Exceedent LLC

Administrative Manual

2020

Introduction

This Exceedent Administrative Manual has been prepared as a resource for providers who are caring for our members of the Froedtert Health Medical Plan. The Manual includes information about requesting prior authorization, how to submit claims, and a guide to using the Exceedent Provider portal. This Manual may be updated as needed. Visit our website at www.exceedenthealth.com for the most up-to-date information. We hope that you find this Manual to be a valuable resource and we appreciate your assistance in delivering quality health care to our members.

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Background

Exceedent LLC is an innovative full-service third party administrator (TPA) focusing on self-funded employer health plans. Exceedent LLC is located in Menomonee Falls, Wisconsin and is wholly owned by Froedtert Health.

Exceedent Products

Exceedent manages the self-funded medical plan for its clients such as Froedtert Health. The Froedtert Health Plan designs can be found on page 5.

Froedtert Provider Network

The Froedtert Health Preferred Network includes nearly 10,000 physicians and advanced practice practitioners.

For the Froedtert Health members residing in an Out-of-Area Plan, the Froedtert Health Preferred Network will continue to be a preferred network. If the member's residence is outside of Wisconsin or outside a 40-mile radius of the Froedtert Health facilities, please visit MyFirstHealth.com to find providers in states outside of Wisconsin or outside the 40-mile radius. First Health's telephone number is 800-226-5116 providers may select option 3 for assistance.

Exceedent Vendors

Exceedent is the primary contact for provider and member information and assistance. MedImpact is the pharmacy benefit manager (PBM) for Froedtert Health. MedImpact and Froedtert Health co-administer the outpatient pharmacy benefit for Froedtert members, including retail, mail order, specialty prescription drugs, and prior authorization/appeal requests for prescription drugs.

Plan Designs and Options

	2020 Medical Network (PPO and High Deductible Medical Plan)		
	Covered Areas		
	Zone A	Zone B	Zone C
Description	Zip codes in Wisconsin that are within 40 miles of 53095, 53051, 53226 and 53144	Includes zip codes within the rest of Wisconsin It does not include zip codes covered in Zone A	Includes zip codes within the rest of the United States It does not include zip codes covered in Zone B or Zone A
Preferred Network Deductible 90% Coinsurance Out-of-Pocket Maximum	**Froedtert Health Preferred Network** Participating providers include: • Froedtert Hospital • Froedtert Menomonee Falls Hospital • Froedtert West Bend Hospital • Froedtert & MCW Community Physicians • Medical College of Wisconsin • Children's Hospital • Froedtert South	Froedtert Health Preferred Network Exceedent Health Network First Health Network	Froedtert Health Preferred Network First Health Network
Out-of-Network Deductible 50% Coinsurance Out-of-Pocket Maximum	All other providers	All other providers	All other providers

Plan Details	PPO Medical Plan (in Zone A)		High Deductible Medical Plan (in Zone A)	
	You Pay Froedtert Health Preferred	You Pay Out-of-Network	You Pay Froedtert Health Preferred	You Pay Out-of-Network
Annual Deductible Individual / Family	$1,000 / $2,000	$3,000 / $6,000	$3,000 / $6,000	$9,000 / $18,000
Out-of-Pocket Maximum Individual / Family	$2,500 / $5,000	$7,500 / $15,000	$5,000 / $10,000	$15,000 / $30,000
Additional Information	In the PPO plan the copays do not count toward the deductible but do count towards the out-of-pocket maximum. This does not apply for the high deductible plan because it doesn't include copays. For both plans, the out-of-pocket maximum includes the deductible and prescription costs.			
Froedtert's HSA Contribution Individual / Family	N/A		$500 / $1,000	
Services				
Preventive Care	FH pays 100%	50% after deductible	FH pays 100%	50% after deductible
Physician Office Visit	$30 copay		10% after deductible	
Specialist Office Visit	$75 copay			
FastCare Clinic	$20 copay	Not available	$65 per visit	Not available
Diagnostic Test	10% after deductible	50% after deductible	10% after deductible	50% after deductible
Surgery – Outpatient				
Hospital Care – Inpatient		$600 copay then 50% after deductible		
Emergency Room		10% after deductible for true medical emergencies		10% after deductible for true medical emergencies
Ambulance		50% after deductible		50% after deductible
Urgent Care				
Morbid Obesity Treatment (Staff and spouses only)		No coverage		No coverage
Chiropractic	$75 copay / $1,000 limit			No coverage

Note: Primary Care Physician Office Visit and Specialist Office Visit is defined by the provider specialty and billing form place of service.

Recommended Preventive Schedule of Benefits Covered 100% when using a provider in the preferred network and coded as routine	
Benefit	**Description**
Well-Baby Care	Office visits and immunizations (0 through 18 months)
Immunizations	• Routine immunizations • One tetanus booster every 10 years • Influenza, annually • HPV, ages 9 - 26 • Pneumococcal, one dose at age 65 or older ◦ Patients under age 65 with high-risk conditions may need re-vaccination after 10 years
Routine Diagnostic Tests	• Lab and x-rays • One cholesterol every 5 years starting at age 20 • One glycohemoglobin every 5 years after age 40
Routine Mammograms	One baseline age 35-39, annually after age 40
Routine Physical Exams	Annually 19 months and up
Routine Pap Test, Pelvic Exam and Breast Exam	Annually
Routine PSA Test and Prostate Exam	One baseline age 45-49, annually after age 50
Colon Cancer Screening	Start at age 50 and continue until age 75 • Fecal occult blood testing (every year), or • Routine colonoscopy (every 10 years), or • Sigmoidoscopy (every 5 years), or • Similar routine surgical procedures
Smoking Cessation Office Visits	Covered as needed
Thyroid Test (TSH)	Start at age 35, then every 5 years thereafter
Skin Cancer Screening – Physician Office Visit	Annually
Diabetes Screening	Adults age 40-70 who are overweight or obese

Recommended Preventive Care Services

The Froedtert Health medical plans provide free preventive care benefits.
To take advantage of the free preventive care benefits:

- Members must use a provider in the preferred network
- The appointment must be coded as a routine preventive service
- The service must be an A or B recommendation by the U.S. Preventive Service Task Force (USPSTF)

When scheduling a routine physical exam, the member must state that the appointment is for their annual routine physical. If during a preventive visit a non-routine service is provided (e.g. additional tests, procedure or lab work) the non-routine services and/or the entire visit may be subject to a copay, deductible and coinsurance.

Eligibility

It is important to verify eligibility prior to a member rendering services. Exceedent's eligibility rules vary by plan and employer. Eligibility can be verified via two methods:

Telephone: Provider Services at 262-532-5241 or toll free 844-532-5241 during the hours of 8:00 a.m. – 4:30 p.m. Central Standard Time, Monday thru Friday.

Online: www.exceedenthealth.com

The website provides access to eligibility information 24 hours a day, 7 days a week.

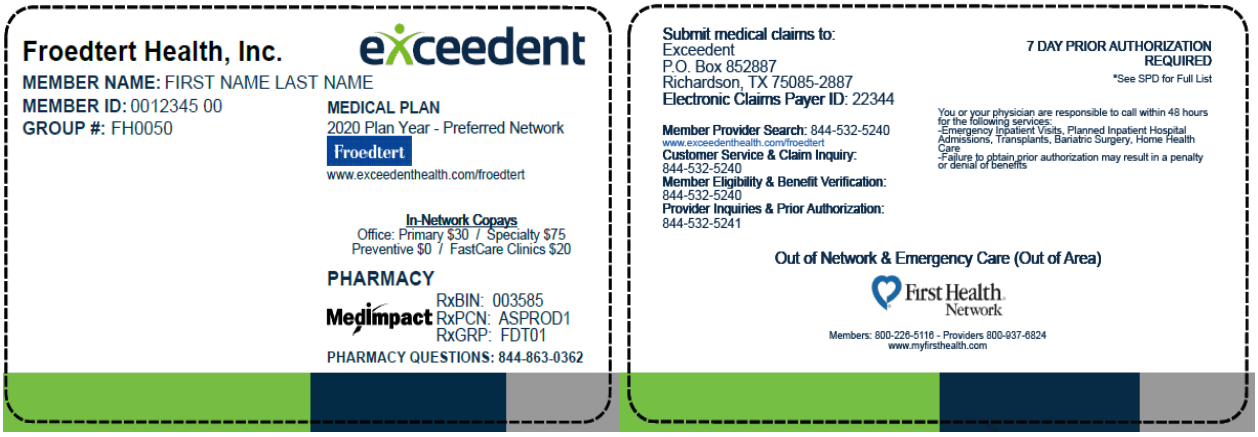
Members only have 30 days!

New Hires/Newly Eligible for Coverage - Have 30 days from the date of hire, eligibility tier change or qualified status change to add, drop or request changes to their benefits.

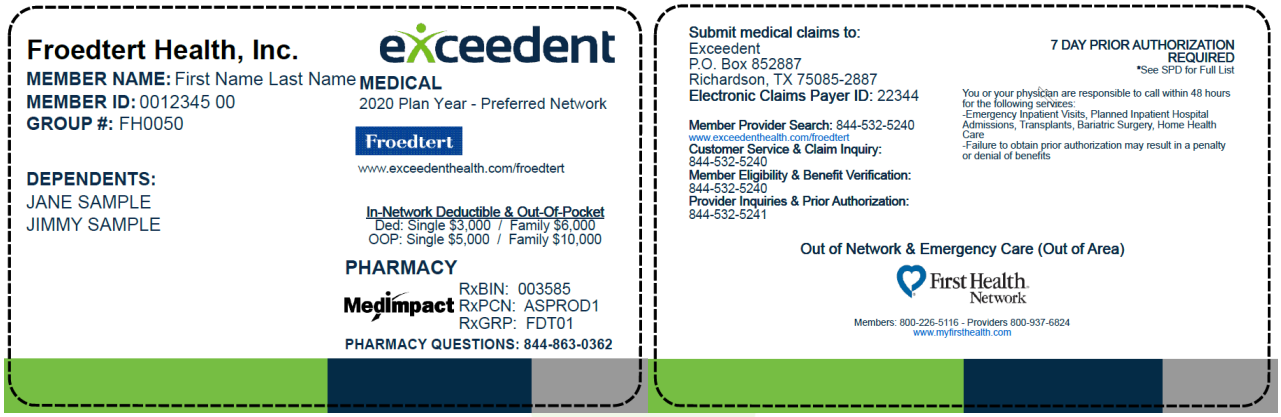
Member ID Cards

Cards may differ slightly between plans or plan options. Below are samples of the in area and out of area identification cards.

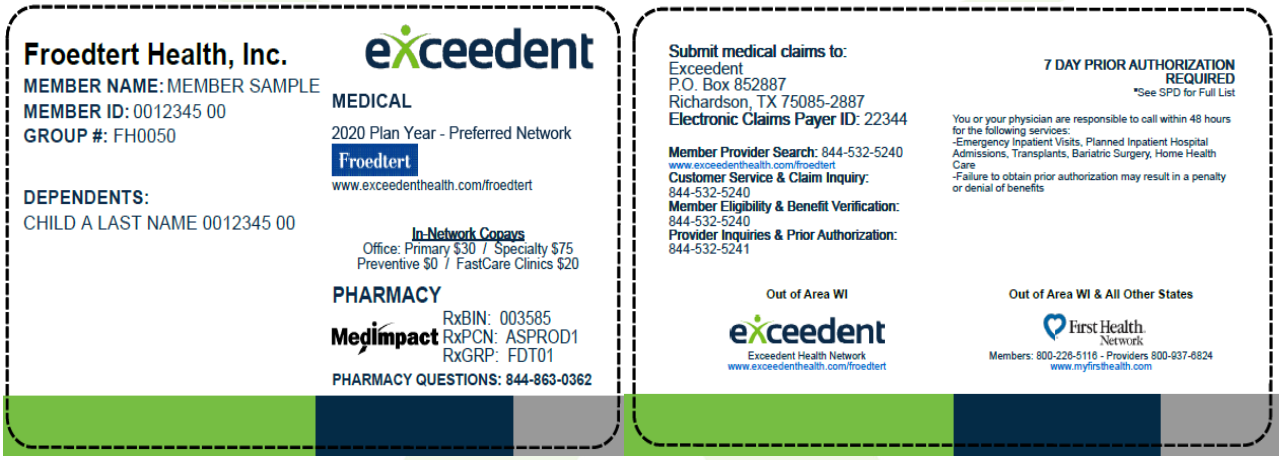
In Area PPO Plan



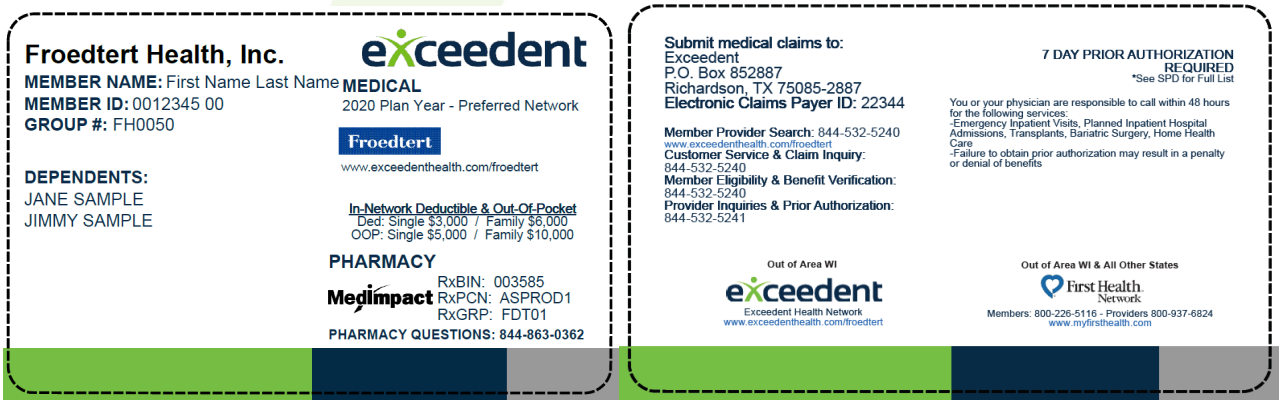
In Area High Deductible Health Plan



Out of Area PPO Plan



Out of Area High Deductible Health Plan



Prior Authorization

To determine if a prior authorization is required, a list of services is available under the Prior Authorization section on the provider portal or in the member's health plan Summary Plan Description (SPD). The SPD and a list of services requiring prior authorization for a member can be viewed online by logging on to the provider portal at www.exceedenthealth.com. To obtain a prior authorization and pre-determination request form or to check the status of an already submitted request, call the telephone number listed on the back of the member's ID card.

Telephone: 262-532-5236 or 844-532-5236 Exceedent Clinical Services hours of operation are as follows: 8:00 a.m. – 4:30 p.m. Central Standard Time, Monday thru Friday.

Fax: Complete the request form and fax with associated medical records to 262-532-5237. The Exceedent Clinical Services Fax line is open 24 hours a day, 7 days a week.

Online: An online request form can be completed at www.exceedenthealth.com. Create and/or Login to your provider account. From the "Quick Links" section on the homepage, select "Pre-Authorization / Pre-Determination" to begin the online process.

Request Response

If additional information is needed to complete a review, you will be contacted in order to accurately process the request. If the request is denied, you and the member will receive written notification, including the appeal rights and process if applicable. Please note "receipt of the request" is considered during our normal hours of operation.

Request turnaround timeframes:

- Concurrent Urgent – 24 hours of receipt of request
- Pre-service Non-urgent – 15 calendar days
- Pre-service Urgent – 72 hours
- Post-service (Retro) – within 30 calendar days of receipt of request

Referrals to Specialists

Exceedent offers the ability for members to see any provider within the network, including specialists, without a referral.

Responsibility and Member Penalty

Providers will need to submit requests for prior authorization or pre-determinations on behalf of members. Failure to obtain prior authorization may result in a financial penalty for the member. This penalty does not apply to emergency services. In addition, it is the member and providers responsibility to check in-network and out-of-network providers and benefits. Prior authorizations and pre-determinations are reviewed for medical necessity only, unless otherwise indicated on the decision letter.

Emergency Room Visits

If you have a true medical emergency that requires a visit to an emergency room, the emergency services will be paid as if it were in the preferred network, regardless of which network it is in. If you are admitted to the hospital, the admission will not be paid at the highest benefit level if the facility is not in the preferred network. You will be responsible for any fees over the allowed amount.

True Medical Emergencies

Emergency rooms handle complex, critical needs, including life- and limb-threatening situations. Symptoms or conditions best evaluated in an emergency room may include:

- Allergic reaction to food, bug or animal bites; severe shortness of breath
- Coughing up or vomiting blood
- Deep or large open wounds
- Gunshot or stab wounds
- Heavy fever with mental confusion, stiff neck
- Heavy, continuous bleeding
- Major broken bones
- Major Burns
- Partial or total amputation of a limb
- Poisoning
- Severe shortness of breath
- Signs of a heart attack such as: sudden or severe chest pain or pressure
- Signs of a stroke such as: numbness of face, arm leg on one side of the body
- Spinal injuries
- Sudden or unexpected loss of consciousness
- Suicidal feelings
- Trauma to the head

Clinical Management

Exceedent Clinical Services staff may assist with clinical management programs. There is no fee to members or providers for these programs.

- Utilization Management
- Case Management
- Basic Health Information

Exceedent Clinical Services Contact Information

Telephone: Call 262-532-5236 or 844-532-5236, available during the hours of 8:00 a.m. – 4:30 p.m. Central Standard Time, Monday – Friday

Utilization Management Prior Authorization Review

Concurrent Review

Concurrent review provides review of medical necessity and level of care for members while they are accessing services in the hospital inpatient, acute rehabilitation, skilled nursing facility or home health setting.

Independent Review Organization (IRO)

IRO's provides clinical review and determinations for medical necessity by independent clinical reviewers. Exceedent Clinical Services Team may contact an IRO's during the review or appeals process.

Case Management

Case Management provides authorization, discharge planning and care coordination for complex and high dollar cases including organ/tissue transplants and high-risk neonates. The assigned Case Manager RN will provide support, guidance and assistance.

Claims

Providers are encouraged to submit claims via electronic claims submission. **Exceedent's EDI Claim Payer ID Number is 22344.** If you wish to obtain more information about electronic claims submission, please call the Exceedent Provider line at **262-532-5241** or toll free at **844-532-5241**.

Claims Submission Guidelines

All paper claims should be submitted on a standard CMS 1500 form or UB 04 form, as applicable, and contain the following information:

UB Forms

- Provider Name, Address and Telephone Number
- Patient Control Number
- Type of Bill
- Federal Tax ID Number
- Statement Covers Period
- Patient's Name
- Patient's Address
- Patient's Birth Date
- Patient's Gender
- Patient's Marital Status
- Admission Date/Start of Care
- Admission Hour
- Type of Admission
- Discharge Hour
- Occurrence Span Code and Dates
- Revenue Code
- Revenue/HCPC/CPT Description
- HCPCS Rates
- Service Date
- Service Units
- Total Charges
- Non-Covered Charges
- Payer Identification
- Provider Number
- Release of Information
- Assignments of Benefits Cert. Information
- Prior Payments
- Insured's Name
- Patient's Relationship to Insured
- Group Name
- Group Number
- Employment Status Code
- Principal Diagnosis Code
- Admitting Diagnosis
- Principal Procedure Code and Date
- Attending/Referring Physician NPI
- Provider Representative Signature
- Date

CMS 1500 Forms

- Patient's full name (as printed on Health Plan ID card)
- Patient's date of birth
- Policyholder/subscriber, Insurance Name and ID # (include any suffix numbers shown on the card to assist with dependent coverage verification)
- Diagnosis (ICD-10-CM code is required)
- Date(s) of service
- CPT-4 procedure codes with description and modifier, if applicable
- Name should be shown of PA, FNP, rendering provider
- Referring physician's name, if applicable
- NPI
- Federal Tax ID Number
- Information on other insurance coverage
- Prior Notification number, if applicable
- Signature of provider rendering service

Claims Inquiries

Claims inquiries should be directed to Exceedent's Customer Service Line at **262-532-5240** or **844-532-5240.**

Claims Submission Only Address

Exceedent LLC
PO BOX 852887
Richardson, TX 75085

**Please mail any correspondence, such as overpayment requests, refund checks, remittance information, appeals, reconsideration requests, medical records, etc. to our physical home office address:

Exceedent LLC
Attn: Claims Department
W129 N7055 Northfield, Dr. Building B
Menomonee Falls, WI 53051

Timely Filing

Completed claims are to be submitted to the third-party administrator, Exceedent LLC, as soon as possible after services are received, but no later than **twelve months** from the date of service. A complete claim means that the Plan has all information that is necessary to process the claim. Claims received after the timely filing period has expired will not be considered for payment.

Coordination of Benefits

Coordination of Benefits (COB) applies whenever a Covered Person has medical coverage under more than one plan. It does not apply to prescription benefits (except for Medicaid) or Vision benefits. The purpose of coordinating benefits is to help Covered Person pay for Covered Expenses, but not to result in total benefits that are greater than the Covered Expenses incurred.

The order of benefit determination rules determines which plan will pay first (Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim, and will reduce the benefits it pays so that the total payment between Primary Plan and Secondary Plan does not exceed the Covered (Allowable) expenses incurred. If the covered benefit under the Plan is less than or equal to the Primary Plan's payment, then no payment is made by the Secondary Plan.

Exceedent has two options for members to submit their COB information.

Option 1: Complete an online form

1. Log into the Exceedent member portal
2. Click Coordination of Benefits Update under Quick Links
3. Select the first link to open online form
4. Enter the required information and click Submit

Option 2: Request a fillable PDF form by phone or download the PDF online

1. Log into the Exceedent member portal
2. Click Coordination of Benefits Update under Quick Links
3. Select the second link to download the PDF form
4. Enter the required information and return to Exceedent via one of the following options:
   - Fax: 262-532-5245
   - Email: fhmembers@exceedenthealth.com
   - Mail: Exceedent Attn: FH Members/COB
     W129 N7055 Northfield Drive, Building B Menomonee Falls WI 53051

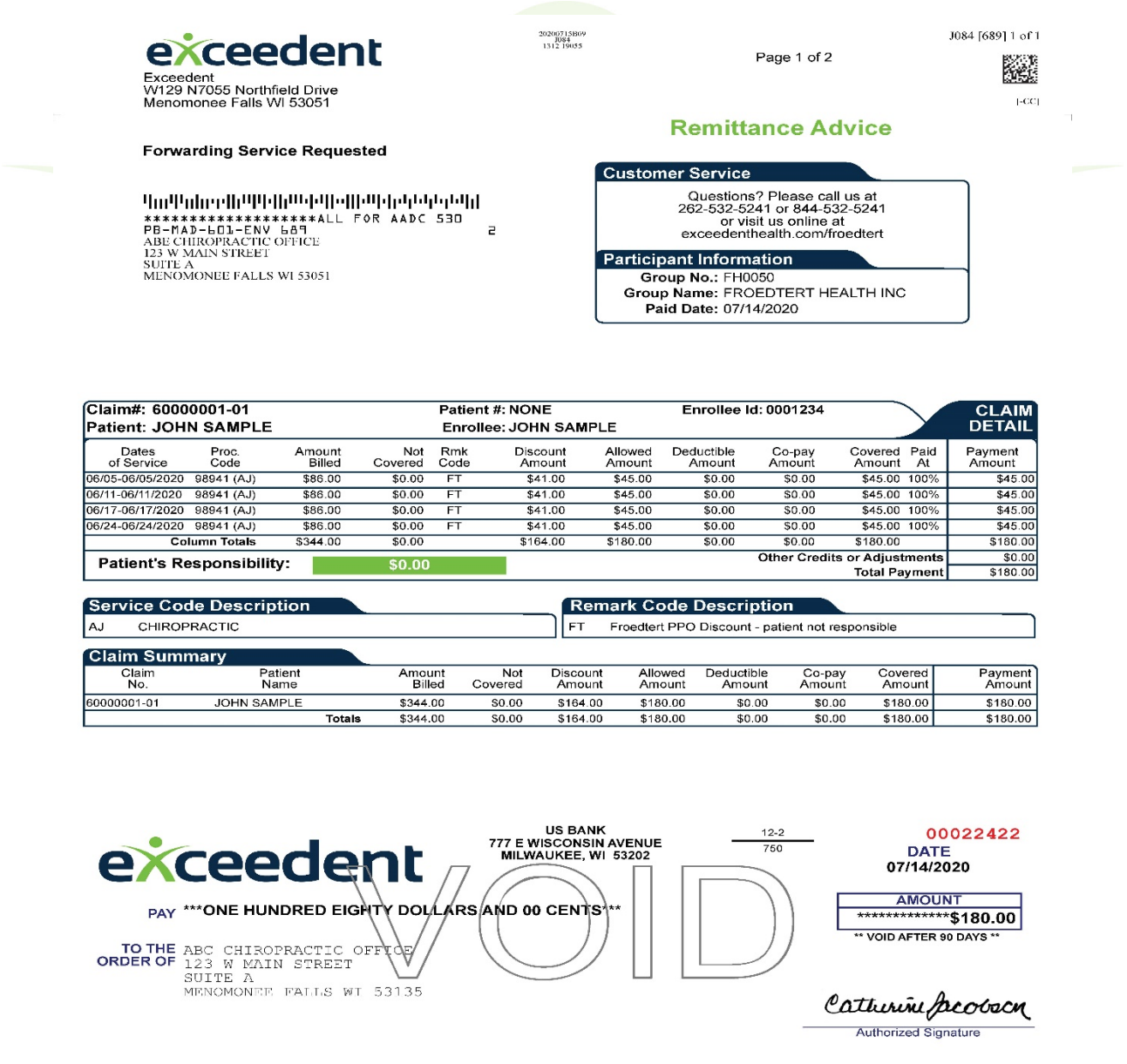
Appeals

If you think a claim was denied in error, members or providers have the right to appeal the decision. Specific details regarding appeal rights and procedures that need to be followed are located within the Froedtert Health Medical Plan (the "Plan") and it's Summary Plan Description ("SPD"). The appeal must be filed within **180 days** of the date you receive the Explanation of Benefits ("EOB") or other notice of Adverse Benefit Determination from the Plan showing that the claim was denied. The Plan will assume that you received the EOB or other notice of Adverse Benefit Determination five days after the Plan mailed the EOB or other notice.

**Please note that any provider submitting an appeal on the member's behalf must have an authorized representative form completed by the member for the appeal to be considered.

Provider Remittance Advice

Exceedent produces weekly check runs. Provider Remittance Advices (RA) and member Explanations of Benefits (EOB) are a fundamental part of finalization of the patient/physician experience. To help familiarize you with the Remittance Advice that your office will receive, below is an example. Claim specific details are also available to you by logging on to the provider portal at: www.exceedenthealth.com.



exceedent

Exceedent
W129 N7055 Northfield Drive
Menomonee Falls WI 53051

Forwarding Service Requested

**********ALL FOR AADC 530
PB-MAD-601-ENV 689
ABE CHIROPRACTIC OFFICE
123 W MAIN STREET
SUITE A
MENOMONEE FALLS WI 53051

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Remittance Advice

Customer Service

Questions? Please call us at
262-532-5241 or 844-532-5241
or visit us online at
exceedenthealth.com/froedtert

Participant Information

Group No.: FH0050
Group Name: FROEDTERT HEALTH INC
Paid Date: 07/14/2020

Claim#: 60000001-01 **Patient #: NONE** **Enrollee Id: 0001234**
Patient: JOHN SAMPLE **Enrollee: JOHN SAMPLE**

CLAIM DETAIL

Dates of Service	Proc. Code	Amount Billed	Not Covered	Rmk Code	Discount Amount	Allowed Amount	Deductible Amount	Co-pay Amount	Covered Amount	Paid At	Payment Amount
06/05-06/05/2020	98941 (AJ)	$86.00	$0.00	FT	$41.00	$45.00	$0.00	$0.00	$45.00	100%	$45.00
06/11-06/11/2020	98941 (AJ)	$86.00	$0.00	FT	$41.00	$45.00	$0.00	$0.00	$45.00	100%	$45.00
06/17-06/17/2020	98941 (AJ)	$86.00	$0.00	FT	$41.00	$45.00	$0.00	$0.00	$45.00	100%	$45.00
06/24-06/24/2020	98941 (AJ)	$86.00	$0.00	FT	$41.00	$45.00	$0.00	$0.00	$45.00	100%	$45.00
	Column Totals	$344.00	$0.00		$164.00	$180.00	$0.00	$0.00	$180.00		$180.00
Patient's Responsibility:		$0.00							**Other Credits or Adjustments**		$0.00
									Total Payment		$180.00

Service Code Description

AJ CHIROPRACTIC

Remark Code Description

FT Froedtert PPO Discount - patient not responsible

Claim Summary

Claim No.	Patient Name	Amount Billed	Not Covered	Discount Amount	Allowed Amount	Deductible Amount	Co-pay Amount	Covered Amount	Payment Amount
60000001-01	JOHN SAMPLE	$344.00	$0.00	$164.00	$180.00	$0.00	$0.00	$180.00	$180.00
	Totals	$344.00	$0.00	$164.00	$180.00	$0.00	$0.00	$180.00	$180.00

exceedent

US BANK
777 E WISCONSIN AVENUE
MILWAUKEE, WI 53202

12-2
750

00022422

DATE
07/14/2020

AMOUNT
**********$180.00

** VOID AFTER 90 DAYS **

PAY ***ONE HUNDRED EIGHTY DOLLARS AND 00 CENTS***

TO THE ORDER OF ABC CHIROPRACTIC OFFICE
123 W MAIN STREET
SUITE A
MENOMONEE FALLS WI 53135

VOID

Authorized Signature

⑈000224224⑈ ⑆075000022⑆ 1823804426466⑈

Important Information

Important Information About Your Appeal Rights

If you think a Claim was denied in error, you have the right to appeal this decision, as stated below. Also, specific details regarding your appeal rights, timelines for filing an appeal, and procedures that you need to follow are in the Froedtert Health, Inc. Group Benefit Plan (the "Plan") and its Summary Plan Description ("SPD"). Please review the Plan and SPD very carefully. If you cannot locate the current Plan and SPD contact Exceedent at 1-844-532-5240 or the Froedtert Health Human Resources Services Center at (414) 777-1999.

What if I need help understanding this denial? Contact the Exceedent customer service department at the phone number listed on the back of your Participant Identification Card. Exceedent is the third party administrator for the Plan.

What if I don't agree with this decision? You have a right to appeal any initial decision not to provide or pay for an item or service (in whole or in part). You must appeal any such initial decision before you could bring a lawsuit against the Plan. If your appeal has already been denied once, you can file a voluntary second level appeal.

How do I file an internal appeal for services I already received and can I provide additional information about my claim? Send your written appeal to: Exceedent, Attn: Froedtert Health Appeal Team, W129 N7055 Northfield Drive, Menomonee Falls, WI 53051. Your written appeal should include a copy of the Adverse Benefit Determination (denial) that you are appealing, and you should supply additional information to explain why you believe the claim should have been approved.

What if my situation is urgent and prior authorization is required from the Plan before I can receive service? If the Plan has denied your prior authorization request to have certain services, and your situation meets the definition of urgent under the law, your review will generally be conducted within 72 hours. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited internal appeal and a simultaneous external review by calling Exceedent's customer service department at the phone number listed on the back of your Participant Identification Card or by submitting a written explanation of your appeal as explained in the above provision for internal appeals.

Who may file an appeal? You or someone you name to act for you (your authorized representative) may file an appeal. Please call Exceedent's customer service department at the phone number listed on the back of your Participant Identification Card to obtain an authorized representative designation form.

Can I request copies of information relevant to my claim? Yes, you may request copies (free of charge). If you think a coding error may have caused this claim to be denied, you have the right to have billing and diagnosis codes sent to you as well. You can request copies of this information by contacting Exceedent's customer service department at the phone number listed on the back of your Participant Identification card.

What happens next? If you appeal, we will review our decision and provide you with a written determination. If we continue to deny the payment, coverage, or service requested, or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party who will review the denial and issue a final decision. An external review is only available for claims involving medical judgment or rescission of coverage.

How do I request an external review? An external review request should be sent, in writing, to:

Exceedent
Froedtert Health Appeal Team
W129 N7055 Northfield Drive
Menomonee Falls, WI 53051

Your written request should include: 1) your specific request for an external review; 2) your name (and, if you are not the employee who receives coverage through the Plan, the employee's name), your address, and member ID number; 3) your designated representative's name and address, when applicable; 4) the service that was denied; and 5) any new, relevant information that was not provided during the internal appeal. Your written request with respect to the denial in this notice must be received by Exceedent within four (4) months after the date you receive this notice. You will be provided more information about the external review process at the time we receive your request.

Are there any time limits for when I can bring a lawsuit to enforce my rights with respect to a denied claim? Yes. No legal action for benefits may be filed against the Plan after one year from the date you receive a final determination on your appeal.

All legal actions relating to the Plan and / or a claim for benefits, of any type, under the Plan must be brought in courts based in Milwaukee County, Wisconsin.

Other resources to help you: In addition to reviewing appeal rights information in your Summary Plan Description, or calling Exceedent's customer service for assistance, you could also contact the Employee Benefits Security Administration at 1-866-444-3272 who may be able to help.

Pharmacy

MedImpact is the prescription benefits administrator for Froedtert Health Plan members. If you have questions or need assistance getting prescriptions for members, you can contact MedImpact Customer Service, 24 hours a day, 7 days a week via:

- Telephone: MedImpact Customer Service Center at **844-863-0362**
- Online: https://www.medimpact.com/

Drug Formulary

The Froedtert Health Formulary is a list of medications covered by the plan. The formulary is developed and maintained by MedImpact and approved by a committee comprised of independent physicians and pharmacists. To find out what drugs are on the formulary, contact MedImpact via telephone or check their website at https://mp.medimpact.com/FDT and click the link.

Prior Authorization

Contact MedImpact for prior authorization at **844-863-0362**. Providers must submit a prior authorization request through MedImpact online portal at medimpact.com (registration required).

Pharmacy Network

The Froedtert pharmacy network includes some retail pharmacies nationwide. For specific information call the customer service line or use the pharmacy locator link on the website.

- Telephone: Call the MedImpact customer service center at **877-787-8660**
- Online: www.medimpact.com

Home Delivery Pharmacy

The Froedtert Medication Management and Home Delivery Pharmacy offers a convenient home delivery service with free shipping. The home delivery service allows you to fill maintenance medications and have them shipped directly to your house. The Home Delivery Pharmacy is an internal pharmacy and is able to fill up to a 90-day supply of generic and brand medications. Specialty medications are also available for up to a 30-day supply.

- Telephone: Call **414-805-5690**
- Online: https://www.froedtert.com/patients-visitors/pharmacy/medication-management/enrollment

Specialty Pharmacy

For certain specialty medications that are administered by the provider or self-administered, the first administration of a new specialty medication will be covered under the Froedtert Health Medical plan. (If the member has been on a medication for a while please send them to MedImpact) Following the initial administration, the medication must be purchased at a retail pharmacy and administered by the provider or self-administered. Medications purchased at a retail pharmacy will be covered by the prescription drug plan; however, you may be required to obtain a prior authorization first from MedImpact.

These types of medications are typically administered subcutaneously (under the skin), intramuscularly (into the muscle) or intravenously (into the vein).

The medications on the Provider and Self-Administered Specialty Medications list are subject to this coverage. The list is subject to change. These medications are either obtained from the pharmacy and taken to your provider (White bagging) or will be delivered from the pharmacy to your provider administrating the medication.

Safe Harbor Preventive Drug List

The high deductible plan includes a Safe Harbor Preventive Drug list. This is a list of select preventive medications that are covered by the plan before the medical deductible is met. You only pay a portion of the cost of these medications, either the copay or coinsurance. The copay/coinsurance that applies is based on the formulary status of the medication, if it is a brand name or generic and if you use an internal or external pharmacy. Visit mp.medimpact.com/FDT to see which medications are on the Safe Harbor Preventive Drug list.

Behavioral Health

Call Exceedent's Provider Service line to verify if prior authorization is required before providing any inpatient or outpatient mental health or substance abuse services.

Contact Information

• Exceedent Clinical Services - **262-532-5236**, 8:00 a.m – 4:30 pm. CT Monday – Friday.
• Exceedent Provider Services - **262-532-5241**, 8:00 a.m – 4:30 pm. CT Monday – Friday.

Employee Assistance Program Resource

If members need help, they have the ability to talk to an EAP counselor. Counselors are on hand 24 hours a day, including holidays. Counseling visits through the EAP can help with:

- Marriage or family problems
- Personal or work-related stress
- Depression, anxiety and other difficulties
- Relocation adjustments

Members should contact ComPsych first if they feel that either themselves or someone in their family may benefit from professional counseling related to a behavioral health or substance abuse issue.

The EAP program is offered as a benefit and is open to all staff and family members, even those who do not enroll in the Froedtert Health medical plan. Up to 10 counseling sessions with a provider in the preferred network are available at no cost for each unique event that may benefit from counseling sessions. Members must contact the EAP and receive a referral before counseling sessions are available at no cost. ComPsych's telephone number is **888-354-4327** and the Froedtert Health Company Code is: **EAPFCH**.

These visits are not subject to medical plan copays, deductibles or coinsurance. If additional medical services are required, copays, deductibles and coinsurance will apply.

Online Benefits and Claim Inquiry

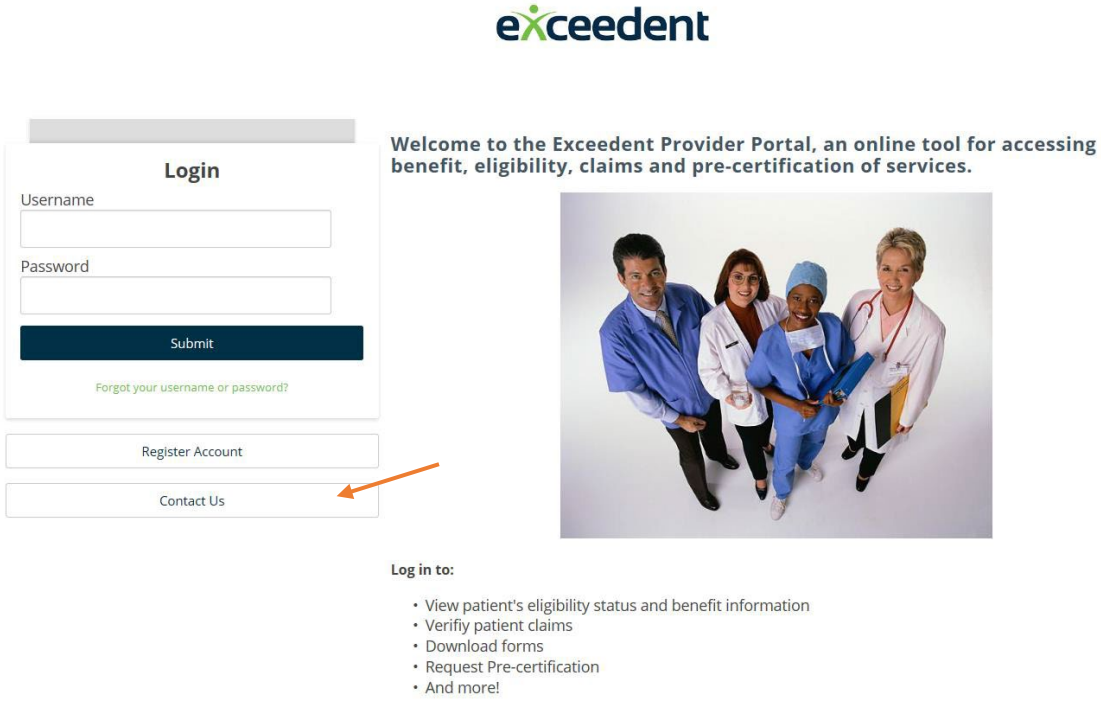
Access information and tools for managing your patients covered by Exceedent 24 hours a day, 7 days a week by going to www.exceedenthealth.com. Logging on to the website provides you and your office the following:

- Claim inquiry information such as payment status, amounts billed and paid, deductibles, discounts and to whom payment was made
- Eligibility and benefits information, including patient specific plan information, claim submission details, prior authorization requirements and member benefit levels
- Contact phone numbers and an email notification form to contact a member of the Exceedent team with your questions.

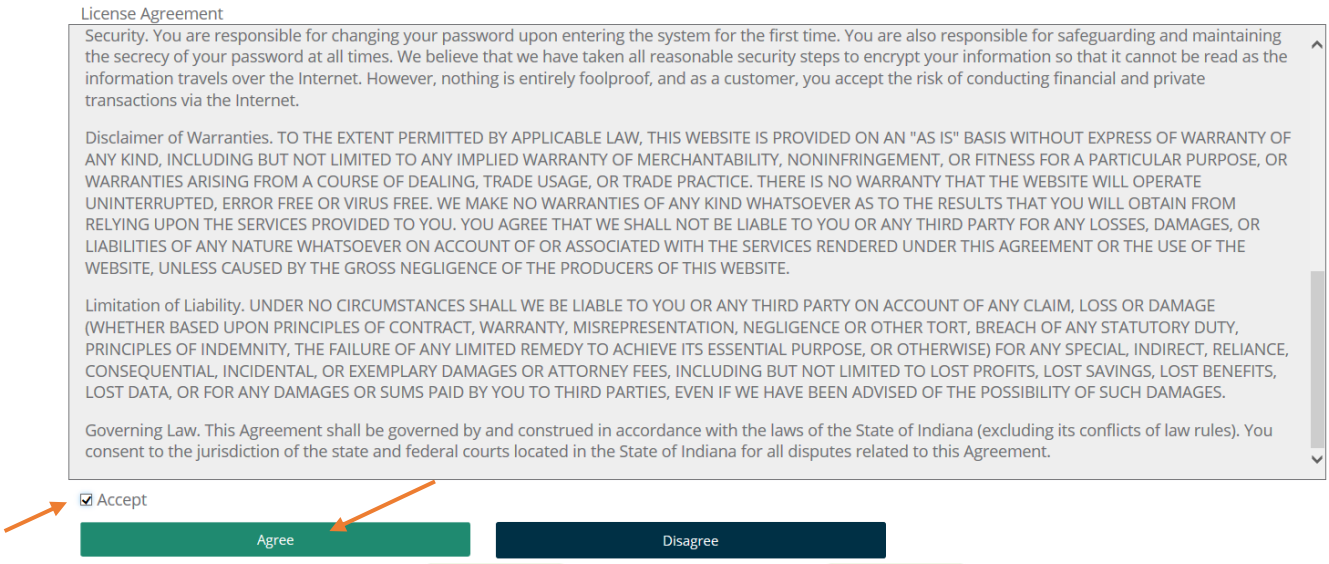
If you have questions or problems related to the website, please contact the Exceedent Customer Service Team at **844-532-5240 or Provider Services at 844-532-5241.**

Register

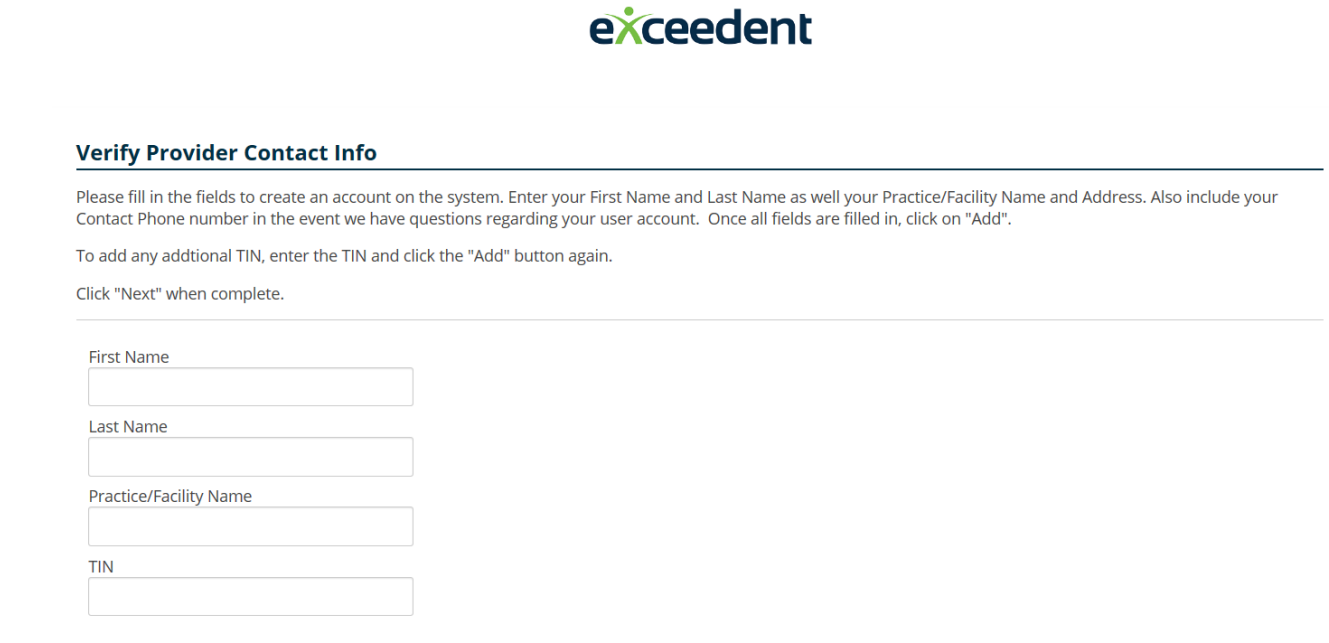
1. Go to https://www.exceedenthealth.com
2. Select "Provider Login" from the upper right hand corner

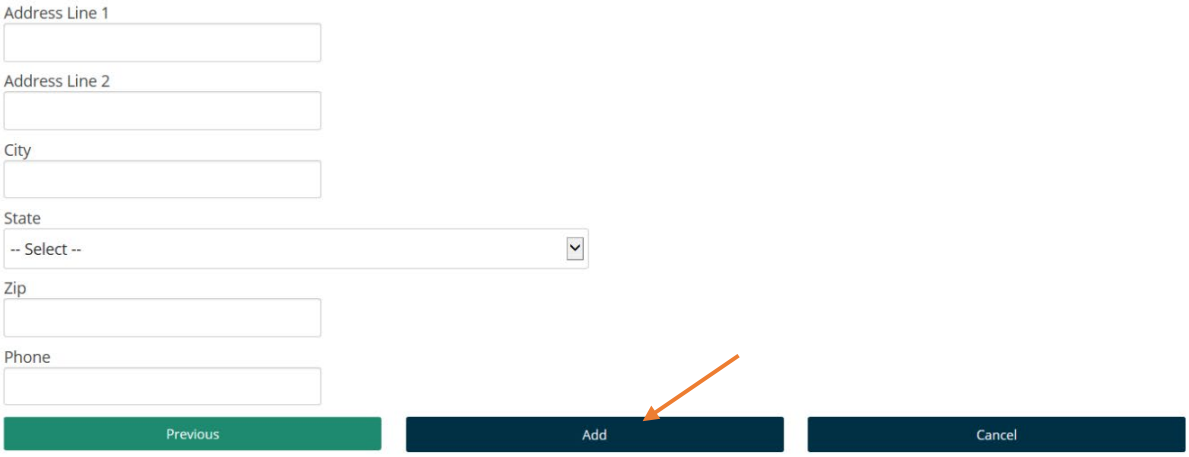


3. Read the License Agreement, check the ‘Accept’ box and then ‘Agree’ to continue with registration.

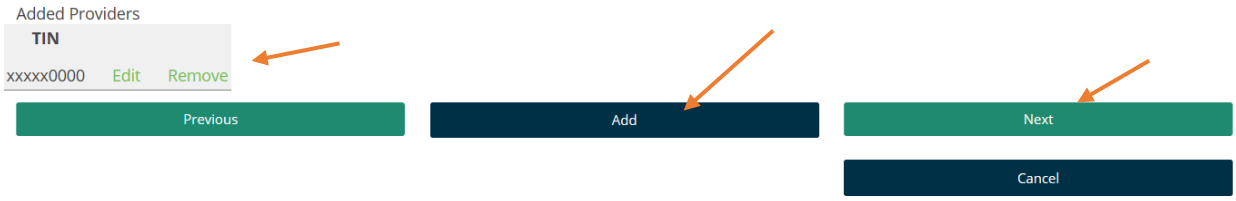


4. Enter the requested information and select ‘Add’ to continue. (Note: Some fields are required)

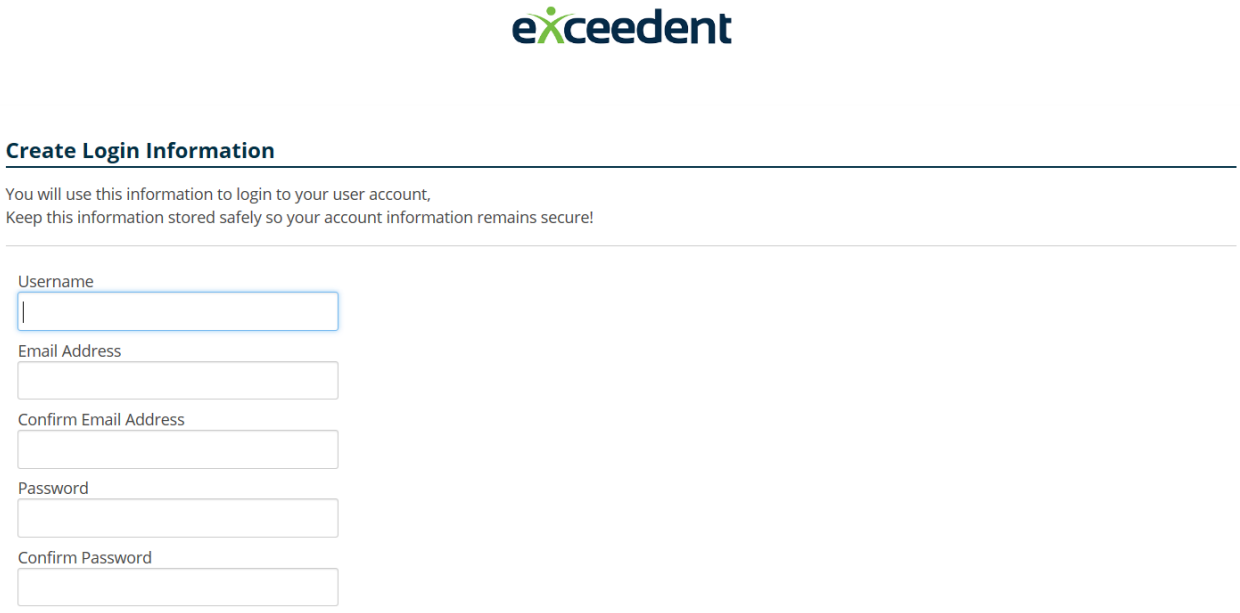


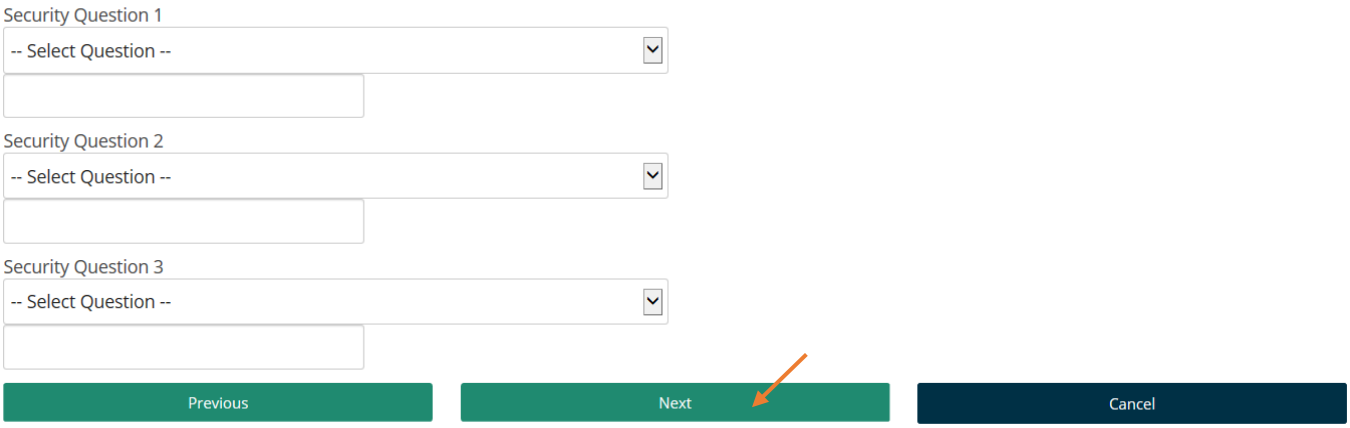


5. The TIN number you entered will display. You will then have the ability to enter additional TIN numbers if needed. Select 'Add' to enter additional TIN numbers, or select 'Next' to continue.

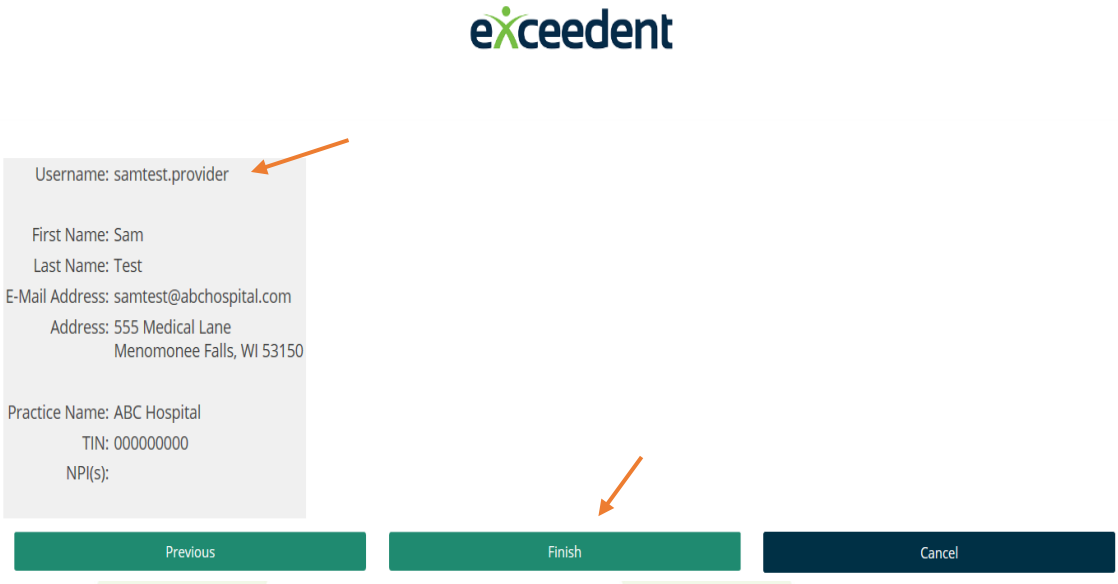


6. Create your login credentials. If a username is already in use, you will be prompted to create a different one. Select 'Next' to continue.

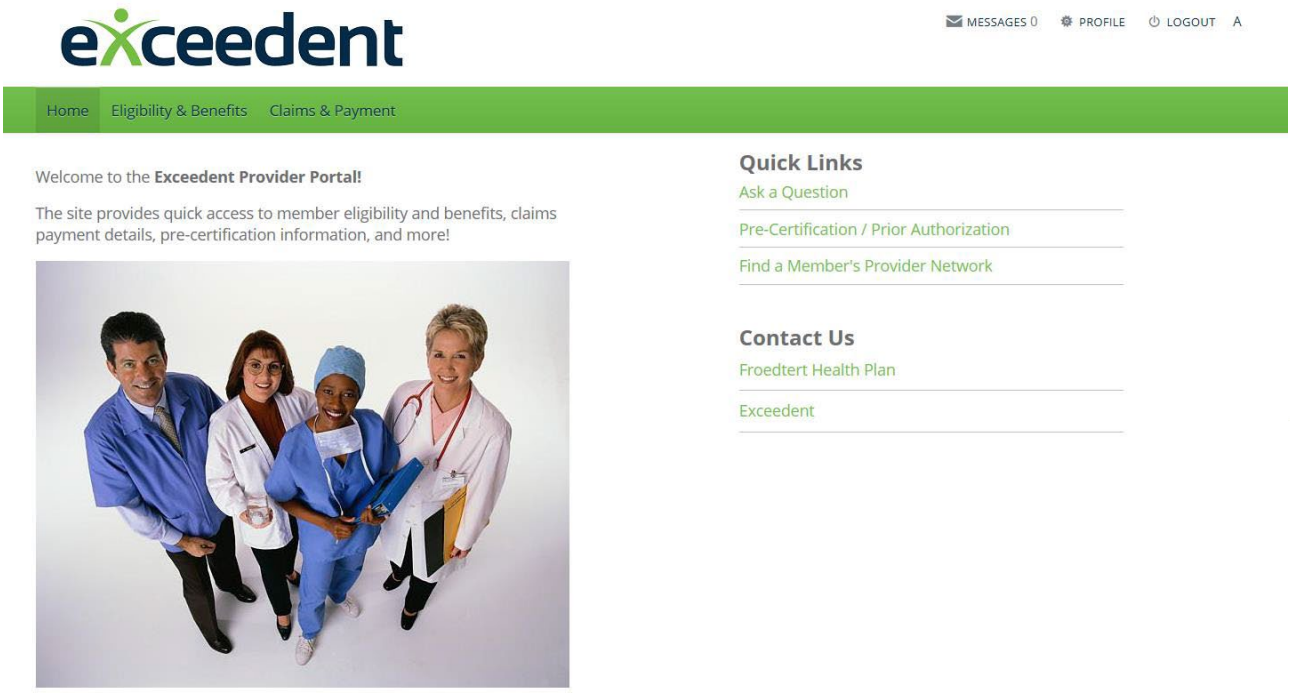




7. Your registration and login credentials will display once successfully created.

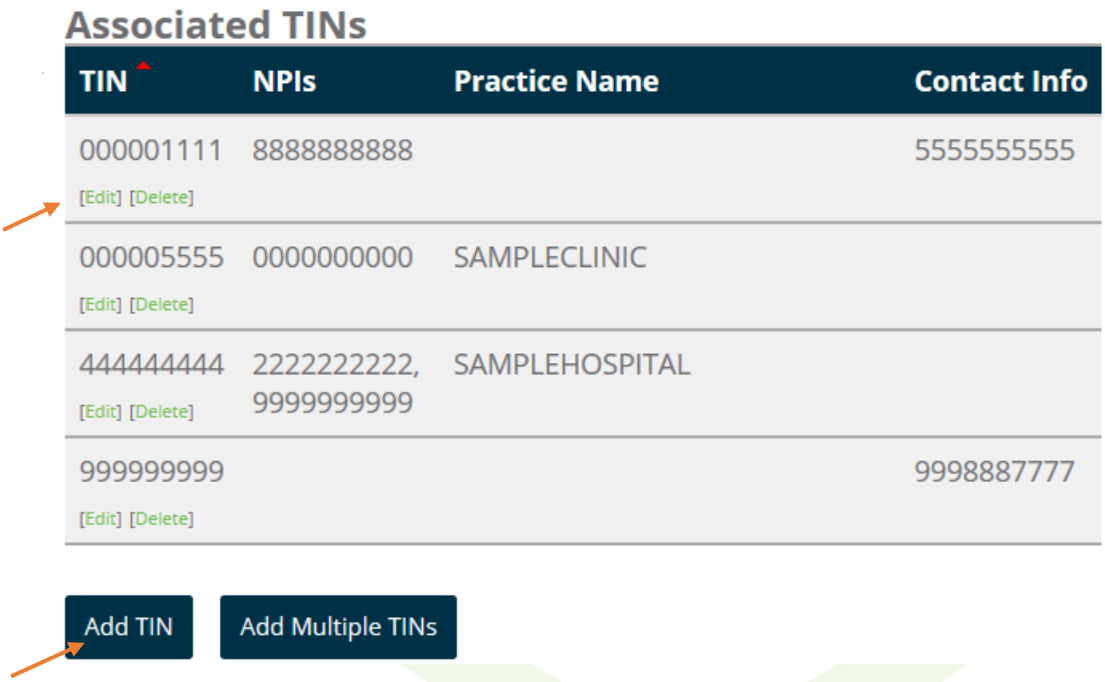


8. Select ‘Finish’ and you will be automatically taken to your provider portal account.



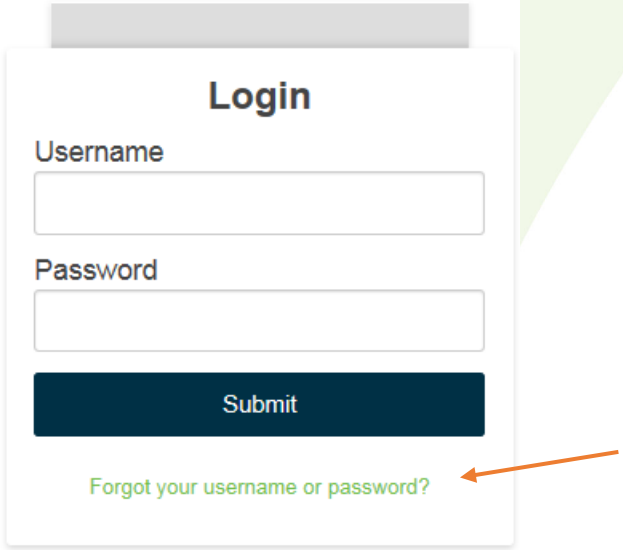
9. You can add additional TIN numbers as needed by selecting ‘Profile’ from the top right corner of your account.

10. From your ‘Profile’ you have the ability to:
    - Edit existing TIN’s, Add new TIN’s, and Delete any Associated TIN’s
    - Change your username and password
    - Update your contact information
    - Change your security questions (Note: You’ll need to enter your password to verify the update of security information)



Reset Password

Should you forget your password, you can select the "*Forgot username or password?*" option to change it.



*If you have any questions please call Provider Services at 262-532-5210.

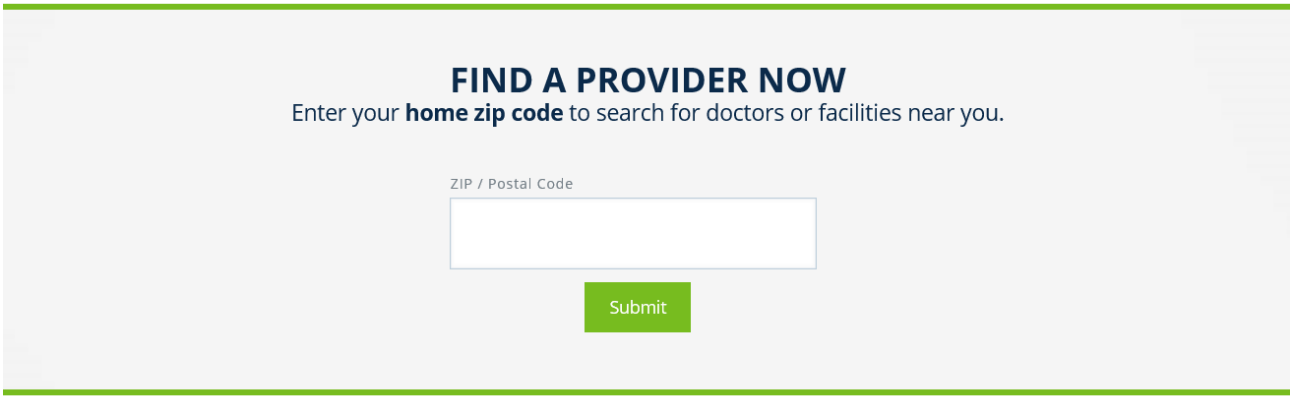
Provider Directories

To obtain the highest level of benefits under the Plan, members need to see an in-network provider, however Exceedent does not limit a member's right to choose his or her own provider or medical care. If a medical expense is not a Covered Expense under the medical benefit plan, or is subject to a limitation or exclusion, a member still has the right to receive such medical service at his or her own personal expense.

To find out which network a provider belongs to, please refer to the Provider Directory or call the toll free number that is listed on the back of the member's identification card. The participation status of providers may change from time to time.

Exceedent Member/Provider Information

• Telephone: Call the Exceedent Froedtert Provider Service Line at **844-532-5241**.
• Online: Available at https://my.exceedenthealth.com/ under the Froedtert Health Member's Corner



Froedtert Health uses a customized network of providers, which includes a variety of hospitals, urgent care centers, primary care physicians and specialists. The medical network is divided into three zones. The zones are Zone A, Zone B and Zone C. Each zone has a preferred network of providers. The zip code of the member's home address will determine which zone they are in and which preferred network to use.

Members will need to register and maintain their dependent's address if they do not live at their home address. Their address will determine which zone they are in and which preferred network to use.

Quick Reference List

Exceedent Provider Service Line
262-532-5241 or 844-532-5241
8:00 a.m. – 4:30 p.m. CT
Monday – Friday
- Eligibility Verification
- Benefit Inquiries
- Claim Inquiries
- Misc Questions
- Provider/Member Appeals

Pharmacy Benefits
844-863-0362
MedImpact
- Drug Formulary
- www.mp.medimpact.com/FDT

Exceedent Portal
www.exceedenthealth.com
- Benefit Inquiries
- Claim Status
- Eligibility Verification

Exceedent Customer Service Line
844-532-5240 - Phone
262-532-5245 - Fax
8:00-4:30 p.m. CT
Monday – Friday
- Eligibility Verification
- Benefit Inquiries
- Claim Inquiries
- Prior Certification
- Provider/Member Appeals
- Provider Directories

Home Office Address:
Exceedent
W129 N7055 Northfield Dr.
Menomonee Falls, WI 53051

Exceedent Clinical Services
844-532-5236
Or 262-532-5236 – Phone
262-532-5237 – Fax
8:00 a.m. – 4:30 p.m. CT
Monday - Friday
- Utilization Review/Prior Authorization

Exceedent Claims Mailing Address
PO BOX 852887
Richardson, TX 75085

Common FAQ's

How do I obtain reimbursement for a breast pump?

The medical plan will cover one breast pump per pregnancy at 100% if purchased through a durable medical equipment (DME) provider in the preferred network. To find a DME provider in the preferred network:

1. Visit www.exceedenthealth.com/froedtert
2. Enter your **home zip code** to search for doctors or facilities near you and click submit
3. Click **Find a Facility**
4. Select **Durable Medical Equipment** in the drop down menu under **Facility Type,** enter your home zip code in the **Zip Code field** and click search

If you purchase a breast pump from an out of network provider/retailer, the cost of the pump will be applied towards your out of network annual deductible. Once you have met your out of network deductible, you will be reimbursed for 90% of the cost.

To request reimbursement, complete the Breast Pump Reimbursement Claim form and submit a copy of your receipt to Exceedent. The completed form and receipt may be emailed, faxed or mailed.

Email: fhmembers@exceedent.com
Fax: 262-532-5245
Mail: Exceedent - Froedtert
Attn: Claims
W129 N7055 Northfield Drive
Menomonee Falls, WI 53051

What are the FastCare Clinic benefits? - $20 co-pay available only at FastCare Clinics that are affiliated with Froedtert Health.

Is Cologuard covered? – covered at 100% deductible waived if ordered by a provider in-network and 50 years of age.

My provider ordered a thyroid test (TSH) is that covered? - Starting at Age 35, then Every 5 Years After covered at 100% deductible waived if ordered and completed by a provider in-network.

My provider ordered a screening mammogram will it be covered at 100%? - One baseline age 35-39, annually after Age 40 covered at 100% deductible waived if ordered and completed by a provider in-network

My durable medical equipment is not working; are there any specifications to obtain a new one? DME needing to be replaced will be required to provide proof that it cannot be repaired. In addition, the provider will need to document in the medical records why replacement is needed. Being out of warranty does not mean the plan will pay for a replacement. Please contact Clinical Services for further instructions or questions.

I had an annual physical on x/date/2019, when can I schedule my annual physical for 2020? The Froedtert Health Plan is on a Calendar year plan.

I need to update my address or my dependent's address, how do I do that? You will need to update your information in the Lawson/Infor system. Froedtert Health sends Exceedent a file twice a week.

What does it mean to be self-funded? The Froedtert Health medical plans is self- funded. This means the dollars that pay for your healthcare come from Froedtert Health, not from an insurance company. The way you use the health plans affects both the organization's cost and employee contributions (payroll deductions).

What is a deductible? Deductible refers to an amount of money paid by the Covered Person before any Covered Expenses are paid by this Plan. When a new Plan Year begins, a new Deductible must be satisfied. The Deductible must be met before any benefits will be paid under this Plan, unless indicated otherwise. Only Covered Expenses will count towards meeting the Deductible. Certain Covered Expenses may be considered Preventive/Routine Care and paid by this Plan before the Deductible is met. Copays and pharmacy expenses do not count towards the Deductible of this Plan.

Within the family deductible, there is an embedded, individual deductible. When one Covered Person accumulates enough Covered Expenses to the point that they meet the individual Deductible, after-deductible benefits, like coinsurance will apply for that specific Covered Person. However, the family

Deductible is also aggregate. This means all Covered Persons accumulate towards the family Deductible. After multiple Covered Persons' Covered Expenses meet the family Deductible, all Covered Persons will receive after-deductible benefits, like the coinsurance. This applies even if a Covered Person does not meet the individual Deductible. For example, a family would meet the preferred network, family Deductible if Covered Person 1 has $500 in expenses plus Covered Person 2 has $900 in expenses plus Covered Person 3 has $600 in expenses.

What is a co-pay? A Co-pay is the amount that the Covered Person must pay to the provider each time certain services are received. Co-pays do not apply toward satisfaction of Deductibles, but do apply toward satisfaction of out-of-pocket maximums. The Co-pay and out-of-pocket maximum are shown on the Schedule of Benefits. Co-pays apply toward the provider's billed amount.

What is co-insurance? Co-insurance means that, after a Covered Person satisfies the individual Deductible, or a family satisfies the family Deductible, the Covered Person(s) and the Plan each pay a percentage of the Covered Expenses until the Covered Person's (or family, if applicable) annual Out-of-Pocket Maximum is reached. The Coinsurance rate is shown on the Schedule of Benefits. The Covered Person(s) will be responsible for paying any remaining charges due to the provider after the Plan has paid its portion of the Covered Expense, subject to the Plan's maximum fee schedule, Negotiated Rate, or Allowed Amounts as applicable. Once the annual Out-of-Pocket Maximum has been satisfied, the Plan will pay 100% of the Covered Expense for the remainder of the Plan Year except for charges above the Allowed Amount. Any payment for an expense that is not covered under this Plan will be the Covered Person's responsibility.

What is an annual out-of-pocket maximum?
Out-of-Pocket Maximum is the amount of money paid by the Covered Person before Covered Expenses are paid in full by this Plan. When a new Plan Year begins, a new Out-of-Pocket Maximum must be satisfied.

Can a provider appeal on behalf of a member? An appeal filed by a provider on the Covered Person's behalf is not considered an appeal under the Plan unless the provider is an Authorized Representative. Contact Exceedent's Customer Service team or review on the Exceedent member/provider portals to obtain a copy of the form.

Why do I need to complete an Accident/Injury Questionnaire?
Exceedent requires accident/injury questionnaires to be completed in full to be certain no other parties are responsible for the services you received.

My claim(s) was denied for coordination of benefits (COB) would they be reconsidered after I submit the COB form? Yes, within 30 days of receipt of the form – if the information is submitted timely.

I noticed a coding issue on my explanation of benefits (EOB)?
Exceedent must process claims according the the coding that was submitted by the provider. Members must contact the provider's billing office directly if you have a coding concern.

Why do I have to complete a COB form every year? COB applies when you or your covered family members on the Froedtert Health medical plan have additional coverage. For example, you may have your family on both your Froedtert Health plan and your spouse's plan. The Plan requires that COB be updated annually, or Exceedent will be unable to process claims on your file.