in a three month grace period?
A. Yes. Call center representatives will notify the provider that a member is in a three month grace period.

Q. Will Availity display information indicating that the member is in a grace period?
A. Anthem is evaluating how we might make this information available to our providers via Availity. We will inform providers of any updates to self-service tools related to the accessibility of
member grace period information in the Network Update newsletter and on provider portals when it becomes available.

Q. Will preauthorizations or precertifications be considered for members that are in the second or third months of a grace period?
A. Yes. Preauthorizations and precertifications will be considered for members in the three month grace period, based on medical necessity.

Q. If a provider contacts Anthem to request a preauthorization, will the representative responding to the request notify the provider that the member is in a three month grace period?
A. Representatives responding to requests for preauthorizations will not provide information about the status of a member’s premium payment or the three month grace period. Requests for preauthorization will be reviewed based on medical necessity.

Q. If a service is preauthorized and is provided during the second or third month of the member’s three month grace period, will the claim be paid?
A. Claims for dates of service during the second and third month of the three month grace period will pend until the premium is received. Once the member pays their portion of the premium due, all claims for dates of service in the second and third month will be reopened and processed (including claims for preauthorized services). If the member does not pay their portion of the premium by the end of the three month grace period, claims for dates of service in the second and third month of the grace period will be denied and the member will be responsible for payment of these services.

DRUG LISTS

Q. What kind of drug lists will the new plans offer?
A. The new health plans will include one of two different drug lists – the National Drug List or the Select Drug List. Anthem’s National Drug List includes a broad list of covered drugs. Anthem’s Select Drug List is a list of drugs that includes a select number of medications in all therapeutic categories and classes.

Q. How does the Select Drug List differ from the National Drug List?
A. The National Drug List includes a broad list of covered drugs that is offered with large group and National Account health plans, as well as some small group health plans. The Select Drug List is a list of drugs that includes a select number of medications in all therapeutic categories and classes, while meeting the requirements of the Affordable Care Act (ACA). Drugs listed on the Select Drug List may be tiered differently than the National Drug List. Multi-source brand drugs (drugs that have a generic equivalent) are not included on the Select Drug List.

Q. How will members know if their current medication is on the drug list utilized by their health plan?
A. Members and consumers can check to see if their current medication is included on a policy’s drug list prior to purchasing the new health plan. Drug lists are also available online for members to review.

Q. How can providers view the Select Drug List and National Drug List?
A. Providers can view both drugs lists online at www.anthem.com>Resources. (Select your state, then the name of the drug list that you want to view.) Plans utilizing the Select Drug List are not effective until January 1, 2014.

Q. A patient’s current medication is not on the drug list for their new health plan. What action should be taken?
A. Members are encouraged to talk with their doctor if their current medication is not included on their new drug list. Members and providers should review the drugs included on the new drug list to see if there is an alternative option available. If there is no alternative option available, providers can contact Express Scripts at 1-800-824-0898 to request an exception to cover the medication. This phone number is also noted on the back of the member ID card.

Q. Are there any changes to current processes related to Drug Prior Authorization or Step Therapy for these new plans?
A. There are no changes to these processes.

Q. Will members be able to use the same pharmacies with new plans?
A. Anthem will continue to offer a broad national network of pharmacies in-network. If a member transitions to a 2014 ACA compliant plan (on or off the Exchange), the member will have the same pharmacy network utilized by their previous Anthem health plan.

Q. How does Anthem make decisions about tiering drugs?
A. Many factors are considered when tiering drugs. These include:
   - How well the drug works when compared to other drugs used for the same type of treatment
   - The cost of the drug as compared to other drugs used for the same type of treatment
   - If there is a lower cost drug option that members can purchase over the counter