Provider and Billing Manual

2027



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PROVIDER MANUAL REVISION LOG

Date	Section Header	Change
1/1/27	Products and Networks Descriptions	Revised product offerings to remove outdated plans, add Marathon Health Solutions, and provide updated product descriptions.
1/1/27	SECURE PROVIDER PORTAL	Revised Secure provider portal content to include Availity information and functionality.
1/1/27	Credentialing and Recredentialing	Revised language to remove the Arkansas-specific reference because the rule applies to all health plans.
1/1/27	Recredentialing	Updated language to reflect current recredentialing process including rights to review and correct information, appeals rights and credentialing decisions.
1/1/27	Appointment Availability and Wait Times	Updated entire section to accurately reflect correct Access and Availability standards and included provider expectations.
1/1/27	Access Requirements	Added language for behavioral health non-life-threatening emergency resources, included unacceptable after-hours coverage examples and methods for ensuring compliance.
1/1/27	Covered Services	Added instructions for accessing Pre Auth Check tool to validate coverage

Date	Section Header	Change
		and requirements for authorization.
1/1/27	Transplant Services	Expanded transplant services information and clarified state-specific coverage requirements.
1/1/27	Tribal Provider (AIAN) American Indian Alaska Native	Revised AIAN/Tribal provider guidance to clarify reimbursement, authorization, Q4 modifier billing, member cost-share, and removal of prior place-of-service restrictions.
1/1/27	Medical Management	Revised entire section to align with current programs and practices.
1/1/27	Use of Artificial Intelligence (AI)-Based Algorithms in Health Care Service Reviews	Added language to clarify and identify the use of AI-based algorithms in health care service reviews.
1/1/27	Utilization Review Criteria	Added decision making criteria for medical necessity.
1/1/27	CMS Interoperability APIs	Added section
1/1/27	Online Claim Submission	Added Availity language for administrator requirements and resources to assist.
1/1/27	Requests for Reconsideration or Claim Disputes	Created new section separate from Corrected claims inclusion.
1/1/27	CPT and HCPCS Coding	Revised entire sections for clarity and readability.
1/1/27	Patient Safety and Quality of Care	Added policy information for severity level definitions for potential quality of care issues.

Date	Section Header	Change
1/1/27	Medical Record Documentation and Review	Added new Medical record and Documentation review section.
1/1/27	988 SUICIDE & CRISIS LIFELINE	Added additional resources for texting, TTY users and emergency services.
1/1/27	Appendix I: Common Causes for Upfront Rejections	Added clarifying language for instances when information is missing from or does not match Ambetter records.
1/1/27	EDI Health Claims	Removed irrelevant Medicaid reference.
1/1/27	Appendix VII: Billing Tips and Reminders	Added clarifying information to multiple sections to provide billing tips and clarifications.
1/1/27	Appendix VIII: Reimbursement Policies	Added clarifying information for modifiers 26 and TC as they relate to EKG payments.
1/1/27	Appendix VIII: Reimbursement Policies	Removed multiple-procedure language from the “lesser of” reimbursement language.
1/1/27	Appendix VIII: Reimbursement Policies	Added language for the non-physician reduction rule and added modifiers to the surgical payment rules.

WELCOME TO AMBETTER HEALTH

Welcome to Ambetter from Superior HealthPlan and Ambetter Health. Thank you for participating in our network of high-quality physicians, hospitals, and other healthcare professionals.

Ambetter offers a range of health insurance products designed to meet the needs of diverse consumer populations:

- Ambetter from Superior HealthPlan provides Health Insurance Marketplace plans targeting lower-income individuals and families who may have previously been uninsured or Medicaid-eligible. These Qualified Health Plans (QHPs), offered through the Health Insurance Marketplace (Exchange), help consumers access coverage through generous premium and cost-sharing subsidies. Ambetter has been successful in attracting and retaining these subsidy-eligible consumers through unique plan designs, incentive programs, and effective communication.
- Ambetter Health, our Individual Coverage Health Reimbursement Arrangement (ICHRA) product, expands access to coverage for individuals who receive employer-funded contributions to purchase health insurance. This innovative solution empowers employers to offer flexible health benefits while allowing employees to choose the plan that best fits their needs.

Partnering with Ambetter gives you the opportunity to serve a broader and more diverse patient population. Whether through Marketplace plans or employer-sponsored ICHRA coverage, Ambetter is committed to increasing healthcare engagement and improving outcomes.

The Affordable Care Act continues to shape the healthcare landscape by:

- Helping more Americans get health insurance and stay healthy.
- Offering consumers a choice of coverage that promotes empowerment and informed decision-making.

How To Use This Provider Manual

Ambetter is committed to assisting its provider community by supporting their efforts to deliver well-coordinated and appropriate healthcare to our members. Ambetter is also committed to disseminating comprehensive and timely information to its providers through this provider manual regarding Ambetter's operations, policies, and procedures. Updates to this manual will be posted on our website at www.AmbetterHealth.com/en/tx. Additionally, providers may be notified via bulletins and notices posted on the website and potentially on *Explanation of Payment* notices. Providers may contact our *Provider Services* department at 1-877-687-1196 or Ambetter Health (Solutions) at 1-833-543-3145 (TTY:711) to request that a copy of this manual be mailed to you.

Ambetter is committed to ensuring that our claims adjudication processes align with standard practices for a commercial line of business. Ambetter relies on providers to bill correctly and appropriately based on the services provided to our members and patients. As part of this approach,

Ambetter no longer reimburses certain Medicare- and Medicaid-specific codes, particularly when an alternative CPT code is available for commercial payors.

In accordance with the Participating Provider Agreement, providers are required to comply with the provisions of this manual and correct coding initiatives. Ambetter routinely monitors compliance with the various requirements in this manual and may initiate corrective action, including denial or reduction in payment, suspension, or termination if there is a failure to comply with any requirements of this manual.

This Manual replaces and supersedes any previous versions dated prior to January 1, 2027.

Dental and Vision Provider Manuals

Centene Dental and Vision provider manuals are available on the Secure Provider Portal. Providers may visit www.CenteneDental.com or centenevisionservices.com and log on or contact us for these provider manuals.

Key Contacts & Important Phone Numbers

The following table includes several important telephone and fax numbers available to providers and their office staff. When calling, it is helpful to have the following information available:

- The provider's NPI number
- The practice Tax ID Number
- The member's ID number

HEALTH PLAN INFORMATION	
Ambetter from Superior HealthPlan & Ambetter Health	Ambetter from Superior HealthPlan 5900 E. Ben White Blvd. Austin, TX 78741 Phone: 1-877-687-1196 Fax: 1-800-735-2989 24-Hour Nurse Advice Line: 1-877-687-1196 (TTY: 1-800-735-2989) Office Hours: 8:00 a.m. to 5:00 p.m. Ambetter Health Member Services & 24-Hour Nurse Advice Line: 1-833-543-3145 (TTY: 711) www.AmbetterHealth.com/en/tx

Department	Phone	Fax/Web Address
Provider Services		N/A

HEALTH PLAN INFORMATION		
Member Services	Ambetter from Superior HealthPlan 1-877-687-1196 (TTY - 1-800-735-2989) Ambetter Health 1-833-543-3145 (TTY: 711)	N/A
Medical Management Inpatient and Outpatient Prior Authorization		1-855-537-3447
Concurrent Review/Clinical Information		1-800-380-6650
Admissions/Census Reports/ Facesheets		1-866-838-7615
Care Management		1-800-732-7562
Behavioral Health Prior Authorization		1-844-307-4442
Centene Pharmacy Services		1-866-399-0929
Centene Vision		www.CenteneVision.com
Centene Dental		www.CenteneDental.com
Interpreter Services		N/A
Billing/Invoicing/Payment Only *Ambetter Health Only	N/A	1-855-227-3804
Prior Authorization requests for: • Advanced Imaging (MRI, CT, PET) • Cardiac Imaging • Therapy Services • Genetic Testing • Interventional Pain Management • Musculoskeletal Procedures	1-800-424-4916	www.radmd.com
TurningPoint Prior Authorization requests for: • ENT Surgical procedures	1-866-422-0800	1-833-409-5393
To report suspected fraud, waste and abuse	1-866-685-8664	N/A

HEALTH PLAN INFORMATION		
EDI Claims assistance	1-800-225-2573 ext. 2	e-mail: EDIBA@centene.com

NONDISCRIMINATION AND SECTION 1557 COMPLIANCE

Ambetter complies with Section 1557 of the Affordable Care Act (ACA), the federal law that prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities. This includes providing nondiscrimination notices and access to language services in all significant member-facing materials and physical locations that serve our members.

All providers participating in the Ambetter Provider Network are also required to comply with Section 1557 and the related guidance issued by the U.S. Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR). Providers must deliver services without regard to a member's race, color, national origin, age, disability, sex, or payment status, and may not refuse service or apply inconsistent policies and practices when collecting member financial responsibility.

Section 1557 builds upon long-standing federal civil rights protections, including:

- Title VI of the Civil Rights Act of 1964.
- Title IX of the Education Amendments of 1972.
- Section 504 of the Rehabilitation Act of 1973.
- The Age Discrimination Act of 1975.

These protections apply to:

- Any health program or activity that receives funding from HHS.
- Any health program or activity administered by HHS.
- Health Insurance Marketplaces and all plans offered by issuers participating in those Marketplaces.

For more information, please visit https://www.hhs.gov/civil-rights/for-individuals/section-1557/fs-sex-discrimination/index.html.

PRODUCTS & NETWORK DESCRIPTIONS

Ambetter Health offers Marketplace insurance plans with different coverage and benefit options and premium levels. And in 2027, Ambetter is expanding its plans to help our members find more coverage options that fit their needs and their budget.

Ambetter networks include:[1]

PREMIER: The Ambetter Health core network with a broad offering of healthcare providers and hospitals.

AMBETTER HEALTH SOLUTIONS: A dedicated 'off-exchange only' product designed to meet the needs of individuals purchasing individual health insurance through a defined contribution/HRA, such as ICHRA or QSEHRA.

AMBETTER HEALTH SOLUTIONS WITH MARATHON HEALTH: Ambetter Health Solutions with Marathon Health: A dedicated 'off-exchange only' product enhanced with additional access to primary care through Marathon Health.[2]

SELECT:

- Plus SELECT: An Ambetter product that partners exclusively with the Piedmont provider network. This product is only offered within certain areas of Georgia.
- Wellstar SELECT: This Ambetter product partners exclusively with the Wellstar provider network and is only offered within certain areas of Georgia.
- St. Joseph Candler's SELECT: Ambetter product that partners exclusively with the St. Joseph Candler's provider network. This product is only offered within certain areas of Georgia.

VALUE: Ambetter's product that has exclusive health care providers and hospitals in the network. Value members are assigned to a Medical Group as well as a primary care provider (PCP) within that Medical Group. Referrals are required to see most specialists.

TXSMP: Ambetter from Superior HealthPlan's state mandated plan offering.

STATE PUBLIC OPTION PLANS:

- NVBBSP: **Nevada Battleborn State Plan.**
- Cascade Complete Care (Cascade Select/Public Option): **Washington's public option.**

[1] Network availability may vary across states.
[2] ICHRA and QSHERA are forms of HRAs that allow organizations to reimburse their employees, tax free, for their individual health insurance premiums.

Each Ambetter Health network is tailored to meet the specific coverage needs of members within their respective states. As a result, plan structures, covered benefits, and referral requirements may vary by state and network.

Each Ambetter Health network is designed to offer members a unique type of coverage option specific to their state. This means that member plans and benefits can vary, and there may be referral requirements for certain types of care to be covered. As a provider, it is important to confirm the member's network and plan to ensure it aligns with your contract before providing care. This information is located on the member's ID card and can also be confirmed when verifying the member's eligibility.

Premier and Washington Cascade Complete Care members have the ability to seek care with Premier providers outside of the member's home state for any type of service.

Solutions members have the ability to seek care with Solutions providers outside of the member's home state for any type of service. (Solutions + Marathon Health providers can access those Solutions + Marathon Health providers outside of their home state too). Select, Value and NVBBSP members have access to the Premier rates in states they travel to and incur emergent or prior authorized care.

	Premier	Premier	Solutions	Select	Value*	Public Option
	On & Off Ex Variants	Off Ex Only		On & Off Ex Variants		
AL	●		●			
AR	● ●	● New				
AZ	●		●			
FL	●		●			
GA	●		●	●,●,●		
IA	●		●			
IL	● ●					
IN	●		●	●		
KS	●		●			
KY	●	●				
LA	● ●					
MI	●	●				
MO	●		●	●		
MS	●		●			
NC	●		●			
NE	●		●			

	Premier	Premier	Solutions	Select	Value*	Public Option
	On & Off Ex Variants	Off Ex Only		On & Off Ex Variants		
NJ	●	●				
NV	●	●				●*
OH	●		●			
OK	●		●			
PA	●		●			
SC	●		●			
TN	●		●			
TX**	●		●		●	
WA	● ●					●

- Green = New for '27 / Orange = Solutions Marathon Health Network
- Purple = National Off-Ex, **Black** = State Required Off-Ex *(Purple dots in column 1 are Off Ex variants that are marketed, those without purple dots have Off-Ex Variants but those are not marketed)*
- Premier Off Ex Only – Variants offered here do not mirror Premier variants
- A member's medical network is determined by the plan and state in which they are enrolled.
- Participating medical network providers vary by state.
- Members must use in-network pharmacies. Network pharmacies may vary by state/county.
- *PCP Referral Requirements are included in this product

Ambetter Health Solutions & ICHRA Overview

Ambetter Health Solutions is designed to support individuals enrolled through an Individual Coverage Health Reimbursement Arrangement (ICHRA). This arrangement enables employers to contribute tax-free funds toward employees' individual health insurance premiums. Employees can use these funds to purchase coverage from any carrier offering individual plans in their area.

Ambetter Health Solutions is an off-exchange product built on the existing Ambetter network and benefits, leveraging established provider relationships. It is available to individuals utilizing ICHRA to obtain coverage.

Ambetter Health Solutions with Marathon Health is our Ambetter Health Solutions product enhanced with additional access to primary care through Marathon Health. This offering is new for 2027 and will be offered to members in limited metro areas.

Market Availability:

- Ambetter Health Solutions is available to members in AL*, AZ, FL, GA, IA*, IN**, KS, MO**, MS, NC*, NE, NJ*, OH, OK, PA*, SC, TN, TX
- * Ambetter Health Solutions is being offered to members in 2027 for the first time in these states

- ** Ambetter Health Solutions with Marathon Health is being offered to members in these states

SECURE PROVIDER PORTAL

Ambetter Health offers two secure portals to support providers in serving members effectively: Availity Essentials, and the Centene Provider Portal.

To begin using either portal, providers must complete the appropriate registration process.

Availity Essentials

Ambetter Health has chosen Availity Essentials as its new, secure provider portal. Providers can validate eligibility and benefits, submit claims, check claim status, submit authorizations, and access Ambetter Health payer resources via Availity Essentials. Our current secure portal will still be available for other functions you may use today.

Availity Essentials Registration

Availity Essentials is the newest and preferred portal. If you are new to Availity Essentials, setting up an account is the first step to working with Ambetter Health. Your organization's designated Availity administrator is responsible for registering the organization and managing user accounts, and this person should have the legal authority to sign agreements on the organization's behalf.

If you are the administrator, you can register at www.availity.com/multi-payer-portal. If you need help with registration, contact Availity Client Services at **1-800-AVAILITY (282-4548)**, Mon. through Fri. from 8 a.m. to 8 p.m. ET. For general questions, contact your Ambetter Health Provider Engagement Account Manager.

Centene Provider Portal Registration

Ambetter offers a robust Secure Provider Portal with functionality that is critical to serving members and to ease administration for the Ambetter product for providers. The Portal can be accessed at www.ambetterhealth.com/en/tx/.

Each user must complete the registration process for the Centene Provider Portal.

Manage Account Access allows account managers to add portal accounts needed for the office. Account managers are also responsible for adding additional users for the health care entity or practice and unlocking user portal accounts as needed.

Functionality

Both provider portals offer a range of tools to help providers manage member care and complete administrative tasks efficiently.

Eligibility and Benefits Review

- Check eligibility
- View member rosters (Ambetter secure provider portal only).

- View a member's specific benefits.
- View member's ID card (Availity Essentials only).
- Check member benefit limitations and usage.
- Verify a member's remaining annual deductible and amounts applied to plan maximums.

Claims and Payments

- View the status of all claims received, regardless of how they were submitted.
- View, submit, copy, and correct claims.
- Submit claim reconsiderations and medical records, when applicable (Ambetter secure provider portal only).
- Submit batch claims using an 837 file.
- View and download explanations of payment (EOPs).

Authorizations

- Check authorization requirements.
- Submit authorizations for members.
- View the status of submitted authorizations.

Member Care Tools

- For primary care providers (PCPs), view and print patient lists that include the member's name, ID number, date of birth, care gaps, disease management enrollment, and enrolled product.
- View a member's health record, including visits, medications, and immunizations. (Ambetter secure provider portal only)
- View care gaps specific to a member, including preventive care services and services needed for chronic conditions.

Practice Management and Communication (Ambetter secure provider portal only)

- Update provider demographic information, such as address and office hours.
- Communicate with Ambetter staff via secure messaging.
- Access patient and provider analytic tools.

Referral Entry for TX Value

Submit referrals for Value members to receive specialty services from our in-network specialist. Paper referrals will not replace the necessity of the referral entry.

Disclaimer

Providers agree that all health information, including that related to patient conditions, medical utilization, and pharmacy utilization available through the portal or any other means, will be used exclusively for patient care and other related purposes as permitted by the HIPAA Privacy Rule.

CREDENTIALING & RECREDENTIALING

The credentialing and re-credentialing process exists to verify that participating practitioners and providers meet the criteria established by Superior HealthPlan, ("Superior"), as well as applicable government regulations and standards of accrediting agencies.

If a practitioner/provider already participates with Superior HealthPlan in the Medicaid or a Medicare product, the practitioner/provider will NOT be separately credentialed for the Ambetter product.

Notice: To maintain a current practitioner/provider profile, practitioners/providers are required to notify Superior HealthPlan of any relevant changes to their credentialing information in a timely manner but in no event later than 10 days from the date of the change.

Whether the standardized credentialing form is utilized, or a practitioner has registered their credentialing information on the Council for Affordable Quality Health (CAQH) website, the following information must be on file:

- Signed attestation as to correctness and completeness, history of license, clinical privileges, disciplinary actions, and felony convictions, lack of current illegal substance use and alcohol abuse, mental and physical competence, and ability to perform essential functions with or without accommodation.
- Completed ownership and control disclosure form unless otherwise prohibited by state requirement;
- Current malpractice insurance policy face sheet, which includes insured dates and the amounts of coverage.
- Current controlled substance registration certificate, if applicable.
- Current drug enforcement administration (DEA) registration certificate for each state in which the practitioner will see Ambetter members.
- Completed and signed W-9 form (initial credentialing only).
- Current educational commission for foreign medical graduates (ECFMG) certificate, if applicable.
- Curriculum vitae listing, at minimum, a five-year work history if work history is not completed on the application with no unexplained gaps of employment over six months for initial applicants.
- Signed and dated release of information form not older than 120 days.
- Current admitting privileges in good standing at an in-network inpatient facility or written documentation from a physician or group of physicians, who participate with Superior, stating that they will assume the inpatient care of all of the practitioner's plan members who require admission, and that they will do so at a participating facility.
- Current clinical laboratory improvement amendments (CLIA) certificate, if applicable.

- Current admitting privileges in good standing at an in-network/inpatient facility or written documentation from a physician/group of physicians, who participate with Superior, stating that they will assume the inpatient care for all of the practitioner's Plan members who require admission and that they will do so at a participating facility.

Superior HealthPlan submits the application to the CVO, Verisys, and the CVO will be the primary source verifying the following information submitted for credentialing and recredentialing:

- License through appropriate licensing agency.
- Board certification, or residency training, or professional education, where applicable.
- Malpractice claims and license agency actions through the national practitioner data bank (NPDB).
- Federal sanction activity, including Medicare/Medicaid services (OIG-Office of Inspector General).

For institutional providers (hospitals and ancillary facilities), a completed Facility/Provider – Initial and Recredentialing Application and all supporting documentation as identified in the application must be received with the signed, completed application.

Once the clean application is received, the Medical Director or Credentials Committee will render a decision on acceptance-in writing no later than 90 days from the receipt of the application.

Eligible Providers

All eligible providers must complete the credentialing process prior to participating in the Ambetter Health network. Recredentialing is required every 36 months to maintain active network status.

Professional Providers

Eligible professional providers include, but are not limited to:

- Physicians: MD, DO
- Behavioral Health Providers: PsyD, PhD, LCSW, LCPC, LMFT, BCBA
- Advanced Practice Providers: PA, APN, APRN, ANP, CNP, CNS, CNM
- Specialty Providers: AUD, OD, DC, DPM, RD, LAC, DN
- Non-Physician Practitioners: NP, LPC, CSW

Institutional Providers

Eligible institutional providers include:

- Hospitals
- Ancillary facilities (e.g., outpatient surgical centers, imaging centers, rehabilitation facilities)

Non Registered CAQH Providers

Primary care providers cannot accept member assignments until they are fully credentialed.

Practitioners/Providers should self-register with CAQH ProView at proview.caqh.org. The CAQH will email the provider a Welcome kit with registration instructions. Practitioners/Providers receive a personal CAQH Provider ID, allowing them to register on the CAQH website and obtain immediate access to the ProView database via the Internet.

Once obtaining authenticating key information, practitioners/providers will have the opportunity to create their own unique username as well as password to begin utilizing the system at any time.

Primary care providers cannot accept member assignments until they are fully credentialed.

Practitioners/Providers should self-register with CAQH ProView at proview.caqh.org. The CAQH will email the provider a Welcome kit with registration instructions. Practitioners/Providers receive a personal CAQH Provider ID, allowing them to register on the CAQH website at proview.caqh.org and obtain immediate access to the ProView database via the Internet.

Once obtaining authenticating key information, practitioners/providers will have the opportunity to create their own unique username as well as password to begin utilizing the system at any time.

Credentialing Committee

The Superior HealthPlan Credentials Committee, including the Medical Director or their physician designee, has the responsibility to establish and adopt necessary criteria for participation, termination, and direction of the credentialing procedures. Committee meetings are typically held at least monthly and more often as deemed necessary. Failure of an applicant to adequately respond to a request for missing or expired information may result in termination of the application process prior to committee decision.

Expedited Credentialing

A physician, podiatrist or therapeutic optometrist who joins an established medical group that has a current contract with Superior HealthPlan may be eligible for expedited credentialing. The qualifying physician must request credentialing to be expedited when the required credentialing documentation is submitted to Superior HealthPlan.

To qualify for expedited credentialing, the eligible applicant physician must 1) be licensed in Texas and in good standing with, the Texas Medical Board; 2) submit all documentation and other information required to begin the credentialing process; and 3) agree to comply with the terms of Superior HealthPlan's participating provider contract currently in force with the applicant physician's established medical group.

Recredentialing

Ambetter recredentials network providers every three (3) years to remain compliant with state, federal, and contractual requirements. This process includes all practitioners, facilities, and ancillary providers previously credentialed and currently participating in the network. The purpose of this process is to identify any changes in the practitioner's/provider's licensure, sanctions, certification, competence, or health status that may affect the practitioner's/provider's ability to perform services under the contract.

Maintaining updated information, current documentation and timely attestation within CAQH Proview helps ensure a seamless recredentialing process. Ambetter will download your current application to complete recredentialing. Please ensure your application and all required supporting documents are current and available, including CAQH or state credentialing application, licensure, DEA, malpractice coverage, hospital admitting privileges or arrangements, malpractice history (if applicable), and ownership disclosure. It is the applicant's responsibility to submit all required documentation in a timely manner. If the health plan is unable to collect all the documentation required to complete the recredentialing process before the recredentialing due date, network participation will be terminated. Between credentialing cycles, Amer conducts provider performance monitoring activities on all network practitioners/providers. Ambetter reviews monthly reports released by both federal and state entities to identify any network practitioners/providers who have been sanctioned or excluded from participation in Medicare or Medicaid. Ambetter monitors monthly reports to review sanctions, limitations, and expiration of licensure. Ambetter also reviews member complaints/grievances against providers on an ongoing basis.

A provider's agreement may be terminated at any time if the Ambetter Credentialing Committee determines that credentialing requirements or standards are no longer being met.

Practitioner Right to Review and Correct Information

All practitioners/providers participating within the network have the right to review information obtained by Superior HealthPlan to evaluate their credentialing and/or recredentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank, CAQH, malpractice insurance carriers, and state licensing agencies. This does not allow a provider to review references, personal recommendations, or other information that is peer review protected.

Practitioners/Providers have the right to correct any erroneous information submitted by another party (other than references, personal recommendations, or other information that is peer review protected) in the event the provider believes any of the information used in the credentialing or recredentialing process to be incorrect or should any information gathered as part of the primary source verification process differ from that submitted by the practitioner. Superior HealthPlan will inform providers in cases where information obtained from primary sources varies from information provided by the practitioner. To request release of such information, a written request must be submitted to the Credentialing Department. Upon receipt of this information, the practitioner will have 30 days from the initial notification to provide a written explanation detailing the error or the difference in information to the Credentialing Committee.

The Superior HealthPlan Credentials Committee will then include this information as part of the credentialing or recredentialing process.

Practitioner Right to Be Informed of Application Status

All practitioners who have applied to join have the right to be informed of the status of their application upon request. To obtain application status, the practitioner should contact the Credentialing Department at **1-800-820-5686** or credentialing@superiorhealthplan.com.

Practitioner Right to Appeal or Reconsideration of Adverse

Credentialing Decisions

Applicants who are existing providers and who are denied continued participation due to adverse credentialing determinations (for reasons such as appropriateness of care or liability claims issues) have the right to request an appeal of the decision. Requests for an appeal must be made in writing within 30 days of the date of the notice.

New applicants who are declined participation may request a reconsideration within 30 days from the date of the notice. All written requests should include additional supporting documentation in favor of the applicant's appeal or reconsideration for participation in the network. Reconsiderations will be reviewed by the Credentialing Committee at the next regularly scheduled meeting and/or no later than 60 days from the receipt of the additional documentation in accordance with state and federal regulations.

Written requests to appeal or reconsider adverse credential decisions should be sent to:

Superior HealthPlan
Attn: Credentialing Department
5900 E. Ben White Blvd.
Austin, TX 78741
credentialing@superiorhealthplan.com

PROVIDER ADMINISTRATION

Provider Types That May Serve As Primary Care Providers

Providers who may serve as primary care providers (PCP) include:

- OB/GYN;
- Internal Medicine;
- Pediatrics;
- General Medicine;
- Family Practice;
- Physician Assistants; and
- Nurse Practitioners.

The PCP may practice in a solo or group setting or at a Federally Qualified Health Center (FQHC), Rural Health Center (RHC), Department of Health Clinic, or similar outpatient clinic. With prior written approval, Ambetter may allow a specialist provider to serve as a PCP for members with special health care needs, multiple disabilities, or with acute or chronic conditions if the specialist is willing to perform the responsibilities of a PCP as outlined in this manual.

Member Panel Capacity

All PCPs have the right to state the number of members they are willing to accept into their panel. Ambetter does not and is not permitted to guarantee that any provider will receive a certain number of members.

The PCP to member ratio shall not exceed the following limits:

Practitioner Type	Ratio
General/Family Practitioners	One per 2,500 members
Pediatricians	One per 2,500 members
Internists	One per 2,500 members

If a PCP has reached the capacity limit for their practice and wants to make a change to their open panel status, the PCP must notify Ambetter 30 days in advance of their inability to accept additional members. Notification can be in writing or by calling Ambetter at **1-877-687-1196 (Relay Texas/TTY 1-800-735-2989)** or Ambetter Health (Solutions) at **1-833-543-3145 (TTY:711)**. A PCP must not refuse new members for addition to their panel unless the PCP has reached their specified capacity limit.

In no event will any established patient who becomes a member be considered a new patient. Providers must not intentionally segregate members from fair treatment and covered services provided to other nonmembers.

Member Selection or Assignment of PCP

Ambetter members will be directed to select a participating Primary Care Provider (PCP) at the time of enrollment. In the event an Ambetter member does not make a PCP choice, Ambetter will usually select a PCP based on:

1. A previous relationship with a PCP. If a member has not designated a PCP within the first 30 days of being enrolled in Ambetter, Ambetter will review and assign the member to that PCP.
2. Geographic proximity of PCP to member residence. The auto-assignment logic is designed to select a PCP for whom the members will not travel more than the required access standards.
3. Appropriate PCP type. The algorithm will use age, gender, and other criteria to identify an appropriate match, such as children assigned to pediatricians.

Pregnant members should be encouraged to select a pediatrician or other appropriate PCP for their newborn baby before the beginning of the last trimester of pregnancy. In the event the pregnant member does not select a PCP, Ambetter will auto-assign one for their newborn.

Members may change their PCP at any time. The change will become effective no later than the first day of the month following the members' request. To initiate a PCP change or for assistance, members should contact the Member Services Department at:

- Ambetter from Superior HealthPlan: 1-877-687-1196; or
- Ambetter Health: 1-833-543-3145

Specialist as PCP

A member with a chronic, disabling, or life-threatening illness can apply to Ambetter to use a specialist as their primary care physician (PCP).

Requirements for a specialist to be a PCP:

For Ambetter to approve the request, a specialist must meet specific requirements, and an application process must be followed.

Application requirements:

- A request for special consideration, including a signed application from the enrollee.
- Certification by the specialist of the medical necessity for the enrollee to use them as a PCP.
- A signed statement from the specialist that they are willing to coordinate all of the enrollee's healthcare needs.

Physician requirements:

- Ambetter's general requirements for PCP participation, which includes credentialing.
- Their contractual obligations must be consistent with those of other PCPs in Ambetter's network.
- The specialist must be provided with a directory of other participating providers in the network.

- Ambetter must approve or deny the request for special consideration and provide written notification of the decision to the enrollee not later than 30 days after receiving the request. If the request is denied, the reasons for denial in the written notification along with appeal rights will be provided.

PCP Coordination of Care with Specialists

When medical care is needed beyond the scope of what the PCP can provide, PCPs are encouraged to initiate and coordinate the care members receive from specialist providers. Paper referrals are not required.

Referrals are required for our HMO plans for specialty care, which are entered via our Provider Portal. Referrals are required from the referring PCP for Value, or the claim will be denied when services are rendered by a provider outside of the member's assigned Primary Care Group/Provider.

In accordance with federal and state law, providers are prohibited from making referrals for designated health services to healthcare providers with which the provider, the member, or a member of the provider's family or the member's family has a financial relationship.

Specialist Provider Responsibilities

Specialist providers must communicate with the PCP regarding a member's treatment plan and referrals to other specialists. This allows the PCP to better coordinate the member's care and ensures that the PCP is aware of the additional service request.

To ensure continuity and coordination of care for the member, every specialist provider must:

- Maintain contact and open communication with the members' referring PCP.
- Obtain authorization from the Medical Management Department, if applicable, before providing services.
- Coordinate the member's care with the referring PCP.
- Provide the referring PCP with consultation reports and other appropriate patient records within five business days of receipt of such reports or test results.
- Be available for or provide on-call coverage through another source 24 hours a day for management of member care.
- Maintain the confidentiality of patient medical information.
- Actively participate in and cooperate with all quality initiatives and programs.

Hospital Responsibilities

Ambetter maintains a comprehensive network of hospitals to ensure access to high-quality care. All hospital services must be delivered in accordance with applicable state and federal regulations, accreditation standards, and Ambetter policies.

Hospital Requirements

Hospitals must:

- Notify the member's PCP immediately, or no later than the close of the next business day, following an emergency room visit.
- Obtain prior authorization for all inpatient and selected outpatient services listed in the Pre-Auth Needed tool at: If you are the administrator, you can register at https://www.ambetterhealth.com/en/tx/provider-resources/manuals-and-forms/pre-auth/.(Emergency stabilization services are excluded.)
- At time of in-patient authorization, providers to report room type for appropriate time of requesting inpatient authorization, providers should notify of room type (private or semi-private) and state clinical or non-clinical justification. Claims should be submitted with a room type and level of care that matches the authorization in order to improve accuracy with claim processing. This includes inpatient versus residential treatment level of care.
- Notify the Medical Management department of all ER admissions within one business day via phone or electronic file. Required information includes:
    - Member name and ID
    - Presenting symptoms/diagnosis
    - Date of service
    - Member phone number
- Notify Medical Management of all ER and inpatient admissions within one business day.
- Notify Medical Management of newborn deliveries within one day of delivery via the Secure Provider Portal, fax, or phone.
- Adhere to the Timeframes for Prior Authorization Requests and Notifications outlined in the Medical Management section of this manual.

Withdrawing from Caring for a Member

Providers may withdraw from caring for a member. Upon reasonable notice and after stabilization of the member's condition, the provider must send a certified letter to Ambetter Member Services detailing the intent to withdraw care. The letter must include information on the transfer of medical records as well as emergency and interim care.

Member Rights and Responsibilities

The following description of Member Rights and Responsibilities may not be an exhaustive list.

Member Rights

Providers must comply with the rights of members as set forth below:

- To participate with providers in making decisions about their healthcare. This includes working on any treatment plans and making care decisions. Providers are required to inform members of any possible risks, problems related to recovery, and the likelihood of success. The member shall not have any treatment without consent freely given by the member or the member's legally authorized surrogate decision-maker. Providers must inform the member of their care options.
- To know who is approving and who is performing the procedures or treatment. All likely treatments and the nature of the problem should be explained clearly.
- To receive the benefits for which the member has coverage.
- To be treated with respect and dignity.
- To privacy of their personal health information, consistent with state and federal laws, and Ambetter policies.
- To receive information or make recommendations, including changes, about Ambetter's organization and services, the Ambetter network of providers, and member rights and responsibilities.
- To candidly discuss with their providers appropriate and medically necessary care for their condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from the member's primary care provider about what might be wrong (to the level known), treatment, and any known likely results. The provider must tell the member about treatments that may or may not be covered by the plan, regardless of the cost. The member has a right to know about any costs they will need to pay. This should be told to the member in a way that the member can understand. When it is not appropriate to give the member information for medical reasons, the information can be given to a legally authorized person. The provider will ask for the member's approval for treatment unless there is an emergency and the member's life in danger.
- To make recommendations regarding the Ambetter member's rights, responsibilities, and policies.
- To voice complaints or appeals about: Ambetter, any benefit or coverage decisions Ambetter makes, Ambetter coverage, or the care provided.
- To refuse treatment for any condition, illness, or disease without jeopardizing future treatment, and to be informed by the provider(s) of the medical consequences.
- To see their medical records.

- To be kept informed of covered and non-covered services, program changes, how to access services, primary care provider assignment, providers, advance directive information, referrals and authorizations, benefit denials, member rights and responsibilities, and other Ambetter rules and guidelines. Ambetter will notify members at least 60 days before the effective date of the modifications. Such notices shall include the following:
- Any changes in clinical review criteria,
- A statement of the effect of such changes on the personal liability of the member for the cost of any such changes.
- To have access to a current list of network providers. Additionally, a member may access information on network providers' education, training, and practice.
- To select a health plan or switch health plans, within the guidelines, without any threats or harassment.
- To adequate access to qualified medical practitioners and treatment or services regardless of age, race, creed, sex, sexual orientation, national origin, or religion. Sex discrimination includes, but is not limited to, discrimination based on pregnancy, gender identity and sex stereotyping.
- To access medically necessary urgent and emergency services 24 hours a day and seven days a week.
- To receive information in a different format in compliance with the Americans with Disabilities Act if the member has a disability.
- To refuse treatment to the extent the law allows. The member is responsible for their actions if treatment is refused or if the provider's instructions are not followed. The member should discuss all concerns about treatment with their primary care provider or other provider. The primary care provider or other provider must discuss different treatment plans with the member. The member must make the final decision.
- To select a primary care provider within the network. The member has the right to change their primary care provider or request information on network providers close to their residence.
- To know the name and job title of people providing care to the member. The member also has the right to know which physician is their primary care provider.
- To have access to an interpreter when the member does not speak or understand the language of the area.
- To a second opinion by a network physician, at no cost to the member, if the member believes that the network provider is not authorizing the requested care, or if the member wants more information about their treatment.

- To execute an advanced directive for health care decisions. An advanced directive will assist the primary care provider and other providers to understand the member's wishes about the member's health care. The advance directive will not take away the member's right to make their own decisions. Examples of advanced directives include:
    a. Living Will
    b. Health Care Power of Attorney
    c. "Do Not Resuscitate" Orders
    d. Members also have the right to refuse to make advance directives. Members may not be discriminated against for not having an advance directive.

Member Responsibilities

- To read their Ambetter contract in its entirety and understand to the best of their ability all materials concerning their health benefits or to ask for assistance if they need it.
- To treat all health care professionals and staff with courtesy and respect.
- To give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about their health. The member should make it known whether they clearly understand their care and what is expected of them. It's recommended that members ask questions of their provider, so they understand the care they are receiving.
- To review and understand the information they receive about Ambetter. The member needs to know the proper use of covered services.
- To show their I.D. card and keep scheduled appointments with their provider and call the provider's office during office hours whenever possible if the member has a delay or cancellation.
- To know the name of their assigned primary care provider. The member should establish a relationship with their primary care provider. The member may change their primary care provider verbally or in writing by contacting the Ambetter Member Services Department.
- It's important for members to understand their health problems and participate with their healthcare providers in developing a mutually agreed upon treatment goal(s)
- To supply, to the extent possible, information that Ambetter and/or their providers need to provide care.
- To follow the treatment plans and instructions for care that they have agreed on with their healthcare providers.

- To understand their health problems and tell their healthcare providers if they do not understand their treatment plan or what is expected of them. The member should work with their primary care provider to develop mutually agreed upon treatment goals. If the member does not follow the treatment plan, the member has the right to be advised of the likely results of their decision.
- To follow all health benefit plan guidelines, provisions, policies, and procedures.
- Members should use any emergency room for any major medical emergency. For all other minor medical care, the member should seek care at an Urgent Care Center or call their primary care provider.
- To give all information about any other medical coverage they have at the time of enrollment. If, at any time, the member gains other medical coverage besides Ambetter coverage, the member must provide this information to Ambetter.
- To pay their monthly premium, all deductible amounts, copayment amounts, or cost-sharing percentages at the time of service.

Provider Rights and Responsibilities

The following description of Provider Rights and Responsibilities may not be an exhaustive list.

Provider Rights

- To be treated by their patients who are Ambetter members and other healthcare workers with dignity and respect.
- To receive accurate and complete information and medical histories for members' care.
- To have their patients, who are Ambetter members, act in a way that supports the care given to other patients and that helps keep the doctor's office, hospital, or other offices running smoothly.
- To expect other network providers to act as partners in members' treatment plans.
- To expect members to follow their health care instructions and directions, such as taking the right amount of medication at the right times.
- To make a complaint or file an appeal against Ambetter and/or a member.
- To file a grievance on behalf of a member, with the member's consent.
- To have access to information about Ambetter quality improvement programs, including program goals, processes, and outcomes that relate to member care and services.
- To contact Provider Services with any questions, comments, or problems.
- To collaborate with other health care professionals who are involved in the care of members.

- To not be excluded, penalized, or terminated from participating with Ambetter for having developed or accumulated a substantial number of patients in Ambetter with high-cost medical conditions.
- To collect member copayments, coinsurance, and deductibles at the time of the service.

Provider Responsibilities

Providers must comply with each of the items listed below.

- To help or advocate for members to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the right to:
- Recommend new or experimental treatments,
- Provide information regarding the nature of treatment options,
- Provide information about the availability of alternative treatment options, therapies, consultations, or tests, including those that may be self-administered,
- Be informed of risks and consequences associated with each treatment option or choose to forego treatment as well as the benefits of such treatment options.
- To treat members with fairness, dignity, and respect.
- To not discriminate against members based on race, color, gender, national origin, limited language proficiency, religion, age, health status, existence of a pre-existing mental or physical disability/condition including pregnancy and/or hospitalization, the expectation for frequent or high-cost care.
- To maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality.
- To give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider's practice and scope of service.
- To provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA.
- To allow members to request restrictions on the use and disclosure of their personal health information.
- To provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records.
- To provide clear and complete information to members - in a language they can understand - about their health condition and treatment, regardless of cost or benefit coverage, and allow member participation in the decision-making process.

- To tell a member if the proposed medical care or treatment is part of a research experiment and give the member the right to refuse experimental treatment.
- To allow a member who refuses or requests to stop treatment the right to do so, if the member understands that by refusing or stopping treatment the condition may worsen or be fatal.
- To respect members' advance directives and include these documents in their medical record.
- To allow members to appoint a parent/guardian, family member, or other representative if they can't fully participate in their treatment decisions.
- To allow members to obtain a second opinion, and answer members' questions about how to access health care services appropriately.
- To follow all state and federal laws and regulations related to patient care and rights.
- To participate in Ambetter data collection initiatives, such as HEDIS® and other contractual or regulatory programs and allow use of provider performance data.
- To review clinical practice guidelines distributed by Ambetter.
- To comply with the Ambetter Medical Management program as outlined herein.
- To disclose overpayments or improper payments to Ambetter.
- To provide members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status.
- To obtain and report to Ambetter information regarding other insurance coverage the member has or may have.
- To give Ambetter timely, written notice if provider is leaving/closing a practice.
- To contact Ambetter to verify member eligibility and benefits, if appropriate.
- To invite member participation in understanding any medical or behavioral health problems that the member may have and to develop mutually agreed upon treatment goals, to the extent possible.
- To provide members with information regarding office location, hours of operation, accessibility, and translation services.
- To object to providing relevant or medically necessary services based on the provider's moral or religious beliefs or other similar grounds.
- To provide hours of operation to Ambetter members which are no less than those offered to other commercial members.

APPOINTMENT AVAILABILITY & WAIT TIMES

Ambetter maintains a provider network that is sufficient in number, geographic distribution, and provider type to ensure that covered services are accessible to members without unreasonable delay, in accordance with 45 CFR §156.230. Ambetter establishes appointment availability and after-hours access standards consistent with all regulatory and accreditation standards.

Providers are expected to comply with these standards to support timely access to care, continuity of services, and member safety. Ambetter monitors compliance through audit activities, including appointment availability surveys and after-hours access evaluations.

The table below depicts the appointment availability for members.

Appointment Standards	
Appointment Type	**Access Standard**
Primary Care Physician & Pediatrics	
Urgent care	≤ 24 hours
Routine care	≤ 15 business days
After-hours access	24 hours/7 days a week
Behavioral Health	
Non life-threatening emergency	≤ 6 hours
Urgent care	≤ 48 hours
Initial routine care	≤ 10 business days
Follow-up routine care	≤ 30 business days
After-hours access	24 hours / 7 days a week
OB/GYN	
Routine care	≤ 30 business days
Specialist	
Routine non-urgent care	≤30 business days

Wait Time Standards for All Provider Types

It is recommended that office waiting times not exceed one (1) hour before an Ambetter member is taken to the exam room.

Travel Distance and Access Standards

Ambetter offers a comprehensive network of PCPs, specialist physicians, hospitals, behavioral healthcare providers, and diagnostic and ancillary services providers to ensure every member has access to covered services.

The travel distance and access standards that Ambetter utilizes to monitor its network adequacy are in line with both state and federal regulations. For the standard specific to your specialty and county, please reach out to your Provider Services department.

Providers must offer and provide Ambetter members appointments and wait times comparable to those offered and provided to other commercial members. Ambetter routinely monitors compliance with this requirement and may initiate corrective action, including suspension or termination, if there is a failure to comply.

Covering Providers

PCPs and specialists are responsible for arranging coverage during both **scheduled and unscheduled absences** to ensure continuity of care.

- For scheduled time off, providers must notify the Ambetter Provider Services department in advance and provide details of coverage arrangements.
- For unscheduled absences, notification must be made to Provider Services as soon as possible.

The provider engaging the covering provider must ensure the covering provider agrees to compensation terms consistent with the **Ambetter fee schedule** outlined in the original provider's agreement.

Provider Phone Call Protocol

PCPs and specialists are expected to maintain timely and responsive communication with members. Responsibilities include:

- Responding to member telephone inquiries promptly.
- Scheduling appointments in accordance with Ambetter's appointment standards.
- Coordinating follow-up appointments based on clinical need and accepted standards of care.
- Identifying and rescheduling cancelled or no-show appointments.
- Recognizing and accommodating special member needs during scheduling (e.g., wheelchair access, language interpretation, cognitive impairments).
- Adhering to the following telephone response time standards:
    - **After-hours, non-emergency symptomatic issues**: response within **30 minutes**.
    - **Routine inquiries during office hours**: response **same day**.
- Ensuring continuous availability of professional, allied, and support personnel during normal office hours.
- Maintaining protocols for coverage during provider absences.
- Documenting all after-hours calls in the member's medical record or a designated call log, with subsequent transfer to the medical record.

Note: For urgent or emergent care after hours, the PCP, specialist, or their designee should notify the receiving urgent care center or emergency department of the member's impending arrival. Prior authorization is not required for emergent care.

Ambetter monitors appointment availability and after-hours responsiveness as part of its Quality Improvement Program (QIP).

24-Hour Access to Providers

Primary care providers and specialists are expected to maintain continuous access to healthcare services for members, 24 hours a day, 365 days a year.

Access Requirements

- During normal business hours: Office phones must be answered directly by staff.
- After hours and weekends: Members must be able to reach a provider through one of the following:
- A covering provider.
- An answering service.
- A triage service or voicemail that provides a secondary phone number that is actively monitored.

Additionally, Behavioral Health providers and the plan must ensure that members experiencing behavioral health-related non-life-threatening emergencies are directed to appropriate resources, including:

- The 988 Suicide and Crisis Lifeline
- Behavioral health urgent care centers
- Emergency departments (hospital-based or psychiatric)
- Mobile crisis response teams

These pathways must support timely access to appropriate behavioral health services based on the member's clinical needs.

- If the provider serves a significant Spanish-speaking population: It is recommended that after-hours messages be recorded in both English and Spanish. Providers should make reasonable efforts to ensure language access supports member understanding and appropriate care navigation.

Unacceptable After-Hours Coverage

The following do not meet after-hours access requirements:

- Instructions to leave a voicemail without clinical follow up.

- Failure to return urgent calls within a reasonable timeframe.
- Inability to reach a clinical decision-maker or appropriate coverage.
- Directing all after-hours calls to the emergency department without triage.
- Messaging that does not provide clear instructions for accessing urgent or behavioral health services.

The selected method of after-hours coverage must connect the caller to someone capable of making a clinical decision or reaching the provider who can. Calls should be returned within 30 minutes whenever possible. After-hours access must be available through the provider's regular office phone number.

Monitoring and Compliance

Ambetter monitors appointment availability and after-hours access through:

- Announced and secret shopper surveys.
- Audit and compliance reviews.
- Vendor performance monitoring.

Standards are evaluated based on actual appointment availability offered to members, consistent with CMS methodologies.

Provider Data Updates and Validation

Ambetter is committed to ensuring members have accurate, up-to-date information to access care. Providers are responsible for notifying Ambetter of any changes to their practice information, including:

- Address or location changes
- Office hours
- Phone numbers
- Specialties
- Hospital affiliations
- Practitioner roster updates

Timely updates help ensure that provider directories remain accurate and accessible to members.

Directory Validation and Audits

Ambetter and its contracted vendors conduct **routine audits** of provider directories. This may include outreach to confirm your practice details. Prompt responses are essential to maintain your listing in the **Ambetter Provider Directory**.

Important: Failure to respond to directory validation outreach may result in removal from the provider directory.

CMS may also conduct audits of provider directories. Please ensure your office staff are informed and prepared to route such inquiries appropriately.

AMBETTER HEALTH BENEFITS

Overview

- The plans vary based on the individual liability limits, including their deductibles, maximum out-of-pocket responsibilities, and/or cost share (deductibles, copays &/or coinsurance) expenses for benefits to the member. The phrase "Metal Tiers" is used to categorize these levels.
- Under the Affordable Care Act (ACA), the Metal Tiers include Platinum, Gold, Silver, and Bronze.
- Essential Health Benefits (EHBs) are the same within all tiers. This means that every health plan will cover the minimum comprehensive benefits as outlined in the Affordable Care Act, and in-line with all applicable state regulations.
- The 10 EHBs outlined in the Affordable Care Act are as follows:
    - Preventive and wellness services and chronic disease management.
    - Maternity and newborn care.
    - Pediatric services including pediatric vision and dental.
    - Outpatient or ambulatory services.
    - Laboratory services.
    - Various therapies (such as physical therapy and devices.)
    - Hospitalization.
    - Emergency services.
    - Mental health and substance use services, both inpatient and outpatient.
    - Prescription drugs.
- Ambetter covers the services described in the Schedule of Benefits and Evidence of Coverage (EOC) document for each Ambetter plan type. If there are questions as to a covered service or required prior authorization, please contact Ambetter at **1-877-687-1196 (Relay Texas/TTY 1-800-735-2989)** or Ambetter Health (Solutions) at **1-833-543-3145 (TTY:711).**
- Detailed information about benefits and services can be found in the current year EOC available at www.ambetterhealth/en/tx/health-plans on the "Our Health Plans" page.

Additional Benefit Information

- Ambetter has a variety of PPO, HMO, and EPO benefit plans offerings based on geographic location. Depending on the benefit plan and any subsidies that the member may receive, plans contain copays, coinsurance, and deductibles (cost shares). As stated elsewhere in this manual, providers have the right to collect cost shares at the time of service. Review the "Verifying Member Benefits, Eligibility, and Cost Shares" section of this manual to determine if the Ambetter Member has an HMO, EPO, or PPO plan and their associated cost share for services. Any cost shares collected at the time of service prior to claim adjudication are subject to member reimbursement if determined no member liability is required.

EPO

- To receive the highest level of benefits at the lowest cost share amounts, members enrolled with Ambetter
- EPO plans are incentivized to utilize in-network participating providers. Members and providers can identify participating providers by visiting our website at www.AmbetterHealth.com/en/tx and clicking on Ambetter Guide.

HMO

- Members who are enrolled in HMO plans with Ambetter must utilize in-network participating providers. Members and providers can identify other participating providers by visiting our website at www.AmbetterHealth.com/en/tx and clicking on Find-A-Provider.
- When an out-of-network provider is utilized, except in the case of emergency services, if the out-of-network provider is prior authorized, or if the care needed isn't available in the network, the member will be 100% responsible for all charges.

Integrated Deductible Products

- Some Ambetter products contain an integrated deductible, meaning that the medical and prescription deductible are combined. In such plans,
- A member will reach the deductible first, then pay coinsurance until they reach the maximum out-of-pocket for their plan.
- Copayments will be collected before the deductible for services that are not subject to the deductible.
- Other copays are subject to the deductible, and the copay will be collected only after the deductible is met.
- Services counting towards the integrated deductible include medical costs, physician services, hospital services, essential health benefit covered services including pediatric vision and mental health services, and pharmacy benefits.
- Claims information including the accumulators will be displayed on the Secure Provider Portal.

Non-Integrated Deductible Products

- Some Ambetter products contain a non-integrated deductible, meaning that the medical and prescription deductible are not combined. In such plans:
- A member will reach the medical deductible separately from the prescription deductible, then pay coinsurance until they reach the maximum out-of-pocket for their plan.
- Copayments will be collected before the deductible for services that are not subject to the deductible.

- Other copays are subject to the deductible, and the copay will be collected only after the deductible is met.
- Services that will not count towards the non-integrated prescription deductible include medical costs, physician services, hospital services, essential health benefit covered services including pediatric vision and mental health services, and any other medical benefits.
- Claims information including the accumulators will be displayed on the Secure Provider Portal.

Maximum Out-of-pocket Expenses

- All Ambetter benefit plans contain a maximum out-of-pocket expense. Maximum out-of-pocket is the highest or total amount that must be paid by the member toward the cost of their health care (excluding premium payments). Maximum out-of-pocket costs can be determined on the Member's Evidence of Coverage available through www.AmbetterHealth.com/en/tx on the "Our Health Plans" page. Below are some rules regarding maximum out-of-pocket expenses:
- A member will reach the deductible first and will continue to pay coinsurance/copay then pay coinsurance until they reach the maximum out-of-pocket for their Ambetter benefit plan.
- Copays will be collected before and after the deductible is met; or until the maximum out-of-pocket is met.
- Only medical costs/claims are applied to the deductible. (For those benefit plans that contain routine adult vision and routine dental coverage, these expenses would not count towards the deductible).
- All out-of-pocket costs, including copays, deductibles, and coinsurance apply to the maximum out-of-pocket. (As mentioned previously, this excludes premium payments).
- Ambetter will continue to pay claims and provide 100% of contracted payment after the member/family policy has met their maximum out-of-pocket costs.
- After a member reaches the out-of-pocket maximum, members don't have to pay copayments, deductible, or coinsurance for the rest of the benefit plan year.

Member Benefits, Eligibility and Cost Share

- It is imperative that providers verify benefits, eligibility, and cost shares each time an Ambetter member is scheduled to receive services.

- Generally, most benefit limits for services and procedures follow state and federal guidelines. Benefits limited to a certain number of visits per year are based on a calendar year (January through December). In addition to verifying member benefits, eligibility and cost share, there may be further steps needed to help Ambetter members maximize their benefit coverage before treatment is rendered. Superior HealthPlan offers a Pre-Auth Check tool to determine if pre-authorization is needed before services are rendered. This tool can be located at the www.AmbetterHealth.com/en/tx under the "For Providers" section of the site. This is in addition to other helpful tools and information Ambetter offers. Please check to be sure the member has not already exhausted benefit limits before providing services by checking our Secure Provider Portal or calling Ambetter Member and Provider Services.

Benefit Design and Cost-Sharing Responsibilities

- Ambetter Health offers a variety of benefit designs that may differ by product and state. These variations affect member cost-sharing responsibilities, including copayments, coinsurance, and deductibles.
- To ensure accurate collection of member cost shares, providers must verify the member's specific benefit design prior to rendering services. Cost-sharing amounts are determined by the member's health plan and should be collected at the time of service when applicable.
- Providers can access detailed benefit and eligibility information through the Secure Provider Portal at www.AmbetterHealth.com/en/tx.

Premium Grace Period for Members Receiving Advanced Premium Tax Credits (APTCs)

- Members enrolled in a Marketplace health plan are responsible for completing their premium payments each month. Members that do not make their premium payments in a timely manner enter a Grace Period, which begins with the first month a payment is missed.
- The way in which Ambetter from Superior HealthPlan pays out claims during the Grace Period is different for members depending upon whether they receive an APTC.
- Claims submitted with dates of service for members that do not receive an APTC for the entire duration of the Grace Period are placed into a '*pend*' – or '*pending*' status. For members that do receive an APTC, claims with dates of service during the initial phase of the Grace Period are considered for payment even though the premium has not been paid. Claims with dates of service submitted after the initial phase of the Grace Period are placed into a '*pending*' status.
- Claims in a *'pending'* – status are considered for payment only after the Member returns to good standing with their premium payments. Should a member not return to good standing and the Grace Period expires, those claims will be denied, and the member's coverage is terminated. (Visit healthcare.gov – or – your state exchange website for more information on the Grace Period in your market.)

Preferred Method to Verify Benefits, Eligibility, and Cost Shares

- Ambetter from Ambetter from Superior HealthPlan encourages our provider partners to review Member Eligibility status, Premium Paid Through Date, and Claims Paid Through Date to identify when it may or may not be appropriate to request payment in advance of an appointment.
- Consider the following statuses when reviewing 'Member Eligibility' on the Availity Essentials and/or other secure portals:

Active: The member is in good standing and has paid premiums in full.

Active – Pending Investigation (Availity Only): The member is behind in paying the premium.

Delinquent (non-Availity Secure Portals Only): The member is behind in paying the premium and the Claims Paid Through Date is in the future.

Suspended (non-Availity Secure Portals Only): The member is behind in paying the premium and the Claims Paid Through Date is in the past.

Inactive: The member is ineligible, and coverage has been terminated.

- The 'Premium Paid Through Date' identifies the latest date through which premiums have been paid.
- The 'Claims Paid Through Date' indicates the last date for which a claim for rendered services has been paid or will be considered for payment. Claims submitted after this date will be pended until the member pays any outstanding premium balances or the grace period ends. Claims submitted for dates of service after this date are at risk for nonpayment/rejection should the member not return to good standing prior to the end of the grace period.
- If your patient is an Ambetter from Superior HealthPlan member and is not in good standing with a premium payment, providers may collect the full billed charges for the services rendered. In the event a Member returns to good standing by paying any outstanding premiums, the provider may submit a claim that will be considered for payment by the health plan. If that claim is paid by the health plan, then the provider is required to reimburse the member in accordance with the terms of the Provider Agreement.
- Members in an *Active – Pending Investigation*, *Suspended*, or *Delinquent* status are encouraged to refer to their responsibilities in the Ambetter from Superior HealthPlan Member Handbook.
- If you have additional questions or want to learn more about changes to the 2027 Health Insurance Marketplace, checking eligibility or submitting claims via the secure portal, we are here to help. Contact Ambetter at **1-877-687-1196 (Relay Texas/TTY 1-800-735-2989)** or Ambetter Health (Solutions) at **1-833-543-3145 (TTY:711)** or send us a message at www.AmbetterHealth.com/en/tx.
- Thank you for your commitment to providing access to quality care to your patients, our members, and for your partnership as we work to improve the health of the communities we serve, one person at a time.

Scenarios: Will My Claim Be Considered for Payment?

Scenario No. 1

- Date of Service: Jan. 1, 2027
- Member Receives APTC: Yes
- Member Eligibility Status: Active
- Premium Paid Through Date: Jan. 31, 2027
- Claims Paid Through Date: Feb. 28, 2027
- Claim Status: Considered for Payment

The member is in good standing with premium payments, and the claim is considered for payment. The Date of Service is prior to the Premium Paid Through Date and Claims Paid Through Date, which is 30 days after the Premium Paid Through Date because the member receives an APTC.

Scenario No. 2

- Date of Service: Jan. 1, 2027
- Member Receives APTC: No
- Member Eligibility Status: *Active*
- Premium Paid Through Date: Jan. 31, 2027
- Claims Paid Through Date: Jan. 31, 2027
- Claim Status: Considered for Payment

The member is in good standing with premium payments, and the claim is considered for payment. The Date of Service is prior to the Premium Paid Through Date and Claims Paid Through Date. The Premium Paid Through Date and Claims Paid Through Date are the same because the member does not receive an APTC.

Scenario No. 3

- Date of Service: Feb. 1, 2026
- Member Receives APTC: No
- Member Eligibility Status: *Active – Pending Investigation* or *Delinquent*
- Premium Paid Through Date: Jan. 31, 2027
- Claims Paid Through Date: Jan. 31, 2027
- Claim Status: Pending

The member is not in good standing with premium payments and has entered the Grace Period. The claim is placed into a 'pending' status because the member is behind in their premium payment, does not receive an APTC, and the Claims Paid Through Date is in the past. This claim will be considered for payment only if the outstanding premium balance is paid in full during the Grace Period. If the outstanding balance is not paid before the end of the Grace Period, the claim will be denied.

Scenario No. 4

- Date of Service: Feb. 1, 2027
- Member Receives APTC: Yes

- Member Eligibility Status: *Active – Pending Investigation* or *Delinquent*
- Premium Paid Through Date: Jan. 31, 2027
- Claims Paid Through Date: Feb. 28, 2027
- Claim Status: Considered for Payment

The member is not in good standing with premium payments and has entered the initial phase of the Grace Period. The claim is considered for payment even though the Date of Service is after the Premium Paid Through Date because the member receives an APTC and Claims Paid Through Date is in the future. The member remains responsible for the outstanding premium payment.

Scenario No. 5

- Date of Service: Feb. 1, 2027
- Member Receives APTC: Yes
- Member Eligibility Status: *Active–Pending Investigation* or *Suspended*
- Premium Paid Through Date: Dec. 31, 2026
- Claims Paid Through Date: Jan. 31, 2027
- Claim Status: Pending

The member is not in good standing with their premium payments and is in the latter phase of the Grace Period. The claim is placed into a 'pending' status. While the Claims Paid Through Date is after the Premium Paid Through Date because the member receives an APTC, the Claims Paid Through Date is prior to the Date of Service. The claim will be considered for payment only if the outstanding premium balance is paid in full during the Grace Period. If the outstanding balance is not paid, the claim will be denied.

Scenario No. 6

- Date of Service: May 1, 2027
- Member Receives APTC: No
- Member Eligibility Status: *Inactive*
- Premium Paid Through Date: Jan. 31, 2027
- Claims Paid Through Date: Feb. 28, 2027
- Claim Status: Denied

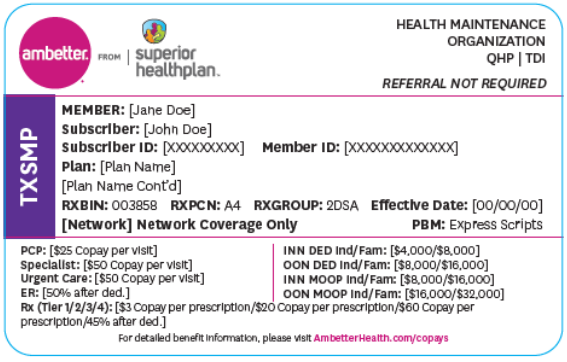
The member did not pay the outstanding balance, the Grace Period has expired, and coverage has been terminated. The claim is denied because the member is no longer covered by the health plan.

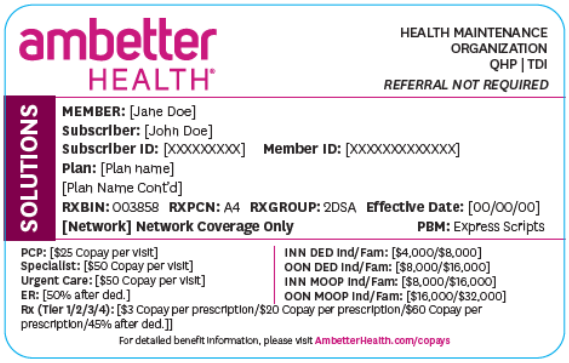
Other Methods to Verify Benefits, Eligibility and Cost Shares	
24/7 Toll Fee Interactive Voice Response (IVR) Line at 1-800-964-2777	The automated system will prompt you to enter the member ID number and the month of service to check eligibility.

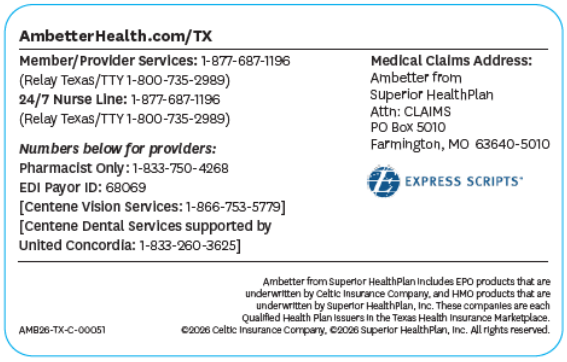
Provider Services at 1-877-687-1196 or Ambetter Health (Solutions) at 1-833-543-3145 (TTY:711).	If you cannot confirm a member's eligibility using the secure portal or the 24/7 IVR line, call Provider Services. Follow the menu prompts to speak to a Provider Services Representative to verify eligibility before rendering services. Provider Services will require the member's name or member ID number and date of birth to verify eligibility.

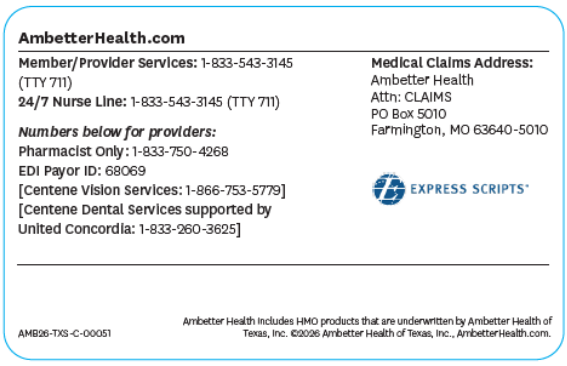
Member Identification Card

All members will receive an Ambetter member identification card. Below is a sample member identification card. The ID card may vary due to the features of the health plan selected by the member.











(The above is a reasonable facsimile of the Member Identification Card)

NOTE: Presentation of a member ID card is not a guarantee of eligibility. Providers must always verify eligibility on the same day services are required.

Covered Services

Please visit the Ambetter website for information on covered services. The "Pre Auth Check" tool under the "For Providers" section of the website allows providers to validate authorization requirements by CPT Code. Refer to our website and the "Medical Management" and "Prior Authorizations" sections of this manual for more information about clinical determination and prior authorization procedures.

Benefit Limits

In general, most benefit limits for services and procedures follow state and federal guidelines. Benefits limited to a certain number of visits per year are based on a calendar year (January through December). Please check to be sure the member has not already exhausted benefit limits before providing services by checking our Secure Provider Portal or calling Ambetter Member and Provider Services.

Preventive Services

Preventive care services are covered in accordance with the Affordable Care Act (ACA). The ACA requires health plans (non-grandfathered) to cover certain identified services under the preventive

care benefit without cost sharing to members (copayments, coinsurance amounts, and deductibles do not apply), when obtained from an in-network provider. ACA required preventive care coverage includes:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).
- Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
- The complete list of recommendations and guidelines can be found at www.healthcare.gov/coverage/preventive-care-benefits.
- Preventive benefits do not generally include services intended to treat an existing illness, injury, or condition. Benefits will be determined based on how the bill is submitted. Claims must be submitted with the appropriate diagnosis and/or procedure code and modifier(s) when applicable to be paid at the 100% benefit level. If during a preventive care visit a member receives services to treat an existing illness, injury, or condition, he/she may be required to pay a copayment, deductible and/or coinsurance for those covered non-preventive services.
- For a listing of services that are covered at 100% and associated preventive benefits, please visit www.AmbetterHealth.com/en/tx.

Preventive Colonoscopy

Ambetter reimburses for preventive colonoscopy in accordance with state mandates and CMS guidelines. Colonoscopies, which are initiated as a screening colonoscopy, during which a polyp/tumor or other procedure due to an abnormality is discovered, should be considered a preventive service. To ensure appropriate reimbursement, the preventative colonoscopy CPT code should be billed with an ICD-10 diagnosis code corresponding to the pathology found rather than the special screening for malignant neoplasms of the colon.

The preventive colonoscopy diagnosis should be entered as the primary diagnosis and the diagnosis codes for any discovered pathology should be entered as the secondary diagnosis on all subsequent claim lines.

Follow the below billing tips to appropriately identify the colonoscopy service to be considered for reimbursement.

- Preventive Colonoscopy Screening
    - One preventive every ten years when billed with preventive screening procedure and preventive diagnosis (must be billed in diagnosis 1 field)
    - Does not require modifier PT or 33 to be billed
- High Risk Colonoscopy Screening
    - One preventive every 24 months when billed with a high-risk procedure code and a high-risk diagnosis code
    - Does not require modifier to be billed
- Diagnostic Colonoscopy Service
    - When the claim is billed with modifier PT or 33, it will be treated as preventive
    - When a modifier is not billed, it indicates the service is diagnostic

Notification of Pregnancy

Providers should notify Ambetter/Marketplace/SBEs immediately of any member who is expecting. We do not require a physician or other healthcare provider to obtain prior authorization for the delivery of the newborn. However, an inpatient stay longer than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery will require prior authorization. Please refer to the provider authorization tool www.ambetterhealth.com/en/tx/ to check if any authorizations are required for additional services.

This notification of pregnancy allows Ambetter members to take advantage of the Start Smart for your Baby Program®, which provides education and care management techniques. The program offers support for pregnant women and their babies by providing educational materials and other resources.

Notification of Pregnancy Surrogacy

Providers should notify Ambetter/Marketplace/SBEs immediately of any member intending to come into a contractual agreement or is expecting because of surrogacy. Please refer to the pregnancy surrogacy form on the Ambetter website. All pregnancy-related services provided to a surrogate mother are not covered, including but not limited to charges related to the baby's birth, hospitalization, or care because of surrogacy. Please see the member's Ambetter Evidence of Coverage for additional details.

Adding a Newborn or an Adopted Child

- Coverage applicable for children will be provided for a newborn child or adopted child of an Ambetter member from the moment of birth or moment of placement for adoptions if the eligible child is enrolled timely as specified in the member's Evidence of Coverage.

Hospital Stay Requirements Under The Newborns' and Mothers'

Health Protection Act (NMHPA)

The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) establishes federal protections regarding the minimum length of hospital stays following childbirth. Under NMHPA, group health plans and health insurance issuers may not restrict benefits for a hospital stay in connection with childbirth to less than:

- 48 hours following a vaginal delivery, or
- 96 hours following a cesarean section.

The applicable time period begins at the time of delivery if the birth occurs in a hospital. If delivery occurs outside of a hospital and the mother is subsequently admitted in connection with childbirth, the period begins at the time of hospital admission.

An attending provider—defined as a licensed individual directly responsible for maternity or pediatric care (e.g., physician, nurse midwife, nurse practitioner, or physician assistant)—may, in consultation with the mother, determine that an earlier discharge is appropriate. Health plans and issuers may not provide incentives or impose penalties to encourage discharge before the minimum required stay.

Applicability of NMHPA

The NMHPA applies to:

- Group health plans, including both:
    - Insured plans (regulated by state insurance departments), and
    - Self-funded plans (regulated under federal law).
- Individual health insurance coverage, unless superseded by state law offering equivalent or greater protections.

If a group health plan is self-funded, NMHPA provisions apply directly. For insured plans, applicability may depend on state law. Many states have enacted their own maternity stay protections that may apply in lieu of or in addition to NMHPA.

Provider Responsibilities

Providers should be aware that:

- Patients must be informed of their rights under NMHPA.
- Summary Plan Descriptions (SPDs) or insurance contracts must include a statement describing applicable federal or state requirements regarding hospital length of stay for childbirth.
- Providers should not be influenced by financial incentives or disincentives related to early discharge decisions.

For questions regarding whether a plan is insured or self-funded, providers should refer to the plan's SPD or contact the plan administrator.

Transplant Services

Please refer to the member Evidence of Coverage for a listing of covered and non-covered (excluded) services related to transplants.

Transplants are a covered benefit when a member is accepted as a transplant candidate. Prior authorization must be obtained through the *"Center of Excellence" before* an evaluation for a transplant. Ambetter may require additional information, such as testing and/or treatment, before determining medical necessity for the transplant benefit. Authorization must be obtained prior to performing any services related to the transplant surgery. Transplant services must meet medical criteria as set by Medical Management Policy.

Claims submission policies related to transplant services available to both the recipient and donor of a covered transplant are as follows:

- If both the donor and recipient have coverage provided by the same insurer, each will have their benefits paid by their own coverage program.
- If only the Transplant Recipient is covered by Ambetter, the Donor's medical and/or travel costs related to the Covered Transplant Services will be covered under the Transplant Recipient's Ambetter benefits, regardless of whether the Donor has other insurance coverage or no coverage. In this case, payments made for the Donor will be charged against the Transplant Recipient's benefits as outlined in their EOC. Refer to Appendix B for additional information.
- If only the Donor is covered by Ambetter, Ambetter will pay for the Donor's medical and/or travel costs as outlined in their EOC. However, no benefits will be provided for the recipient unless the Transplant Recipient is covered by Ambetter (see scenarios #1 and #2).
- If the Transplant Recipient's and/or Donor's coverage lapses due to non-payment of premium, no services related to transplant will be paid as a covered benefit for the Transplant Recipient or Donor, as applicable.

For additional questions or information on prior authorization, please review the *Medical Management* section of this manual for guidelines.

Tribal Provider (AIAN) American Indian Alaska Native

For Indian Health Services (I.H.S) and Tribal 638 facilities, most services are paid at the Office of Management and Budget (OMB) Rate, using the UB claim form and either a revenue code for dental clinic (0512) or for physical health clinic (0519). For a Behavioral Health practitioner service revenue code 0919 is used. Some services are not part of the Office of Management Budget rate and are billed on the CMS 1500 form and paid at regular fee schedule rates. Note: Dental claims are not a covered service unless related to an emergency.

Ambetter American Indian and Alaska Natives members may use an Indian healthcare as a primary care provider or choose to use a network primary care provider to get healthcare services. To avoid paying extra, member must obtain a referral from their Indian healthcare provider or from the network primary care provider for any specialty or other services not provided by your Indian healthcare provider.

Ambetter claims billed by a network primary care provider or specialist on behalf of an American Indian and Alaska Native member are required to bill with modifier Q4 to indicate that these services are an extension of services not provided by an Indian healthcare provider but billed by a network primary care provider or specialist.

Ambetter requires that all Tribal 638 facilities billing on CMS 1500 forms be billed with a place of service as recognized by CMS as indicated below:

Overview

American Indian and Alaska Native (AIAN) members may seek services from Indian Health Service (IHS), Tribal 638 facilities, or non-tribal providers. Billing and member responsibility requirements differ based on provider type and referral circumstances.

Authorization Requirements

Tribal and IHS providers are treated as participating providers (regardless of contract status) for authorization purposes.

Authorization is not required for services rendered to AIAN members by:

- Indian Health Service (IHS) providers
- Tribal 638 providers
- Non-tribal providers when services are provided in accordance with AIAN referral guidelines

Member Responsibility

Services rendered by Tribal and IHS providers or non-tribal provider services billed with modifier Q4 do not have AIAN member responsibility (copayment, coinsurance, or deductible).

Services rendered by non-tribal providers, without referral by a Tribal or IHS provider, will apply standard member cost share as outlined by the AIAN benefit plan.

AIAN Member Referral to Non-Tribal Provider

When an AIAN member is referred by a Tribal or IHS provider to a non-tribal provider, modifier Q4 must be billed by the non-tribal provider.

Modifier Q4 indicates that service is an extension of care not provided by the Tribal/IHS provider and applicable AIAN member responsibility rules apply (cost share waived).
NOTE: If modifier Q4 is not included, claims will process under standard benefit plan cost share requirements

Place of Service Requirements

Tribal or IHS providers do not have place of service billing restrictions.
NOTE: This removes the prior requirements to bill with place of service 05-08.

Services rendered by Indian Health Services (IHS) and Tribal 638 facilities are reimbursed based on IHS-established rates and applicable federal requirements.

Providers are expected to submit claims consistent with recognized IHS billing methodologies. Reimbursement will align with those methodologies, including any state-specific variations where applicable.

Non-Covered Services

Please refer to the member Evidence of Coverage for a listing of non-covered (excluded) services.

MEDICAL MANAGEMENT

The components of the Ambetter Medical Management program are Utilization Management, Care Management and Concurrent Review, Health Management and Behavioral Health. These components will be discussed in detail below.

Care Management

Care Management is a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs, using communication and available resources to promote quality, cost effective outcomes. Service/Care Coordination and Care Management is a member-centered, goal-oriented, culturally relevant, and logically managed processes to help ensure that a member receives needed services in a supportive, efficient, timely, and cost-effective manner.

Ambetter's Care Management teams support physicians by tracking compliance with the Care Management plan and facilitating communication between the PCP, member, managing physician, and the Care Management team. The Care Manager also facilitates referrals and links to community providers, such as behavioral health providers, local health departments and school-based clinics. The managing physician maintains responsibility for the member's ongoing care needs. The Ambetter Care Manager will contact the PCP and/or managing physician if the member does not follow the care plan or requires additional services.

Ambetter will provide individual Care Management services for members who have high-risk, high-cost, complex, or catastrophic conditions. The Ambetter Care Manager will work with all involved providers to coordinate care and provide referral assistance and other care coordination as required. The Ambetter Care Manager may also assist with a member's transition to other care, as indicated, when Ambetter benefits end.

Start Smart for Your Baby® (Start Smart) is a Care Management program available to members who are pregnant or who have just had a baby. Start Smart is a comprehensive program that covers all phases of pregnancy, postpartum, and newborn periods including perinatal and postnatal depression. The program includes mailed educational materials for newly identified pregnant members and new mothers after delivery. The initial mailing also includes an Edinburgh Depression Screening which is scored, and members identified as needing assistance with depression are contacted for care management services.

Telephonic and Digital Care Management by registered nurses, licensed mental health professionals and social services specialists as well as Marketplace Coordinators is available. Ambetter's Care Managers work with the member to create a customizable plan of care to promote healthcare as well as adherence to Care Management plans. Care Managers will coordinate with physicians, as needed, to develop and maintain a care plan to meet the needs of all involved.

All Ambetter members with identified needs are assessed for Care Management enrollment. Members with needs may be identified via clinical rounds, referrals from other Ambetter staff

members, via hospital census, via direct referral from providers, via self-referral, or referral from other providers.

To refer a member for enrollment in Ambetter's Care Management program, contact Provider Services Monday through Friday 8 a.m. to 5 p.m. (CST) at **1-877-687-1196** or Ambetter Health (Solutions) at **1-833-543-3145 (TTY:711)**, or submit a Care Management referral via Superior's Secure Provider Portal.

Health Management

Health management is the concept of reducing health care costs and improving quality of life for individuals with a chronic condition through ongoing integrated care. Health management supports the physician or practitioner/patient relationship and plan of care; it emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.

Ambetter's Member Wellbeing Survey

Ambetter members are requested to complete a Wellbeing Survey upon enrollment with us. Ambetter utilizes the information to better understand the member's health care needs to provide customized, educational information and services specific to their needs. Ambetter members can login to their secure online account at www.AmbetterHealth.com/en/tx to complete their Wellbeing survey or they can call our Member Services at:

- Ambetter from Superior HealthPlan: 1-877-687-1196; or
- Ambetter Health: 1-833-543-3145

Ambetter's My Health Pays Member Rewards Program

Our My Health Pays™ rewards program gives members the opportunity to earn reward dollars for taking charge of their health. This program provides incentives when they take advantage of their preventive care benefits by helping them earn reward dollars.

When members take an active role in their healthcare, you can help them experience healthier outcomes.

Members earn My Health Pays™ rewards by completing healthy behaviors. These include:

- Completing their Member Wellbeing Survey, which verifies demographic information and health information;
- Getting their annual wellness exam;
- Plus, much more!

Visit our website for more information www.ambetterhealth.com/en/tx/health-plans/my-health-pays.

My Health Pays Visa Prepaid Card

These rewards are automatically added to a Visa® Prepaid Card or My Health Pays™ rewards card. Members can redeem their rewards to help offset costs such as:

- Doctor copays3
- Deductibles
- Coinsurance
- Monthly premium payments

Other spend options are available to our members. Visit our website for more information www.AmbetterHealth.com/en/tx. Together we can help members take advantage of their preventive services and earn rewards.[4]

Utilization Management

The Ambetter Utilization Management initiatives are focused on optimizing each member's health status, sense of well-being, productivity, and access to appropriate health care while at the same time actively managing cost trends. The Utilization Management Program's goals are to provide covered services that are medically necessary, appropriate to the member's condition, rendered in the appropriate setting, and meet professionally recognized standards of care. Ambetter does not reward providers, employees who perform utilization reviews, or other individuals for issuing denials of authorization. Neither network inclusion nor hiring and firing practices influence the likelihood or perceived likelihood for an individual to deny or approve coverage. There are no financial incentives to deny care or encourage decisions that result in underutilization.

Prior authorization or Prospective Review is the request to the Utilization Management Department for approval of certain services before the service is rendered. Authorization must be obtained prior to the delivery of certain elective and scheduled services. Failure to obtain authorization will result in denial of payment.

Medically Necessary

Medically Necessary means any medical service, supply, or treatment authorized by a physician to diagnose and treat a member's illness or injury which:

- Is consistent with the symptoms or diagnosis.
- Is provided according to generally accepted medical practice standards

[3]My Health Pays™ rewards cannot be used for pharmacy copays.

[4] Visa® Prepaid Card is issued by The Bancorp Bank pursuant to a license from Visa U.S.A. Inc. The Bancorp Bank Member FDIC. Visa® Prepaid cards cannot be used everywhere Visa debit cards are accepted. See Cardholder Agreement for complete usage restrictions.

- Is not custodial care
- Is not solely for the convenience of the physician or the member
- Is not experimental or investigational
- Is provided in the most cost-effective care facility or setting
- Does not exceed the scope, duration, or intensity of that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment; and
- When specifically applied to a hospital confinement, it means that the diagnosis and treatment of the medical symptoms or conditions cannot be safely provided as an outpatient.

Utilization Determination Timeframes

Authorization decisions are made as expeditiously as possible. Below is a list of specific timeframes utilized by Ambetter. In some cases, it may be necessary for an extension to extend the timeframe below. You will be notified if an extension is necessary. Please contact Ambetter if you would like a copy of the policy for UM timeframes.

Type	Timeframe
Prospective/Urgent	Determination within the appropriate time to the circumstances relating to the delivery of the services to the member and to the member's condition, but no more than 72 hours from receipt of request for service for adverse determinations, and two working days after receipt of the request for approvals.
Prospective/Non-Urgent	Determination within three working days after receipt of the request for adverse determinations and two working days after receipt of the request for approvals.
Concurrent/Urgent	Determination within 1 working day of receipt of request. No authorization is required for post-stabilization care or life-threatening condition.
Retrospective	Determination within 30 calendar days of receipt of request

Concurrent Review

The Ambetter Utilization Management Department will concurrently review the treatment and status of all members who are inpatient through contact with the hospital's Utilization and Discharge Planning Departments and when necessary, the member's attending physician. An inpatient stay will be reviewed as indicated by the member's diagnosis and response to treatment. The review will include an evaluation of the member's status, proposed plan of care, discharge plans, and subsequent diagnostic testing or procedures.

Use of Artificial Intelligence (AI)-Based Algorithms in Health Care Service Reviews

Ambetter Health uses AI systems and machine learning to improve operations, enhance member experiences, and strengthen clinical support. We design and use these tools responsibly, with a focus on human well-being, fairness, accountability, and transparency.

AI-based algorithms may be used to support the approval of certain healthcare service requests. However, these tools do not make denial decisions and are only one part of the overall review process.

Ambetter Health does not use AI-based algorithms as the sole basis to deny, delay, or modify healthcare service requests. These determinations are made by appropriately licensed clinicians.

If you have questions about this disclosure, please contact Ambetter at **1-877-687-1196 (Relay Texas/TTY 1-800-735-2989)** or Ambetter Health (Solutions) at **1-833-543-3145 (TTY:711)**.

PREAUTHORIZATION

Preauthorization is a form of prospective utilization review proposed to be provided to an enrollee. Concurrent utilization review is a form of utilization review for ongoing health care or for an extension of treatment beyond previously approved health care. Retrospective utilization review is a form of utilization review for health care services that have been provided to an enrollee. Retrospective utilization review does not include review of services for which prospective or concurrent utilization reviews were previously conducted or should have been previously conducted.

Services Requiring Prior Preauthorization

To verify if a service requires preauthorization, please visit the Ambetter website at www.AmbetterHealth.com/en/tx and use the "Pre-Auth Needed" tool under For Providers – Provider Resources or call the Utilization Management Department with questions. Failure to obtain the required prior authorization or pre-certification will result in a denied claim. Note: All out of network services require preauthorization, excluding emergency room services, life threatening conditions and post-stabilization care.

It is the responsibility of the facility in coordination with the rendering practitioner to ensure that an authorization has been obtained for all inpatient and selected outpatient services, except for emergency stabilization services. All elective inpatient admissions require preauthorization.

Any anesthesiology, pathology, radiology, or hospitalist services related to a procedure or hospital stay requiring a preauthorization will be considered downstream and will not require a separate authorization.

Services related to an authorization denial will result in denial of all associated claims.

Timeframes for Authorization Requests and Notifications

The following timeframes are required of the ordering provider for prior authorization and notification:

Service Type	Timeframe
Elective admissions	Prior Authorization required 5 days prior to the scheduled admission date
Outpatient services that require prior authorization	Prior Authorization requests five (5) business days prior to the outpatient service date
Non-Elective (emergent) inpatient admissions	Notification within one (1) business day of admission
Newborn admissions	Notification within one (1) business day of birth
Inpatient admission facility transfers or changes in level of care	Notification within one (1) business day of facility transfer
Organ transplants initial evaluation	Prior Authorization required at least (30) days prior to the initial evaluation for organ transplant services.

Service Type	Timeframe
Clinical trials services	Prior Authorization required at least thirty (30) days prior to receiving clinical trial services.

Procedure for Requesting Prior Authorizations for Medical and Behavioral Health Services

Secure Portal

The preferred method for submitting authorizations is through the Secure Provider Portal at www.AmbetterHealth.com/en/tx. The provider must be a registered user on the Secure Provider Portal. If a provider is already registered for the Secure Provider Portal for one of our other products, that registration will grant the provider access to Ambetter. If the provider is not already a registered user on the Secure Provider Portal and needs assistance or training on submitting prior authorizations, the provider should contact their dedicated Provider Relations Representative. Other methods of submitting the prior authorization requests are as follows:

Phone

Call the Utilization Management Department at **1-877-687-1196** or Ambetter Health (Solutions) at **1-833-543-3145 (TTY:711)**. Our 24/7 Nurse Advice line can assist with urgent prior authorizations after normal business hours.

Fax

Submit prior authorization requests utilizing the Prior Authorization fax forms posted on the Ambetter website at www.AmbetterHealth.com/en/tx. Please note the fax machine will not be monitored after hours and will be responded to on the next business day.

For urgent admission notifications or urgent prior authorization requests, please contact our 24-Hour Nurse Advice Line:

Ambetter from Superior HealthPlan
1-877-687-1196
TTY: 1-800-735-2989

Ambetter Health
1-833-543-3145
TTY: 711

The requesting or rendering provider must provide the following information to request prior authorization (regardless of the method utilized):

- Member's name, date of birth and ID number.
- Provider's Tax ID, NPI number, taxonomy code, name, and telephone number.

- Facility name if the request is for an inpatient admission or outpatient facility services.
- Place of Service if the request is for an ambulatory or office procedure.
- Admission date or proposed surgery date if the request is for a surgical procedure.
- The procedure code(s) Note: If the procedure codes submitted at the time of authorization. differs from the services performed, it is required within 72 hours or prior to the time the claim is submitted that you phone Ambetter at **1-877-687-1196 (Relay Texas/TTY 1-800-735-2989)** or Ambetter Health (Solutions) at **1-833-543-3145 (TTY:711)**.
- Update the authorization; otherwise, this may result in claim denials.
- Diagnosis with ICD code.
- Relevant clinical information (e.g., Past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed).
- Discharge plans.
- For obstetrical admissions, the date and method of delivery, targeted admission date, and information related to the newborn or neonate.

Evolent Authorizations

Evolent provides an interactive website, www1.radmd.com, which should be used to obtain on-line authorizations. For urgent authorization requests please call **1-800-424-4916** and follow the prompt for radiology authorizations. For more information call our Provider Services department.

Medical Necessity Approvals, Denials and Appeals

Prior Authorization Approval Notifications

Ambetter's utilization review team will mail or otherwise transmit the member and provider notice of approval of a prior authorization request not later than the second working day after receiving the request and all information necessary to complete the review.

Adverse Determination Notifications

For a member who is hospitalized at the time of the adverse determination, notice of denial will be provided within one working day by either telephone or electronic transmission to the provider of record, followed by a letter within three calendar days of the request, notifying the member and the provider of record of the adverse determination, including appeal rights.

- For a member who is not hospitalized at the time of the adverse determination, within three working days in writing to the provider of record and the member.

- For a concurrent review of the provision of prescription drugs or intravenous infusions for which the member is receiving health benefits under the health insurance policy not later than the 30th day before the date on which the provision of prescription drugs or intravenous infusions will be discontinued.

Reasonable Opportunity to Discuss Prior to Medical Necessity Denial

Before an adverse determination is issued based on medical necessity, the appropriateness, or the experimental or investigational nature of a health care service, the provider who ordered, requested, or is to provide the service is given a reasonable opportunity to discuss the patient's treatment plan and the clinical basis for the adverse determination with a health care provider who is of the same specialty as the health plan's Medical Director.

Medical Necessity Appeal

The procedures for filing an Appeal are outlined in the Ambetter member's Evidence of Coverage. Additionally, information regarding the Appeal process can be found on our website at www.AmbetterHealth.com/en/tx or by calling Ambetter at **1-877-687-1196 (Relay Texas/TTY 1-800-735-2989)** or Ambetter Health (Solutions) at **1-833-543-3145 (TTY:711)**.

Mailing Address and Fax Numbers

Ambetter from Superior HealthPlan

Attn: Appeals and Grievances Department
5900 E. Ben White Blvd.
Austin, TX 78741
Appeals Fax: 1-866-918-2266
Grievances Fax: 1-866-683-5369

Ambetter Health

Attn: Appeals and Grievances Department
PO Box 10341
Van Nuys, CA 91410-0341
Fax: 1-833-886-7956

Medical Necessity Appeals Process

A member or provider or other person authorized by the member has 180 calendar days from Ambetter's notice of action to file an appeal of an adverse determination. Ambetter shall acknowledge receipt of each appeal within five business days after receiving an appeal. Ambetter shall resolve each appeal and provide written notice of the appeal resolution, as expeditiously as the member's health condition requires, but shall not exceed 30 calendar days from the date Ambetter receives the appeal.

A health care provider who has not previously reviewed the case and who is of the same or a similar specialty as the health care provider that typically manages the medical condition, procedure, or treatment under review through the appeal will make the appeal determination.

If an appeal is received related to an adverse determination due to lack of/no clinical received at time of determination, the URA will conduct an appeal review using the most appropriate and relevant medical necessity criteria based on the clinical documentation received at the time of appeal.If an appeal is requested or denied and, within 10 working days from the request or denial, the health care provider requests a particular type of specialty provider review the case, the appeal or the decision denying the appeal must be reviewed by a health care provider in the same or similar specialty that typically manages the medical, dental, or specialty condition, procedure, or treatment under discussion for review of the adverse determination. The specialty review will be completed within 15 working days of receipt of the request, and written response provided.

A member or member's representative may also request an external review through MAXIMUS Federal Services if the adverse determination is upheld on appeal. A request for External Review, along with any additional information for a standard External Review must be sent directly to MAXIMUS by mail, fax, or online using the following information:

MAXIMUS Federal Services
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534
FAX: 1-888-866-6190
https://externalappeal.cms.gov/
(under the "Request a Review Online" heading)

Expedited Appeal for Denial of Emergency Care, Continued Hospitalization, Prescription Drugs or Intravenous Infusions

The procedures for appealing an adverse determination must include, in addition to the written appeal, a procedure for an expedited appeal of a denial of emergency care, a denial of continued hospitalization, or a denial of another service if the requesting health care provider includes a written statement with supporting documentation that the service is necessary to treat a life-threatening condition or prevent serious harm to the patient.

An expedited appeal will be completed based on the immediacy of the medical or dental condition, procedure, or treatment, but no later than one working day from the date all information necessary to complete the appeal is received, or 72 hours, whichever is less. The expedited appeal determination may be provided by telephone or electronic transmission but will be followed with a letter within three working days of the initial telephonic or electronic notification.

Exemption from Preauthorization Requirements for Physicians and Providers Providing Certain Health Care Services

The health plan will not require a physician or provider to obtain preauthorization for a particular health care service if, in the most recent one-year evaluation period, (1) the health has approved or would have approved not less than 90 percent of the preauthorization requests submitted by the physician or provider for the particular health care service; and (2) the physician or provider has provided the particular health care service at least five times during the evaluation period. A physician or provider is not required to request an exemption to qualify for the exemption.

The health plan will evaluate whether a physician or provider qualifies for an exemption from preauthorization requirements once every year and may continue an exemption without evaluating whether the physician or provider qualifies for the exemption for a particular evaluation period.

Musculoskeletal Care Management (MSK)

In keeping with our commitment of promoting continuous quality improvement for services provided to Ambetter members, Ambetter has partnered with Evolent to implement a Musculoskeletal Care Management (MSK) program. This program includes prior authorization for non-emergent MSK procedures for Ambetter members. This decision is consistent with industry-wide efforts to ensure clinically appropriate quality of care and to manage the increasing utilization of these services.

How the Program Works

MSK Surgeries: Prior authorization will be required for the following non-emergent inpatient and outpatient hip, knee, shoulder, lumbar and cervical surgeries:

Hip

- Revision/Conversion Hip Arthroplasty.
- Total Hip Arthroplasty/Resurfacing.
- Femoroacetabular Impingement (FAI) Hip Surgery (includes CAM/pincher & labral repair).
- Hip Surgery – Other (includes synovectomy, loose body removal, debridement, diagnostic hip arthroscopy, and extra-articular arthroscopy knee).

Knee

- Revision Knee Arthroplasty.
- Total Knee Arthroplasty (TKA).
- Partial-Unicompartmental Knee Arthroplasty (UKA).
- Knee Manipulation under Anesthesia (MUA).
- Knee Ligament Reconstruction/Repair.
- Knee Meniscectomy/Meniscal Repair/Meniscal Transplant.

- Knee Surgery – Other (includes synovectomy, loose body removal, diagnostic knee arthroscopy, debridement with or without chondroplasty, lateral release/patellar realignment, articular cartilage restoration).

Shoulder

- Revision Shoulder Arthroplasty.
- Total/Reverse Shoulder Arthroplasty or Resurfacing.
- Partial Shoulder Arthroplasty/Hemiarthroplasty.
- Shoulder Rotator Cuff Repair.
- Shoulder Labral Repair.
- Frozen Shoulder /Adhesive Capsulitis Repair.
- Shoulder Surgery – Other (includes debridement, manipulation, decompression, tenotomy, tenodesis, synovectomy, claviculectomy, diagnostic shoulder arthroscopy).

Cervical

- Cervical Anterior Decompression with Fusion –Single & Multiple Levels.
- Cervical Posterior Decompression with Fusion –Single & Multiple Levels.
- Cervical Posterior Decompression (without fusion).
- Cervical Artificial Disc Replacement – Single & Two Levels.
- Cervical Anterior Decompression (without fusion.)

Lumbar

- Lumbar Microdiscectomy.
- Lumbar Decompression (Laminotomy, Laminectomy, Facetectomy & Foraminotomy).
- Lumbar Spine Fusion (Arthrodesis) With or Without Decompression – Single & Multiple Levels.
- Lumbar Artificial Disc – Single & Multiple Levels.

Sacroiliac

- Sacroiliac Joint Fusion.

As a part of the Evolent clinical review process, actively practicing, orthopedic surgeon specialists (hip, knee, and shoulder) or neurosurgeons (spine) will conduct the medical necessity reviews and determinations of musculoskeletal surgery cases.

Please refer to the “Solutions” tab on the Evolent home page www.RadMD.com for additional information on the MSK program. Checklists and tip sheets are available there to help providers ensure surgical procedures are delivered according to national clinical guidelines.

Should you have any questions, please contact Evolent at **1-800-424-4916**.

Preventive Health Care

Ambetter is committed to the promotion of the lifelong benefits of preventive care. Members may see a network provider, who is contracted with Ambetter to provide health care services directly, without prior authorization for:

- Medically necessary maternity care;
- Preventive care (well care) and general examinations;
- Gynecological care; or
- Follow-up visits for the above services.

If the member's health care provider diagnoses a condition that requires a prior authorization to other specialists or hospitalization, prior authorization must be obtained in accordance with Ambetter's prior authorization requirements.

Retrospective Review

Retrospective review is an initial review of services after services have been provided to a member. This may occur when authorization or timely notification to Ambetter was not obtained due to extenuating circumstances (i.e., member was unconscious at presentation, member did not have their Ambetter ID card or otherwise indicated other coverage, services authorized by another payer who subsequently determined member was not eligible at the time of service). Requests for retrospective review must be submitted promptly.

If a claim is denied for lack of authorization for a service that requires authorization, Ambetter will not retrospectively review the request for authorization, as this type of request does not meet the Ambetter retrospective review guidelines of extenuating circumstances. If a clinical review is warranted due to extenuating circumstances, a decision will be made within 30 calendar days following receipt of all necessary information.

Utilization Review Criteria

Utilization management decision-making is based on appropriateness of care and service and the existence of coverage. Ambetter does not reward providers or other individuals for issuing denials of authorizations.

Ambetter has adopted the following utilization review criteria to determine whether services are medically necessary for the purpose of health plan benefits:

Services	Criteria
Medical Services	InterQual® Adult, Clinical Policies and Pediatric Guidelines and internally developed criteria by Ambetter healthcare professionals and related specialists.
Behavioral Health Services	InterQual® Behavioral Health Criteria (Adult and Geriatric or Child and Adolescent Psychiatry)

	and internally developed criteria by Ambetter behavioral healthcare professionals and related specialists.
High Tech Imaging and Therapy Services	Internally developed criteria by Evolent. Criteria developed by representatives in the disciplines of radiology, internal medicine, nursing, and cardiology. The criteria are available at www1.radmd.com.
Substance Use Disorder Services	American Society for Addiction Medicine (ASAM) Patient Placement Criteria. The criteria are available at www.asam.org.

Ambetter's Medical Director, or other healthcare professionals who have appropriate clinical expertise in treating the member's condition or disease, reviews all potential adverse determinations and will make a decision in accordance with currently accepted medical or healthcare practices, considering special circumstances of each case that may require deviation from InterQual® or other criteria as mentioned above. Providers may obtain the criteria used to make a specific adverse determination by contacting the Utilization Management department at 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989) or Ambetter Health (Solutions) at 1-833-543-3145 (TTY:711). Providers can discuss any adverse decisions with an Ambetter physician or other appropriate reviewer at the time of the notification to the requesting provider of an adverse determination. The Medical Director may be contacted by calling Ambetter at 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989) or Ambetter Health (Solutions) at 1-833-543-3145 (TTY:711) and asking for the Medical Director. An Ambetter Care Manager may also coordinate communication between the Medical Director and the requesting provider.

Members or healthcare professionals, with the member's consent, may request an appeal related to a medically necessary decision made during the authorization or concurrent review process orally or in writing to:

Emergency Medical, Behavioral Health, or Substance Use Disorder Condition

Emergency care means medical or behavioral health (BH) services provided after the sudden or unexpected onset of a medical or behavioral health condition manifesting itself by acute symptoms (including severe pain and injury caused by an accident), which are severe enough that the lack of immediate medical or BH attention could reasonably be expected to result in any of the following:

- The patient's life or health would be placed in serious jeopardy; or, in the case of a pregnant woman, the health of the woman or her unborn child.
- Vital bodily functions would be seriously impaired; and
- There would be serious and permanent dysfunction of a bodily organ or part

- Emergency medical or BH condition status is not affected if a later medical or BH review finds no actual emergency present.

CMS INTEROPERABILITY APIS

Provider Overview

In support of federal CMS interoperability requirements, Ambetter offers a set of standardized application programming interfaces (APIs) that support improved data sharing between providers, health plans, and members. Two of these - the **Prior Authorization API** and the **Provider Access API** - are designed specifically to reduce administrative burden, streamline clinical workflows, and strengthen care coordination through the secure, electronic exchange of information within participating EHR/EMR systems.

Prior Authorization API

Providers whose EHR/EMR vendor has connected to the Prior Authorization API may be able to check authorization requirements, identify required documentation, submit prior authorization requests, and receive status updates and decisions electronically within their existing clinical workflow. These capabilities bring greater transparency to the process and support more efficient prior authorization processing for medical items and services.

Provider Access API

Providers whose EHR/EMR vendor has connected to the Provider Access API may be able to retrieve eligible patient claims, clinical, and prior authorization information to support treatment and care coordination. Access is generally limited to providers with an active treatment relationship and remains subject to applicable member consent and privacy requirements.

Additional Interoperability APIs

CMS interoperability requirements also include the **Patient Access API**, which allows members to share their health information with third-party applications; the **Payer-to-Payer API**, which supports electronic data exchange when members change plans or are covered by more than one health plan; and the **Provider Directory API**, which makes provider directory information available to third-party applications.

For detailed educational materials, implementation guidance, a list of connected EHR/EMR vendors, and frequently asked questions, providers are encouraged to visit: www.ambetterhealth.com/en/tx/.

PHARMACY

The pharmacy benefits for Ambetter members vary based on the plan benefits. Information regarding the members' pharmacy coverage can be best found via our Secure Provider Portal. Additional resources available on the website include the Ambetter Formulary, the Express Scripts (Pharmacy Benefit Manager) Provider Manual, and Medication Request/Exception Request forms.

The Ambetter formulary is designed to assist contracted healthcare prescribers with selecting the most clinically and cost-effective medications available. The formulary provides instruction on the following:

- Which drugs are covered, including restrictions, prior authorization requirements, and limitations;
- The pharmacy management program requirements and procedures;
- An explanation of limits and quotas;
- How prescribing providers can make an exception request; and;
- How Ambetter conducts generic substitution, therapeutic interchange, and step-therapy.

The Ambetter formulary does not:

- Require or prohibit the prescribing or dispensing of any medication;
- Substitute for the professional judgment of the physician or pharmacist; or
- Relieve the physician or pharmacist of any obligation to the member.

The Ambetter formulary will be approved initially by the Pharmacy and Therapeutics Committee (P&T), led by the Pharmacist and Medical Director, with support from community-based primary care providers and specialists. Once established, the Formulary will be maintained by the P & T Committee, through quarterly meetings, to ensure Ambetter members receive the most appropriate medications. The Ambetter formulary contains those medications that the P & T Committee has chosen based on their safety and effectiveness. If a physician feels that a certain medication merits addition to the list, the Formulary Change Request policy can be used as a method to address the request. The P & T Committee reviews the request, along with supporting clinical data, to determine if the drug meets the safety and efficacy standards established by the Committee. Copies of the formulary are available on our website, www.AmbetterHealth.com/en/tx. Providers may also call Provider Services for hard copies of the formulary.

Our Pharmacy Services is simplifying the prescriber process with a streamlined method to access Prior Authorizations online through CoverMyMeds®. CoverMyMeds® automates prior drug authorizations for any medication and allows prescribers to begin the process electronically. This site can be accessed at www.covermymeds.com/main/prior-authorization-forms.

CLAIMS

The appropriate Center for Medicare and Medicaid Services (CMS) billing form is required for paper and electronic data interchange (EDI) claim submissions. The appropriate CMS billing forms are CMS 1450 for facilities and CMS 1500 for professionals. In general, Ambetter follows the CMS billing requirements for paper, EDI, and secure web-submitted claims. Ambetter is required by state and federal regulations to capture specific data regarding services rendered to its members. The provider must adhere to all billing requirements to ensure timely processing of claims and to avoid unnecessary upfront rejections or denials. The Reimbursement Policy can be viewed on our website and in the Appendix of this Manual.

Clean Claim Validation

All claims filed with Ambetter are subject to verification procedures. These include, but are not limited to, verification of the following:

- All required fields are completed on an original CMS 1500 Claim Form, CMS 1450 (UB-04) Claim Form, EDI electronic claim format, or the claim is submitted on our Secure Provider Portal, individually or in a batch.
- All claim submissions are subject to 5010 validation procedures based on CMS Industry Standards.
- Member ID and date of birth combination must exactly match a participating Ambetter member.
- Claims must contain the CLIA number when CLIA is waived or CLIA certified services are provided. Paper claims must include the CLIA certification in Box 23 when CLIA is waived or CLIA certified services are billed.
- For EDI submitted claims, the CLIA certification number must be placed in:
    - X12N 837 (5010 HIPAA version) loop 2300 (single submission) REF segment with X4 qualifier; or
    - X12N 837 (5010 HIPAA version) loop 2400 REF segment with X4 qualifier, (both laboratory services for which CLIA certification is required and non-CLIA covered laboratory tests).
- Taxonomy codes are required. Please see further details in this Manual for taxonomy requirements.
- All Diagnosis, Procedure, Modifier, Location (Place of Service), Revenue, Type of Admission, and Source of Admission codes are valid for:
    - Date of Service
    - Provider Type and/or provider specialty billing
    - Age and/or sex for the date of service billed

    - Bill type
- All Diagnosis Codes are available to their highest number of digits.
- The National Drug Code (NDC) is billed in the appropriate field on all claim forms when applicable. This includes the quantity and type. Type is limited to the list below:
    - F2 – International Unit
    - GR – Gram
    - ME – Milligram
    - ML – Milliliter
    - UN – Unit
- Principal diagnosis billed reflects an allowed principal diagnosis as defined in the volume of ICD-10-CM for the date of service billed.
- For a CMS 1500 Claim Form, this criteria looks at all procedure codes billed and the diagnosis they are pointing to. If a procedure points to the diagnosis as primary, and that code is not valid as a primary diagnosis code, that service line will deny.
- All inpatient facilities are required to submit a Present on Admission (POA) Indicator. Claims will be denied (or rejected) if the POA indicator is missing. Please reference the CMS Billing Guidelines regarding POA for more information and for excluded facility types. Valid 5010 POA codes are:
    - N – No
    - U – Unknown
    - W – Not Applicable
    - Y – Yes
- Member is eligible for services under Ambetter during the time in which services were provided.
- Services are provided by a participating provider.
- Services are provided by a non-participating (“out of network”) provider, prior authorization is required to provide services to the eligible member. (Except services by an “out of network” provider for an emergency medical condition; however, authorization requirements do not apply for post stabilization services.
- An authorization is given for services that require prior authorization by Ambetter.
- Third party coverage is clearly identified, and appropriate COB information is included with the claim submission.

Claims eligible for payment must meet the following requirements:

- The member is effective on the date of service.
- The service provided is a covered benefit under the member's contract on the date of service, and prior authorization processes are followed when required.
- Payment for services is contingent upon compliance with referral and prior authorization policies and procedures, as well as the billing guidelines outlined in the guide.

Clean Claim Definition

A clean claim means a claim for payment of health care expenses that is submitted on a CMS 1500, or a CMS 1450 (UB04) claim form, in a format required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) with all required fields completed in accordance with Ambetter's published claim filing requirements.

Non-Clean Claim Definition

A clean claim shall not include a claim:

- that contains invalid or missing data elements, a claim that has been suspended to get more information from the provider, or a claim that requires manual intervention/processing
- For which Ambetter requires additional information to resolve the claim.

Upfront Rejections vs. Denials

Prepayment Rejection

A prepayment rejection is defined as an unclean claim that contains invalid or is missing data elements required for acceptance of the claim into the claim processing system. These data elements are identified in the Companion Guide located in Appendix IX of this manual. A list of common upfront rejections is in Appendix I of this manual. Upfront rejections do not enter our claims adjudication system, so there is no Explanation of Payment (EOP) for these claims. The provider receives a letter or a rejection report if the claim is submitted electronically. If a claim is rejected, the identified issue must be corrected, and the claim resubmitted as an original claim.

Denial

If all edits pass and the claim is accepted, it is entered into the system for processing. A **denial** is defined as a claim that passes edits and is entered into the system but is billed with invalid or inappropriate information causing the claim to deny. In this case, an EOP is sent that includes the denial reason. A list of common delays and denials is found with explanations in Appendix II.

Timely Filing

Timely filing requirements are essential to ensure accurate and efficient claims processing. The following guidelines outline the filing deadlines for initial claims, reconsiderations or appeals, and coordination of benefits based on provider's participation status.

Initial Claims		Reconsiderations or Claim Dispute/Appeals		Coordination of Benefits	
Calendar Days		Calendar Days		Calendar Days	
Par	Non-Par	Par	Non-Par	Par	Non-Par
95 days	95 days	120 days	120 days	95 days from the primary payers EOP date .	95 days from the primary payers EOP date.

- Initial Claims - Days are calculated from the Date of Service (DOS) to the date received by Ambetter or from the EOP date. For observation and inpatient stays, the date is calculated from the date of discharge.
- Claims Dispute/Appeals - Days are calculated from the date of the Explanation of Payment issued by Ambetter to the date received.
- Coordination of Benefits - Days are calculated from the date of Explanation of Payment from the primary payers to the date received.

Refunds and Overpayments

Ambetter routinely audits all claims for payment errors. Claims identified as underpaid or overpaid will be reprocessed appropriately. Providers are responsible for reporting overpayments or improper payments to Ambetter. Providers have the option of requesting future offsets to payments or may mail refunds and overpayments. Providers submitting a refund check for an overpayment must complete and include the **Refund Check Information Sheet (RCIS)** with their submission. The RCIS helps ensure refunds are accurately applied to the appropriate claim and member account. The form must be completed in its entirety and should be used only when submitting **one refund check for one claim**. It should not be used for multiple claims. The completed RCIS form should be enclosed with the refund check when mailed for processing. Information can be mailed to the following address:

Ambetter from Superior HealthPlan
P. O. Box 664007
Dallas, TX 75266-4007

Provider Claim Billing

All providers who have rendered services for Ambetter members can file claims. It is important that providers ensure Ambetter has accurate and complete information on file. Please confirm with the Provider Services department or your dedicated Provider Relations Representative that the following information is current in our files:

1. Provider Name (as noted on current W-9 form);
2. National Provider Identifier (NPI);

3. Group National Provider Identifier (NPI) (if applicable);
4. Tax Identification Number (TIN);
5. Taxonomy code (This is a REQUIRED field when submitting a claim);
6. Physical location address (as noted on current W-9 form); and
7. Billing name and address (as noted on current W-9 form).

We recommend that providers notify Ambetter 30-60 days in advance of changes pertaining to billing information. If the billing information change affects the address to which the end of year 1099 IRS form is mailed, a new W-9 form is required. Changes to a provider's TIN and/or address are NOT acceptable when conveyed via a claim form or a 277 electronic file.

Claims for billable services provided to Ambetter members must be submitted by the provider who performed the services or by the provider's authorized billing vendor.

Electronic Claims Submission

Providers are encouraged to participate in Ambetter's Electronic Claims/Encounter Filing Program through Centene. Ambetter (Centene) has the capability to receive an ANSI XS12N 837 professional, institutional, or encounter transaction. In addition, Ambetter (Centene) has the capability to generate an ANSI X12N 835 electronic remittance advice known as an Explanation of Payment (EOP). For more information on electronic filing, contact:

Ambetter c/o Centene EDI Department
1-800-225-2573
Email: EDIBA@centene.com

Providers who bill electronically are responsible for filing claims within the same filing deadlines as providers filing paper claims. Providers who bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

Ambetter can receive coordination of benefits (COB or secondary) claims electronically. Ambetter follows the 5010 X12 HIPAA Companion Guides for requirements on submission of COB data.

The Ambetter Payer ID is 68069. For a list of the clearinghouses that we currently work with, please visit our website at superiorhealthplan.com/providers/resources/electronic-transactions.html.

Specific Data Record Requirements

Claims transmitted electronically must contain all the required data of the X12 5010 Companion Guides. Please contact the clearinghouse you intend to use and ask if they have additional data record requirements.

Electronic Claim Flow Description & Important General Information

To send claims electronically to Ambetter, all EDI claims first must be forwarded to one of Ambetter's clearinghouses. Complete this via direct submission to a clearinghouse or through another EDI clearinghouse.

Once the clearinghouse receives the transmitted claims, they are validated against their proprietary specifications and plan-specific requirements. Claims not meeting the requirements are immediately rejected and sent back to the sender via a clearinghouse error report. It is very important to review this error report daily to identify any claims that were not transmitted to Ambetter. The name of this report can vary based upon the provider's contract with their intermediate EDI clearinghouse. Accepted claims are passed to Ambetter, and the clearinghouse returns an acceptance report to the sender immediately.

Claims forwarded to Ambetter by a clearinghouse are validated against provider and member eligibility records. Claims that do not meet provider and/or member eligibility requirements are upfront rejected and sent back daily to the clearinghouse. The clearinghouse in turn forwards the upfront rejection back to its trading partner (the intermediate EDI clearinghouse or provider). It is very important to review this report daily. The report shows rejected claims; these claims must be reviewed and corrected timely. Claims passing eligibility requirements are then passed to the claim processing queues.

Providers are responsible for verification of EDI claims receipts. Acknowledgements for accepted or rejected claims received from the clearinghouse must be reviewed and validated against transmittal records daily.

Since the clearinghouse returns acceptance reports directly to the sender, submitted claims not accepted by the clearinghouse are not transmitted to Ambetter.

If you would like assistance in resolving submission issues reflected on either the acceptance or claim status reports, please contact your clearinghouse or vendor Customer Service Department.

Rejected electronic claims may be resubmitted electronically once the error has been corrected. Be sure to submit the rejected claim as an original claim.

Invalid Electronic Claim Record Upfront Rejections/Denials

All claim records sent to Ambetter first must pass the clearinghouse proprietary edits and plan specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received by Ambetter. In these cases, the claim must be corrected and re-submitted within the required filing deadline as previously mentioned in the Timely Filing section of this manual. It is important that you review the acceptance or claim status reports received from the clearinghouse to identify and re-submit these claims accurately.

Questions regarding electronically submitted claims should be directed to our EDI BA Support at **1-800-225-2573** or via e-mail at EDIBA@Centene.com. If you are prompted to leave a voice mail, you will receive a return call within 24 business hours.

The full Companion Guides can be located on the Executive Office of Health and Human Services (EOHHS) on the state specific website.

Specific Ambetter Electronic Edit Requirements – 5010 Information

- Institutional Claims – 837Iv5010 Edits
- Professional Claims – 837Pv5010 Edits

Please refer to the EDI HIPAA Version 5010 Implementation section on our website for detailed information.

Corrected EDI Claims

- CLM05-3 Required 7 or 8.
- IN 2300 Loop/REF segment is F8; Ref 02 must input the original claim number assigned.
    - Failure to include the original claim number will result in upfront rejection of the adjustment (error code 76).

Electronic Billing Inquiries

Please direct inquiries as follows:

Action	Contact
Submitting Claims Through a Clearinghouse: Ambetter Payer ID number for all clearinghouses (Medical and Behavioral Health) is 68069.	We use Availity as our primary clearinghouse, which provides us with an extensive network of connectivity. You are free to use whatever clearinghouse you currently do as Availity maintains active connections with many clearinghouses.
General EDI Questions	Contact EDI Support at 1-800-225-2573, 314-505-6525 or via e-mail at EDIBA@Centene.com.
Claims Transmission Report Questions	Contact your clearinghouse technical support area.
Claim Transmission Questions (Has my claim been received or rejected?)	Contact EDI Support at 1-800-225-2573 or via e-mail at EDIBA@Centene.com.
Remittance Advice Questions	Contact Ambetter Provider Services or the Secure Provider Portal.
Provider Payee, UPIN, Tax ID, Payment Address Changes	Notify Provider Service in writing and include an updated W9.

Important Steps to a Successful Submission of EDI Claims:

1. Select a clearinghouse to utilize.
2. Contact the clearinghouse regarding what data records are required.
3. Verify with Provider Services at Ambetter that the provider is set up in the Ambetter system prior to submitting EDI claims.
4. You will receive two reports from the clearinghouse. Always review these reports daily. The first report will be a report showing the claims that were accepted by the clearinghouse and are being transmitted to Ambetter and those claims not meeting the clearinghouse requirements. The second report will be a claim status report showing claims accepted and rejected by Ambetter. Always review the acceptance and claims stats report for rejected claims. If rejections are noted, correct, and resubmit.

5. Most importantly, all claims must be submitted with providers identifying the appropriate coding. See the CMS 1500 (02/12) and CMS 1450 (UB-04) Claims Forms instructions and claim form for details.

Online Claim Submission

Ambetter has made it easy and convenient to submit claims directly using Availity Essentials at http://www.Availity.com or the secure provider portal at www.ambetterhealth.com/en/tx/provider-resources/provider-toolkit/provider-toolkit-secure-provider-portal/.

To request access to the secure provider portal, register for a username and password. If you have technical support questions, contact Provider Services.

Organizations enrolled in Availity are self-administered. One staff member, such as an office manager or administrator, is designated as the Availity Administrator. This individual is responsible for registering the organization, onboarding staff as users, and assigning appropriate claim roles. Once you have access to Availity, you may file first-time claims individually or submit first-time batch claims. You can also find, view, and correct any previously processed claims. Detailed instructions for submitting via Availity are available on the Claims page in Availity and under Help and Training.

Exclusions

The following inpatient and outpatient claim types are excluded from EDI submission options and must be filed on paper:

- Claim records that require supportive documentation or attachments, e.g., consent forms. Note: COB claims can be filed electronically.
- Medical records to support billing miscellaneous codes.
- Claims for services that are reimbursed based on purchase price e.g., custom DME, prosthetics. The provider is required to submit the invoice with the claim.
- Claims for services requiring clinical review, e.g., complicated, or unusual procedure. The provider is required to submit medical records with the claim.
- Claim for services requiring documentation and a Certificate of Medical Necessity, e.g., oxygen, motorized wheelchairs.

Paper Claim Submission

The mailing address for first time claims (Medical and Behavioral Health), claim disputes/appeals, corrected claims, and requests for reconsideration:

Ambetter from Superior HealthPlan
Attn: Level I - Request for Reconsideration
PO Box 5010
Farmington, MO 63640-5010

Ambetter from Superior HealthPlan
Attn: Level II – Claim Dispute
PO Box 5010
Farmington, MO 63640-5010

Ambetter encourages all providers to submit claims electronically. The Companion Guides for electronic billing are available on our websites. Paper submissions are subject to the same edits as electronic and web submissions.

All paper claims sent to the claim's office must first pass specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected. If a paper claim has been rejected, the provider should correct the error and resubmit the paper claim as an original claim. If the paper claim passes the specific edits and is denied after acceptance, the provider should submit the denial letter with the corrected claim.

Acceptable Forms

Ambetter only accepts the CMS 1500 (02/12) and CMS 1450 (UB-04) paper claim forms. Other claim form types will be upfront rejected and returned to the provider.

Professional providers and medical suppliers complete the CMS 1500 (02/12) Claim Form and institutional providers complete the CMS 1450 (UB-04) Claim Form. Ambetter does not supply claim forms to providers. Providers should purchase these from a supplier of their choice. All paper claim forms must be typed with either 10- or 12-point Times New Roman font and on the required original red and white version to ensure clean acceptance and processing. Black and white forms, handwritten forms and nonstandard will be upfront rejected and returned to the provider. To reduce document handling time, do not use highlights, italics, bold text, or staples for multiple page submissions. If you have questions regarding what type of form to complete, contact Provider Services.

Important Steps to Successful Submission of Paper Claims

1. Providers must file claims using standard claims forms (CMS 1450 (UB-04) for hospitals and facilities; CMS 1500 for physicians or practitioners).
2. Complete all required fields on an original, red CMS 1500 (Version 02/12) or CMS 1450 (UB-04) Claim Form. NOTE: Non-red, nonstandard, and handwritten claim forms will be rejected back to the provider.
3. Enter the provider's NPI number in the "Rendering Provider ID#" section of the CMS 1500 form (see box 24J).
4. Providers must include their taxonomy code (e.g., 207Q00000X for Family Practice) and corresponding ID qualifier in this section for correct processing of claims.
5. Ensure all Diagnosis Codes, Procedure Codes, Modifier, Location (Place of Service); Type of Bill, Type of Admission, and Source of Admission Codes are valid for the date of service. Refer to Ambetter Taxonomy (PDF) located on our website at www.AmbetterHealth.com/en/tx
6. Ensure all Diagnosis and Procedure Codes are appropriate for the age of sex of the member.

7. Ensure all Diagnosis Codes are coded to their highest number of digits available.
8. Ensure member is eligible for services during the time in which services were provided.
9. Ensure provider receives authorization to provide services to the eligible member, when appropriate.
10. The provider's billing CLIA services on a CMS 1500 paper form must enter the CLIA number in Box 23 of the CMS 1500 form.
11. Ensure all paper claim forms are typed or printed with either 10- or 12-point Times New Roman font. Do not use highlights, italics, bold text, ink stamps, or staples for multiple page submissions.
12. Ensure print is properly aligned on the form. Ambetter utilizes OCR software to convert paper forms to EDI transactions and improperly aligned information may not process correctly and result in a rejected claim.

Claims missing the necessary requirements are not considered "clean claims" and will be returned to providers with a written notice describing the reason for return.

Claims Reconsiderations

A request for reconsideration of the claim can be initiated by a provider. If initiated by the provider, the reconsideration request may be submitted orally or in writing and must be received within 120 Days of the original adjudication of the claim.

- Oral request - No additional information or documentation is required from the provider to re-adjudicate the claim.
- Written request - Additional information/documentation is required to support the reconsideration (adjustment) request. – These may be submitted on paper or electronically through the secure provider portal.
- If submitted on paper, the provider must submit the Reconsideration Request Form with the applicable documentation (See Claim Reconsideration Form, found in the Attachment section.) Examples of reconsideration requests that require written request include:
    - Claims denied for other insurance, primary Payer Explanation of Payment required.
    - Claims denied for invoice required.
    - Claims denied for itemized bill required.
    - Claims denied as result of billing an unlisted procedure code.
    - Claims denied administratively, requesting medical records to substantiate payment (Not related to medical necessity denial/appeal.)

The required documentation must be submitted along with the Claim Reconsideration Request Form, found in the Attachments section, within 120 Days of the deficient claim denial

Corrected Claims

Providers must submit a corrected claim when changes are needed to a previously submitted initial claim that has been paid. If a claim was partially paid due to an error in the original submission, or the provider identifies a necessary correction to the previously paid claim to accurately reflect services rendered and all diagnoses, the provider must revise the relevant section and submit a corrected claim. This process applies only to previously paid or partially paid claims. Denied or rejected claims must be fixed and submitted as new claims. All requests for corrected claims must be received within 120 days from the date of the original Explanation of Payment. Corrected claims received outside of the timely filing window will deny for timely filing unless a qualifying circumstance is offered, and appropriate documentation is provided to support the qualifying circumstance via Claim Reconsideration or Claim Dispute process. Qualifying circumstances include:

- A catastrophic event that substantially interferes with normal business operation of the provider, or damage or destruction of the provider's business office or records by a natural disaster, mechanical and administrative delays, and errors by Ambetter or the federal and/or state regulatory body.
- The provider was unaware that the member was eligible for services at the time they were rendered. Consideration is granted in this situation only if all the following conditions are met:
    - The provider's records document that the member refused or was physically unable to provide their ID card or information.
    - The provider can substantiate that they continually pursued reimbursement from the patient until eligibility was discovered.
    - The provider has not filed a claim for this member prior to the filing of the claim under review.

Corrected Claims

A provider is changing the original claim that has paid.

Corrected claims must clearly indicate they are corrected in one of the following ways:

- Submission of a corrected claim via Availity or the secure provider portal. Follow the instructions on the portal/Availity for submitting a correction.
- Submission of a corrected claim electronically via a clearinghouse.
    - Institutional Claims (UB): Field CLM05-3=7 and Ref*8 = Original Claim Number
    - Professional Claims (CMS): Field CLM05-3=7 and REF*8 = Original Claim Number
- Submission of a corrected paper claim to:

Ambetter
Attn: Corrected Claims
P.O. Box 5010
Farmington, MO 63640-5010

- For submission of corrected paper claims, the original claim number must be typed in field 22 (CMS 1500) or in field 64 CMS 1450 (UB-04) with the corresponding frequency codes in field 22 of the CMS 1500 and in field 4 of the CMS 1450 (UB-04) form.
- Corrected paper claims must be submitted on standard red and white forms. Handwritten corrected claims will be upfront rejected.
- Once a corrected claim has been processed, any claim reconsideration or claim dispute regarding the service must reference the corrected claim number.
- Important: Claims submitted without the required resubmission indicators and original claim number will be treated as new submissions and may be denied as duplicates.

Requests for Reconsideration or Claim Disputes

All requests for reconsiderations or claim disputes must be received within 120 days from the date of the original Explanation of Payment or denial. Prior processing will be upheld for provider requests for reconsideration or disputes/appeals received outside the 120 day timeframe, unless a qualifying circumstance is offered and appropriate documentation is provided to support it. Qualifying circumstances include:

- A catastrophic event that substantially interferes with normal business operation of the provider, damage or destruction of the provider's business office or records by a natural disaster, mechanical and administrative delays, or errors by Ambetter or the federal and/or state regulatory body.
- The provider was unaware that the member was eligible for services at the time they were rendered. Consideration is granted in this situation only if all the following conditions are met:
- The provider's records document that the member refused or was physically unable to provide their ID Card or information.
- The provider can substantiate that they continually pursued reimbursement from the patient until eligibility was discovered.
- The provider has not filed a claim for this member prior to the filing of the claim under review.

Request for Reconsideration

A request for reconsideration is a communication from the provider expressing disagreement with the way a claim was processed. Generally, medical records are not required for a request for reconsideration. However, if the request for reconsideration concerns a code audit, code edit, or authorization denial, medical records **must accompany** the request. If the medical records are not received, the original denial will be upheld.

Reconsiderations may be submitted in the following ways:

- Providers may submit a request for reconsideration via the secure provider portal (preferred method).

- Providers may elect to call Provider Services. This method is for requests that do not require the submission of supporting or additional information. An example of this is when a provider believes a particular service should be reimbursed at a particular rate, but the payment amount does not reflect that rate.

Providers may submit a request for reconsideration using the Reconsideration and Claim Dispute form found at www.ambetterhealth.com/en/tx/.

- Providers may send a written letter that includes a detailed description of the reason for the request. To ensure timely processing, the letter must contain sufficient identifying information, including, at a minimum, the member's name, member ID number, date of service, total charges, provider name, original EOP, and/or the claim.

It is not necessary to attach a copy of the submitted claim.

Written requests for reconsideration and any applicable attachments may be mailed or faxed to:

Ambetter
Attn: Request for Reconsideration
P.O. Box 5010
Farmington, MO 63640-5010

When the request for reconsideration results in an overturn of the original decision, the provider will receive a revised EOP.

Claim Dispute

A provider disagrees with the outcome of the request for reconsideration.

A claim dispute/claim appeal should be used only when a provider has received an unsatisfactory response to a request for reconsideration. If a dispute form is submitted and a reconsideration request is not located in our system, this will be considered a reconsideration and treated as outlined above.

A claim dispute/appeal must be submitted on a Reconsideration and Claim Dispute form which can be found on Ambetter's website. The Claim Dispute form must be completed in its entirety. The completed form can be submitted as an attachment through the secure provider portal's Claim Dispute function, or sent by mail or fax to:

Ambetter
Attn: Claim Dispute
P.O. Box 5010
Farmington, MO 63640-5010

A claim dispute/appeal will be resolved within 60 calendar days. The provider will receive a written letter detailing the decision to overturn or uphold the original decision. If the original decision is upheld, the letter will include the rationale for upholding the decision. Disputed claims are resolved to a paid or denied status in accordance with state law and regulation.

Electronic Funds Transfers (EFT) and Electronic Remittance Advices (ERA)

Ambetter partners with specific vendors to provide an innovative web-based solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs). This service is provided at no cost to providers and allows online enrollment. Providers can enroll after they have received their completed contract or submitted a claim. Please visit our website for information about EFT and ERA or contact Provider Services.

Benefits include:

- Elimination of paper checks - all deposits transmit via EFT to the designated bank account.
- Convenient payments & remittance information retrieval.
- Electronic remittance advices presented online.
- HIPAA 835 electronic remittance files for downloading directly to a HIPAA-Compliant Practice Management for Patient Accounting System.
- Reduced accounting expenses – Electronic remittance advices can be imported directly into practice management or patient accounting systems, eliminating the need for manual re-keying.
- Improved cash flow – Electronic payments can mean faster payments, leading to improvements in cash flow.
- Maintain control over bank accounts - You keep total control over the destination of claim payment funds. Multiple practices and accounts are supported.
- Match payments to advices quickly – You can associate electronic payments with electronic remittance advices quickly and easily.
- Manage multiple Payers – Reuse enrollment information to connect with multiple payers and assign to different payers to different bank accounts as desired.

For more information, please visit our provider home page on our website at www.AmbetterHealth.com/en/tx. If further assistance is needed, please contact Ambetter at **1-877-687-1196 (Relay Texas/TTY 1-800-735-2989)** or Ambetter Health (Solutions) at **1-833-543-3145 (TTY:711)**.

RISK ADJUSTMENT & CORRECT CODING

Risk adjustment is a critical element of the Affordable Care Act (ACA) that will help ensure the long-term success of the Health Insurance Marketplace. Accurate risk adjustment calculation requires accuracy and specificity in diagnostic coding. Providers should, always, document and code according to CMS regulations and follow all applicable coding guidelines for ICD-10-CM, CPT, and HCPCs code sets. Providers should note the following guidelines:

- Code all diagnoses to the highest level of specificity, which means assigning the most precise ICD code that most fully explains the narrative description in the medical chart of the symptom or diagnosis;
- Ensure medical record documentation is clear, concise, consistent, complete, legible, and meets CMS signature guidelines (each encounter must stand alone);
- Submit claims and encounter information in a timely manner;
- Alert Ambetter of any erroneous data submitted and follow Ambetter's policies to correct errors in a timely manner;
- Provide medical records as requested in a timely manner; and
- Provide ongoing training to their staff regarding appropriate use of ICD coding for reporting diagnoses.

Accurate and thorough diagnosis coding is imperative to Ambetter's ability to manage members, comply with Risk Adjustment Data Validation audit requirements, and effectively offer a Marketplace product. Claims submitted with inaccurate or incomplete data will often require retrospective chart review.

Coding of Claims/ Billing Codes

Ambetter requires claims to be submitted using codes from the current version of ICD-10-CM, ASA, DRG, CPT, and HCPCS Level II for the date the service was rendered. These requirements may be amended to comply with federal and state regulations, as necessary. Below are some code-related reasons a claim may reject or deny:

- The billed code is missing, invalid, or deleted at the time of services.
- Code is inappropriate for the age of the member.
- Diagnosis code is missing digits.
- Procedure code is pointing to a diagnosis that is not appropriate to be billed as primary.
- Code billed is inappropriate for the location or specialty billed.
- Code billed is a part of a more comprehensive code billed on same date of service.
- Written descriptions, itemized statements, and invoices may be required for non-specific types of claims or at the request of Ambetter.

Newborn services provided in the hospital will be reimbursed separately from the mother's hospital stay. Submit separate claims for the mother and newborn(s).

Billing from independent provider-based Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) for covered RHC/FQHC services furnished to members should be made with specificity regarding diagnosis codes and procedure code/modifier combinations.

Code all documented conditions that coexist at the time of the encounter/visit and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

For more information regarding billing codes, coding, and code auditing/editing, please contact Ambetter Provider Services or visit www.AmbetterHealth.com/en/tx. The clinical and payment policies are located under the "Provider Resources" link.

Clinical Lab Improvement Act (CLIA) Billing Instructions

CLIA numbers are required for CMS 1500 claims where CLIA Certified or CLIA waived services are billed. If the CLIA number is not present, the claim will be upfront rejected. Below are billing instructions on how and/or where to provide the CLIA certification or waiver number on the following claim type submissions:

Paper Claims

If a particular claim has services requiring an authorization number and CLIA services, only the CLIA number must be provided in Box 23.

*Note

An independent clinical laboratory that elects to file a paper claim form shall file Form CMS 1500 for a referred laboratory service (as it would be for any laboratory service). The line-item services must be submitted with modifier 90. An independent clinical laboratory that submits claims in paper format may not combine non-referred (i.e., self-performed) and referred services on the same CMS 1500 claim form. When the referring laboratory bills for both non-referred and referred tests, it shall submit two separate claims, one claim for non-referred tests, the other for referred tests. If billing for services that have been referred to more than one laboratory, the referring laboratory shall submit a separate claim for each laboratory to which services were referred (unless one or more of the reference laboratories are separately billing). When the referring laboratory is the billing laboratory, the reference laboratory's name, address, and ZIP Code shall be reported in item 32 on the CMS 1500 claim form to show where the service (test) was performed. The NPI shall be reported in item 32a. Also, the CLIA certification or waiver number of the reference laboratory shall be reported in item 23 on the CMS 1500 claim form.

EDI

If a single claim is submitted for those laboratory services for which CLIA certification or waiver is required, report the CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2300, REF02. REF01 = X4;

-Or-

If a claim is submitted with both laboratory services for which CLIA certification or waiver is required and non-CLIA covered laboratory test, in the 2400 loop for the appropriate line report the CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2400, REF02. REF01 = X4.

*Note

The billing laboratory submits, on the same claim, tests referred to another (referral/rendered) laboratory, with modifier 90 reported on the line item and reports the referral laboratory's CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2400, REF02. REF01 = X4.

Please refer to the 5010 implementation guides for the appropriate loops to enter the CLIA number. If a particular claim has services requiring an authorization number and CLIA services, only the CLIA number must be provided.

Web

Complete Box 23 with CLIA certification or waiver number as the prior authorization number for those laboratory services for which CLIA certification or waiver is required.

Taxonomy Code Billing Requirement

Taxonomy numbers are required for all Ambetter claims. Claims submitted without taxonomy numbers will be upfront rejected with an EDI Reject Code of 91. If the claim was submitted on paper, a rejection letter will be returned indicating that the taxonomy code was missing.

The verbiage associated with Reject 91 is as follows: Invalid or Missing Taxonomy Code. Please contact Provider Services to resolve this issue.

Claim Reconsiderations Related To Code Editing and Editing

Claims reconsiderations resulting from claim-editing are handled per the provider's claims dispute process outlined in this manual. When submitting claims reconsiderations, please submit medical records, invoices, and all related information to assist with the appeals review.

If you disagree with a code edit and request claim reconsideration, you must submit medical documentation (medical records) related to the reconsideration. If medical documentation is not received, the original code-edit(s) will be upheld.

CODE EDITING

Ambetter uses HIPAA-compliant code auditing software to improve accuracy and efficiency in claims processing, payment, and reporting. The software detects and documents coding errors on provider claims prior to payment by analyzing CPT, HCPCS, ICD-10, modifier, and place of service codes against correct coding guidelines. While code auditing software is a useful tool to ensure provider compliance with correct coding, it will not wholly evaluate all clinical patient scenarios. Consequently, Ambetter uses clinical validation by a team of experienced nursing and coding experts to further identify claims for potential billing errors. Clinical validation allows for consideration of exceptions to correct coding principles and may identify where additional reimbursement is warranted. Ambetter may have policies that differ from correct coding principles. Accordingly, exceptions to general correct coding principles may be required to ensure adherence to health plan policies and to facilitate accurate claims reimbursement.

Ambetter may request medical records or other documentation to verify that all procedures and/or services billed are properly supported in accordance with the correct coding guidelines.

CPT and HCPCS Coding

The Healthcare Common Procedure Coding System (HCPCS) is a standardized coding system used to report medical procedures, supplies, products, and services for claims processing and consists of two levels of coding. HCPCS Level I is the Current Procedural Terminology (CPT) code set maintained by the American Medical Association (AMA), and HCPCS Level II is maintained by CMS.

Level I HCPCS codes are based on the AMA's CPT code set. CPT codes are five-digit numeric codes used to report medical procedures and services and are updated annually through additions, revisions, and deletions.

Level II HCPCS codes are used to report supplies, products, and services not included in CPT, such as durable medical equipment, orthotics, prosthetics, ambulance services, and certain drugs and supplies. Level II is an alphanumeric coding system maintained by CMS and updated through established coding cycles.

Miscellaneous or unlisted codes may be used when no existing CPT or HCPCS code accurately describes the service, supply, or procedure billed. Claims submitted with miscellaneous or unlisted codes may be subject to manual review. To support that review, providers may be required to submit medical records and any applicable pricing or supporting documentation with the initial claim submission. The documentation should clearly describe the service or procedure performed and may include office notes, operative reports, pathology reports, invoices, or other relevant records. Once received, the documentation may be reviewed to determine whether a more specific code more accurately describes the service or procedure rendered and whether related services are integral to the primary procedure.

Temporary national codes are part of the Level II HCPCS coding system and may be used to report services or items when no permanent national code exists. These codes are temporary and may be

replaced when a permanent code is established. Examples may include certain G, Q, K, S, H, and T code ranges.

Modifiers provide additional information about the CPT or HCPCS code billed and may be required to describe special circumstances affecting the reported service. For example, modifier -25 may be appended to an evaluation and management service to indicate that a significant, separately identifiable E/M service was provided on the same day as another procedure or service.

International Classification of Diseases (ICD-10)

ICD-10 is an alphanumeric system used by providers to classify diagnoses and symptoms. These codes consist of three to seven digits, which allows for a high level of specificity in coding a wide range of health problems.

Revenue Codes

These 4-digit numeric codes are utilized by institutional providers to represent services, procedures, and/or supplies provided in a hospital or facility setting. Claims submitted with revenue codes should indicate a corresponding procedure code.

Edit Sources

The claims editing software contains a comprehensive set of rules addressing coding inaccuracies such as unbundling, frequency limitations, fragmentation, up coding, duplication, invalid codes, mutually exclusive procedures, and other coding inconsistencies. Each rule is linked to a generally accepted coding principle. Guidance surrounding the most likely clinical scenario is applied. This information is provided by clinical consultants, health plan medical directors, current research, etc.

- The following sources are utilized in determining correct coding guidelines for the software: Centers for Medicare & Medicaid Services (including National Correct Coding Initiative (NCCI) Policy Manual and Claims Processing Manual guidelines as well as current PTP and MUE tables).
- American Medical Association (CPT, HCPCS, and ICD-10 guidelines and publications including CPT manual, AMA website, CPT Assistant, CPT Insider's View, etc.).
- Public domain specialty provider associations (such as American College of Surgeons, American College of Radiology, American Academy of Orthopedic Surgeons, American College of Obstetricians and Gynecologists, etc.).
- State provider manuals, fee schedules, periodic provider updates (bulletins/transmittals).
- CMS coding resources such as National Physician Fee Schedule, Provider Benefit Manual, MLN Matters and Provider Transmittals.
- Health Plan policies and provider contract considerations.
- In addition to nationally recognized coding guidelines, the software has flexibility to allow business rules that are unique to the needs of individual product lines.

Code Editing and the Claims Adjudication Cycle

Code editing is the final step in the claims adjudication process. Once a claim has completed all previous adjudication steps (such as benefits and member/provider eligibility review), the claim is ready for analysis.

As a claim progresses through the code editing cycle, each service line on the claim is processed through the code editing rules engine and evaluated for correct coding. As part of this evaluation, the prospective claim is analyzed against other codes billed on the same claim as well as previously paid claims found in the member/provider history.

Depending upon the code edit applied, the software will make the following recommendations:

- Deny: Code editing rule recommends the denial of a claim line. The appropriate explanation code is documented on the provider's explanation of payment along with reconsideration/appeal instructions.
- Pend: Code editing recommends that the service line pend for clinical review and validation. This review may result in a pay or deny recommendation. The decision is documented on the provider's explanation of payment along with reconsideration/appeal instructions.
- Replace and Pay: Code editing recommends the denial of a service line, and a new line is added and paid. In this scenario, the original service line is left unchanged on the claim and a new line is added to reflect the software recommendations. For example, an incorrect CPT code is billed for the member's age. The software will deny the original service line billed by the provider and add a new service line with the correct CPT code, resulting in a paid service line. This action does not alter or change the provider's billing, as the original billing remains on the claim.

Code Editing Principles

The below principles do not represent an all-inclusive list of code editing principles, but rather an area sampling of edits which are applied to physician and/or outpatient facility claims.

PTP Practitioner and Hospital Edits

CMS has designated certain combinations of codes that are generally not separately reimbursable on the same date of service. These are known as Procedure-to-Procedure (PTP) and/or Column 1/Column II edits. Within the PTP edit category, there are Practitioner edits (applicable to claims submitted by physicians, non-physician practitioners, and ambulatory surgical centers) and Hospital edits (applicable to hospitals, skilled nursing facilities, home health agencies, outpatient physical therapy, speech-language pathology, and comprehensive outpatient rehabilitation facilities).

The procedure code listed in column I is the most comprehensive code; reimbursement for the column II code is subsumed into the payment for the comprehensive code. The column II code is considered an integral component to the successful outcome of the column I code.

While these code pairs should not be billed together under most circumstances, there are circumstances when an NCCI-associated modifier may be appended to the column II code to indicate a significant and separately identifiable or distinct service. When these modifiers are used,

prepay clinical validation will be performed to ensure that services are reported appropriately. For more information on the PTP edits, please visit www.cms.gov.

Medically Unlikely Edits for Practitioners, DME Providers and Facilities

Medically Unlikely Edits, MUE, is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. These edits are based on CPT/HCPCS code descriptions, anatomic specifications, nature of the service/procedure, nature of the analyte, equipment prescribing information and clinical judgment. Not all HCPCS/CPT codes have a MUE limit.

Code Bundling Rules Not Sourced To CMS

Many specialty medical organizations and health advisory committees have developed rules around how codes should be used in their area of expertise. These rules are published and are available for use by the public domain. Procedure code definitions and relative value units are considered when developing these code sets. Rules are specifically designed for professional and outpatient facility claims editing.

Procedure Code Unbundling

Two or more procedure codes are used to report a service when a single, more comprehensive code should have been used. The less comprehensive code will be denied.

Mutually Exclusive Editing

These are combinations of procedure codes that may differ in technique or approach but result in the same outcome. The procedures may be impossible to perform together anatomically. Procedure codes may also be considered mutually exclusive when an initial or subsequent service is billed on the same date of service. The procedure with the highest RVU is considered the reimbursable code.

Incidental Procedures

These are procedure code combinations that are considered clinically integral to the successful completion of the primary procedure and should not be billed separately.

Global Surgical Period Editing/Medical Visit Editing

CMS publishes rules surrounding payment of an evaluation and management service during the global surgical period of a procedure. The global surgery data is taken from the CMS Medicare Fee Schedule Database (MFSDB).

Procedures are assigned a 0, 10 or 90-day global surgical period. Procedures assigned a 90-day global surgical period are designated as major procedures. Procedures assigned a 0- or 10-day global surgical period are designated as minor procedures.

Evaluation and Management services for a major procedure (90-day period) that are reported 1-day preoperatively, on the same date of service or during the 90-day post-operative period are not recommended for separate reimbursement.

Evaluation and Management services that are reported with minor surgical procedures on the same date of service or during the 10-day global surgical period are not recommended for separate reimbursement.

Evaluation and Management services for established patients that are reported with surgical procedures that have a 0-day global surgical period are not recommended for reimbursement on the same day of surgery because there is an inherent evaluation and management service included in all surgical procedures.

Global Maternity Editing

Procedures with "MMM"

Global periods for maternity services are classified as "MMM," Evaluation and management services billed during the antepartum period (270 days), on the same date of service or during the postpartum period (45 days) are not recommended for separate reimbursement if the procedure code includes antepartum and postpartum care.

Diagnostic Services Bundled to the Inpatient Admission (3-Day Payment Window)

This rule identifies outpatient diagnostic services that are provided to a member within three days prior to and including the date of an inpatient admission. When these services are billed by the same admitting facility or an entity wholly owned or operated by the admitting facility, they are considered bundled into the inpatient admission and therefore are not separately reimbursable.

Multiple Code Rebundling

This rule analyzes instances in which a provider billed two or more procedure codes when a single more comprehensive code should have been billed to represent all the services performed.

Frequency and Lifetime Edits

The CPT and HCPCS manuals define the number of times a single code can be reported. Some codes are allowed a limited number of times on a single date of service, over a given period or during a member's lifetime. State fee schedules also delineate the number of times a procedure can be billed over a given period or during a member's lifetime. A frequency edit is applied by code editing software when the procedure code is billed more than these guidelines.

Duplicate Edits

The code editing software evaluates prospective claims to determine if there is a previously paid claim for the same member and provider in history that is a duplicate to the prospective claim. The software also looks across different providers to determine if another provider was paid for the same procedure, for the same member on the same date of service. Finally, the software analyzes multiple services within the same range of services performed on the same day. For example, a nurse practitioner and physician billing for office visits for the same member on the same date of service.

National Coverage Determination Edits

CMS establishes guidelines that identify whether some medical items, services, treatments, diagnostic services, or technologies can be paid under Medicare. These rules evaluate diagnosis to procedure code combinations.

Anesthesia Edits

This rule identifies anesthesia services that have been billed with a surgical procedure code instead of an anesthesia procedure code.

Invalid Revenue to Procedure Code Editing

Identifies revenue codes billed with incorrect CPT codes.

Assistant Surgeon

Rule evaluates claims billed with an assistant surgeon that normally do not require the attendance of an assistant surgeon. Modifiers are reviewed as part of the claims analysis.

Co-Surgeon/Team Surgeon Edits

Evaluates claims billed with a co-surgeon or team surgeon that normally does not require a co-surgeon/team surgeon. CMS guidelines define whether an assistant, co-surgeon or team surgeon is reimbursable and the percentage of the surgeon's fee that can be paid to the assistant, co-operating room team surgeon.

Add-on and Base Code Edits

This rule analyzes claims in which an add-on CPT code was billed without the primary service CPT code. Additionally, add-on codes are denied if the primary service code was denied. This rule also looks for circumstances where the primary code was billed in a quantity greater than one, when an add-on code should have been used to describe the additional services rendered.

Bilateral Edits

This rule looks for claims in which the modifier -50 has been billed, but the same procedure code is submitted on a different service line on the same date of service without modifier -50. This rule is highly customized, as many health plans allow this type of billing.

Replacement Edits

These rules recommend that single service lines or multiple service lines are denied and replaced with a more appropriate code. For example, a provider bills more than one outpatient consultation code for the same member in the member's history. This rule will deny the office consultation code and replace it with the appropriate evaluation and management service, established patient or subsequent hospital care code. Another example of the rule's function is when a provider has billed a new patient evaluation and management code within three years of a previous new patient visit. This rule will replace the second submission with the appropriate established patient visit. A crosswalk is used to determine the appropriate code to add.

Missing Modifier Edits

This rule analyzes service lines to determine if a modifier should have been reported but was omitted. For example, professional providers would not typically bill the global (technical and professional) component of a service when performed in a facility setting. The technical component is typically performed by the facility and not the physician.

Inpatient Facility Claim Editing

Potentially Preventable Readmissions Edit

This edit identifies readmissions within a specified time interval that may be clinically related to previous admission. For example, subsequent admission may be plausibly related to the care rendered during or immediately following a prior hospital admission in the case of readmission for a surgical wound infection or lack of postoperative follow up. Admissions to non-acute care facilities (such as skilled nursing facilities) are not considered readmissions and not considered for reimbursement. CMS determines the readmission time interval as 30 days; however, this rule is highly customizable by state rules and provider contracts.

Administrative and Consistency Rules

These rules are not based on clinical content and serve to validate code sets and other data billed on the claim. These types of rules do not interact with historically paid claims or other service lines on the prospective claim. Examples include, but are not limited to:

- Procedure code invalid rules: Evaluates claims for invalid procedure and revenue or diagnosis codes.
- Deleted Codes: Evaluates claims for procedure codes which have been deleted.
- Modifier to procedure code validation: Identifies invalid modifier to procedure code combinations. This rule analyzes modifiers affecting payment. As an example, modifiers such as -24, -25, -26, -57, -58 and -59.
- Age Rules: Identifies procedures inconsistent with member's age.
- Gender Procedure: Identifies procedures inconsistent with member's gender.
- Gender Diagnosis: Identifies diagnosis codes inconsistent with member's gender.
- Incomplete/invalid diagnosis codes: Identifies incomplete or invalid diagnosis codes.

Prepayment Clinical Validation

Clinical validation is intended to identify coding scenarios that historically result in a higher incidence of improper payments. An example of Ambetter's clinical validation services is the review of modifiers -25 and -59. Within the CMS NCCI PTP edit tables, some code pairs allow an NCCI-associated modifier to be appended when the have a correct coding modifier indicator is "1". Furthermore, public-domain specialty organization edits may also be considered for override when billed with these modifiers. When these modifiers are billed, the provider's documentation should support a separately reimbursable service. Some examples of separately identifiable services include a different session,

site or organ system, surgery, incision/excision, lesion, or separate injury. Ambetter's clinical validation team uses the information on the prospective claim and claims history to determine whether it is likely that a modifier was used correctly based on the unique clinical scenario for a member on a given date of service.

The Centers for Medicare and Medicaid Services (CMS) supports this type of prepayment review. The clinical validation team uses nationally published guidelines from CPT and CMS to determine if a modifier was used correctly.

Modifier -59

The NCCI (National Correct Coding Initiative) states that the primary purpose of modifier -59 is to indicate that procedures or non-E/M services that are not usually reported together are appropriate for separate reimbursement under the circumstances. The CPT Manual defines modifier -59 as follows: "Modifier -59: Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, which are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.

Some providers routinely assign modifier 59 when billing a combination of codes that will result in a denial due to unbundling. Modifier -59 is commonly misused as related to the portion of the definition that allows its use to describe "different procedure or surgery". NCCI guidelines state that providers should not use modifier -59 solely because two different procedures/surgeries are performed or because the CPT codes are different procedures. Modifier -59 should only be used if the two procedures/surgeries are performed at separate anatomic sites, at separate patient encounters or by different practitioners on the same date of service. NCCI defines different anatomic sites to include different organs or different lesions in the same organ. However, it does not include treatment of contiguous structures of the same organ.

Ambetter uses the following guidelines to determine if modifier -59 was used correctly:

- The diagnosis codes or clinical scenario on the claim indicate multiple conditions or sites were treated or are likely to be treated;
- Claim history for the patient indicates that diagnostic testing was performed on multiple body sites or areas which would result in procedures being performed on multiple body areas and sites.
- Claim history supports that each procedure was performed by a different practitioner or during different encounters or those unusual circumstances are present that support modifier 59 were used appropriately.

To avoid incorrect denials, providers should assign to the claim all applicable diagnosis and procedure codes used, and all applicable anatomical modifiers designating which areas of the body were treated.

Modifier -25

Both CPT and CMS in the NCCI policy manual specify that by using a modifier 25 the provider is indicating that a "significant, separately identifiable evaluation and management service was provided by the same physician on the same day of the procedure or other service". Additional CPT guidelines state that the evaluation and management service must be significant and separate from other services provided or above and beyond the usual pre-, intra-, and postoperative care associated with the procedure that was performed.

The NCCI policy manual states that "If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. (Osteopathic manipulative therapy and chiropractic manipulative therapy have global periods of 000.) The decision to perform a minor surgical procedure is included in the value of the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI does contain some edits based on these principles, but the Medicare Carriers and A/B MACs processing practitioner service claims have separate edits.

Ambetter uses the following guidelines to determine whether modifier -25 was used appropriately. If any one of the following conditions is met, the clinical nurse reviewer will recommend reimbursement for the E/M service.

- The E/M service is the first time the provider has seen the patient or evaluated a major condition
- A diagnosis on the claim indicates that a separate medical condition was treated in addition to the procedure that was performed
- The patient's condition is worsening as evidenced by diagnostic procedures being performed on or around the date of services
- Other procedures or services performed for a member on or around the same date of the procedure support that an E/M service would have been required to determine the member's need for additional services.
- To avoid incorrect denials, providers should assign all applicable diagnosis codes that support additional E/M services.

Code Editing Assistant

A web-based code editing reference tool designed to "mirror" how code editing products evaluate code and code combinations during the editing of claims. The tool is available for providers who are registered on the Secure Provider Portal. You can access the tool in the Claims Module by clicking "Claim Editing Tool" in the Secure Provider Portal.

- Prospectively access the appropriate coding and support clinical edit clarifications for services *before* claims are submitted.

- Proactively determine the appropriate code/code combination representing the service to ensure accurate billing.

The tool reviews the codes entered to determine if the code or code combinations are correct based on the age, sex, location, modifier (if applicable), or other code(s) entered.

The Code Editing Assistant is intended for use as a "what if" or hypothetical reference tool. It is meant to apply coding logic only. The tool does not take into consideration historical claims information which may be used to determine if an edit is appropriate.

The code editing assistant can be accessed from the Secure Provider Portal.

Disclaimer: This tool is used to apply coding logic *only*. It will not consider individual fee schedule reimbursement, authorization requirements, or other coverage considerations. Whether a code is reimbursable or covered is separate and outside of the intended use of this tool.

Automated Clinical Payment Policy Edits

Clinical payment policy edits are developed to increase claims processing effectiveness, to decrease the administrative burden of prior authorization, to better ensure payment of only correctly coded and medically necessary claims, and to provide transparency to providers. The purpose of these policies is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. These policies may be documented as a medical policy or pharmacy policy.

Clinical payment policies are implemented through prepayment claims edits applied within our claims adjudication system.

Clinical medical policies can be identified by an alpha-numeric sequence such as CP.MP.xxx in the reference number of the policy. Clinical pharmacy policies can be identified by an alpha-numeric sequence such as CP.PHAR.xxx, HIM.PA.xxx, and CP.PMN.xxx in the reference number of the policy.

Most clinical payment policy edits are applied when a procedure code (CPT/HCPCS) is billed with a diagnosis (es) that does not support medical necessity as defined by the policy. When this occurs, the following explanation (EX) code is applied to the service line billed with the disallowed procedure. This EX-code can be viewed on the provider's explanation of payment.

Some clinical payment policy edits may also occur as the result of a single code denial for a service that is not supported by medical necessity. When this occurs, the EX-code applied to the service line billed with the disallowed procedure contains a description like *"Service denied according to a payment or coverage policy"*. This can also be viewed on the provider's explanation of payment.

Claim Reconsiderations: Code Editing and Clinical/Payment Policies

Reconsiderations resulting from claim editing are handled per the provider claims dispute process outlined in this manual. When submitting claims for reconsideration, please submit medical records, invoices, and all related information to assist with the review. Clinical policy denials may be appealed based on medical necessity if a provider disagrees with a denial and believes that the service rendered was medically necessary and clinically appropriate.

If you disagree with a correct coding or clinical/payment policy edit and request claim reconsideration, you must submit documentation (medical records) related to the reconsideration. If

medical documentation is not received, the original code edit will be upheld. The reconsideration/appeal may include information such as:

- Statement of why the service is medically necessary.
- Medical evidence which supports the proposed treatment.
- How the proposed treatment will prevent illness or disability.
- How the proposed treatment will alleviate physical, mental, or developmental effects of the patient's illness.
- How the proposed treatment will assist the patient to maintain functional capacity.
- A review of previous treatments and results, including, based on your clinical judgment, why a new approach is necessary.
- How the recommended service has been successful in other patients.

THIRD PARTY LIABILITY

Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer related, self-insured, self-funded, or commercial carrier, automobile insurance and worker's compensation) or program that is or may be liable to pay all or part of the health care expenses of the member.

If third party liability coverage is determined after services are rendered, Ambetter will coordinate with the applicable health insurance carrier to collect overpayment of claims paid by Ambetter in error. Ambetter may also pursue overpayment recovery from a provider if the payer responsible for the medical expense.

BILLING THE MEMBER

Covered Services

Ambetter providers are prohibited from billing the member for any covered services except for copayments, coinsurance, and deductibles. Copayments, coinsurance, and any unpaid portion of a deductible may be collected from the member at the time of service. If the amount collected from the member is higher than the actual amount owed upon claim adjudication, the provider must reimburse the member the overpaid amount within 45 days.

For members who are in a suspended status and seeking services from providers:

- Providers may advise the member that services may not be delivered because the member is in a suspended status. (Status must be verified through our Secure Provider Portal or by calling Provider Services. Providers should follow their internal policies and procedures regarding this situation.)
- Should a provider make the decision to render services, the provider may collect from the member. Providers must submit a claim to Ambetter.
- If the member subsequently pays their premium and is removed from a suspended status, claims will be adjudicated by Ambetter. The provider would then be responsible to reconcile the payment received from the member and the payment received from Ambetter. The provider may then bill the member for an underpayment or return to the member any overpayment.
- If the member does not pay their premium and is terminated from their Ambetter plan, providers may bill the member for their full billed charges.
- Non-participating providers may be limited by state or other regulations when balance billing members for amounts not considered to be copayments, coinsurance, or deductible.

Non-Covered Services

Contracted providers may only bill Ambetter members for non-covered services if the member and provider sign an agreement outlining the member's responsibility to pay prior to the services being rendered. The agreement must be specific to the services being rendered and clearly state:

- The specific service(s) to be provided
- A statement that the service is not covered by Ambetter
- A statement that the member chooses to receive and pay for the specific service
- The member is not obligated to pay for the service if it is later found that service was covered by Ambetter at the time it was provided, even if Ambetter did not pay the provider for the service because the provider did not comply with Ambetter requirements

Billing for “No-Shows”

Providers may bill the member a reasonable and customary fee for missing an appointment when the member does not call-in advance to cancel the appointment. The “no show” appointment must be documented in the medical record.

Failure to Obtain Authorization

Providers may not bill members for services when the provider fails to obtain an authorization, and the claim is denied by Ambetter.

No Balance Billing

Payments made by Ambetter to providers excluding any copays, coinsurance, or deductibles which are the financial responsibility of the member, will be considered payment in full. Providers may not seek payment from Ambetter members for the difference between the billed charges and the contracted rate paid by Ambetter.

COMPLAINTS AND APPEALS

Complaints

A complaint is a verbal or written expression by a member or provider which indicates dissatisfaction or dispute with Ambetter's policies, procedure, or any aspect of Ambetter's functions. Ambetter logs and tracks all complaints whether received verbally or in writing.

If the dissatisfaction is related to claim(s) payment, the provider must follow the process for claim reconsideration and claim dispute as noted in the Claims section of this Provider Manual prior to filing a complaint.

Provider Complaint Process

The provider can contact Provider Services with any questions or concerns. We will attempt to answer and address any issues during initial contact, as most incidents of dissatisfaction can be resolved with a phone call by clarifying any miscommunication or misunderstanding. If we are unable to resolve the issue, the provider may file a verbal complaint with Provider Services or send details of the complaint in writing.

The mailing address for Provider Complaints is:

Ambetter **from Superior HealthPlan**
Attn: Complaints Department
5900 E. Ben White Blvd.
Austin, TX 78741
Phone: 1-877-687-1196
Fax 1-866-683-5369
www.superiorhealthplan.com/contact-us/complaint-form-information.html

Complaints are acknowledged upon receipt and an approved acknowledgement letter is mailed by the Complaints Coordinator to the complainant no later than five (5) business days from date of receipt. The letter of acknowledgement provides a brief description of the substance of the complaint. The letter contains: the date of receipt of the complaint, a summary of the complaint and the timeframes for receipt and processing of the complaint.

A complaint resolution letter is prepared and mailed to the complainant no later than thirty (30) calendar days from the date of receipt of the complaint. The resolution letter includes the decision/resolution of the provider's complaint, the facts utilized to resolve the complaint, and the provider's right to pursue arbitration if the provider is not satisfied with the resolution of the complaint, as well as a provider's right to file a complaint with the Texas Department of Insurance if not satisfied with Ambetter's resolution.

Information on how to file a provider complaint with the Texas Department of Insurance can be found at www.tdi.texas.gov/hprovider/providercompl.html.

Appeals

An Appeal is the mechanism by which members or providers contest actions or decisions made by Ambetter including prior authorization denials, or if the member is aggrieved by any rule, policy, procedure, or other actions taken by Ambetter.

Expedited appeals may be filed with Ambetter if the member's provider determines that the time expended in a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. No punitive action will be taken against a provider that requests an expedited resolution or supports a member's appeal. In instances where the member's request for an expedited appeal is denied, we will send a written notice to let the member know the request will be downgraded to the standard appeal processing timeframe.

Provider Claim Appeal Process

Claim Appeal requests must follow the claim reconsideration and claim dispute process. Please refer to the instructions outlined under Request for Reconsideration and Claim Dispute sections of this Provider Manual. Providers can use the Claim Dispute form found on our website under Provider Resources to submit either request. If assistance accessing the form is required, a provider can contact Provider Services for support.

Claim reconsiderations and disputes should be mailed to:

Ambetter from Superior HealthPlan
Attn: Level I – Request for Reconsideration
P.O. Box 5010
Farmington, MO. 63640-5010

or

Ambetter from Superior HealthPlan
Attn: Levell II – Claim Dispute
P.O. Box 5010
Farmington, MO. 63640-5010

Medical necessity and authorization denials are handled through the Member Appeal process below. The provider may file a medical necessity or authorization denial appeal on behalf of the member. (Written consent may be required.).

Member Complaint Process

To ensure Ambetter member's rights are protected, all Ambetter members are entitled to a Complaint/Grievance and Appeals process. The procedures for filing a Complaint/Grievance are outlined in the Ambetter member's Evidence of Coverage.

If a member is dissatisfied with the health plan, the member's provider or any other aspect of the health care delivery through the health plan:

- The member should contact our Member Services Department at **1-877-687-1196 (Relay Texas/TTY 1-800-735-2989)** or **1-833-543-3145 (TTY 711)** for Solutions members. The Member Services representative will assist the member.

- If the member issue cannot be resolved by clearing up any miscommunication or misunderstanding, the member, may file a complaint. Our Member Services Department is available to assist with this process. Information regarding this process can be found at www.AmbetterHealth.com/en/tx or AmbetterHealth.com/memberforms for Solutions

members.

- The member will receive a complaint acknowledgement letter within 5 business days of receipt of the complaint, and a complaint response within 30 business days. If the member is not satisfied with the outcome of the complaint, a complaint appeal panel will be conducted at a location and format convenient for the member and completed within 30 days. Equal numbers of members, providers and health plan employees will attend the complaint appeal panel to make a recommendation for resolution of the member's complaint.

- A member may designate any person they choose as an authorized representative to act on their behalf in the complaint/grievance or appeal process in writing or by submitting a completed and signed Authorization of Representation (AOR) Form.

When multiple complaints are received related to a provider's quality of care, Ambetter may conduct a site review. Site reviews are performed to evaluate the following of a provider's office location or facility location:

- Physical accessibility.
- Physical appearance.
- Adequacy of waiting and examining room space.
- Adequacy of medical/treatment record keeping

Mailing Address and Fax Numbers for Member Complaints

Ambetter from Superior HealthPlan members:

Ambetter
Attn: Appeals and Grievances Department
5900 E. Ben White Blvd.
Austin, TX 78741
Fax: 1-866-683-5369

Solutions members:

Ambetter
Attn: Appeals and Grievances Department
PO Box 10341
Van Nuys, CA 91410-0341
Fax: 1-833-886-7956

Member Appeals Process

A member has 180 calendar days from Ambetter's notice of action to file the appeal. Ambetter shall acknowledge receipt of each appeal within five business days after receiving an appeal. Ambetter

shall resolve each appeal and provide written notice of the appeal resolution, as expeditiously as the member's health condition requires, but shall not exceed 30 calendar days from the date Ambetter receives the appeal.

Decisions for expedited appeals are issued as expeditiously as the member's health condition requires, not exceeding 72 hours from the initial receipt of the appeal or after the member provides any specified information required to complete the review. Ambetter will afford a reasonable amount of time for the member to provide the information.

Procedures for filing an appeal are outlined in the Ambetter member's Evidence of Coverage. Additional information is available on our website www.AmbetterHealth.com/en/tx or by calling Ambetter at **1-877-687-1196 (Relay Texas/TTY 1-800-735-2989).** For Solutions members, visit us at AmbetterHealth.com/memberforms or by calling Member Services at **1-833-543-3145 (TTY 711)**.

Mailing Address and Fax Numbers for Member Appeals

(For Physical Health related authorization appeals)

Ambetter from Superior HealthPlan members:

Ambetter
Attn: Appeals and Grievances Department
5900 E. Ben White Blvd.
Austin, TX 78741
Fax: 1-866-918-2266

Solutions members:

Ambetter
Attn: Appeals and Grievances Department
PO Box 10341
Van Nuys, CA 91410-0341
Fax: 1-833-886-7956

(For Behavioral Health related authorization appeals, including Solutions members)

Ambetter
Attn: BH Appeals Department
PO Box 10378
Van Nuys, CA 91410-0378
Fax: 1-866-714-7991

(For Pharmacy related authorization appeals, including Solutions members)

Ambetter
Attn: Pharmacy Services—Pharmacy Appeals

PO Box 31398
Tampa, FL 33631-3398
Retail Rx Fax: 1-888-865-6531
Medical Rx Fax: 1-844-235-5091

Providers may also invoke any remedies as determined in the Participating Provider Agreement.

FRAUD, WASTE & ABUSE

Ambetter takes the detection, investigation, and prosecution of fraud, waste and abuse very seriously and has a Fraud, Waste, and Abuse (FWA) program that complies with the federal and state laws. Ambetter, in conjunction with its parent company, Centene Corporation, operates a Fraud, Waste, and Abuse unit. Ambetter routinely conducts audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic audits during the claim payment process. To better understand this system, please review the billing and claims section of this manual. The Centene Special Investigation Unit (SIU) also performs retrospective audits, which, in some cases, may result in taking actions against providers who commit fraud, waste, and/or abuse. These actions include but are not limited to:

- Remedial education and training to prevent the billing irregularity.
- More stringent utilization review.
- Recoupment of previously paid monies.
- Termination of provider agreement or other contractual arrangement.
- Civil and/or criminal prosecution.
- Announced or unannounced onsite audit investigations.
- Corrective Action Plan (CAP).
- Any other remedies available to rectify.

Some of the most common FWA practices include:

- Unbundling of codes.
- Up-coding services.
- Add-on codes billed without primary CPT.
- Diagnosis and/or procedure code not consistent with the member's age.
- Use of exclusion codes.
- Excessive use of units.
- Misuse of benefits.

- Claims for services not rendered.

Ambetter investigators consider state and federal laws and regulations, provider contracts, billing histories, and fee schedules in making determinations of claims payment appropriateness. If necessary, a clinician of like specialty may also review specific cases to determine if billing is appropriate. Investigators issue a findings Results Letter to each provider upon completion of the audit, which includes a claims report identifying all records reviewed during the audit. If the reviewer determines that clinical documentation does not support the claims payment in some or all circumstances, Ambetter will seek recovery of all overpayments. Depending on the number of services provided during the review period, Ambetter may calculate the overpayment using an extrapolation methodology. Extrapolation is the use of statistical sampling to calculate and project overpayment amounts. It is used by Medicare Program Safeguard Contractors, CMS Recovery Audit Contractors, and Medicaid Fraud Control Units in calculating overpayments, and is recommended by the OIG in its Provider Self-Disclosure Protocol (63 Fed. Reg. 58,399; Oct. 30, 1998).

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential FWA hotline at **1-866-685-8664**. Ambetter takes all reports of potential fraud, waste, or abuse very seriously and investigates all reported issues.

FWA Program Compliance Authority and Responsibility

The Vice President of Compliance has overall responsibility and authority for carrying out the provisions of the compliance program. Ambetter is committed to identifying, investigating, sanctioning, and prosecuting suspected fraud, waste, and abuse.

The Ambetter provider network must cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials, and in any other process, including investigations.

Post-Processing Claims Audit/Investigation

A post-processing claims audit consists of a review of clinical documentation and claims submissions to determine whether the payment made was consistent with the services rendered. To start the audit, Ambetter auditors request medical records for a defined review period. Providers have 30 to respond to the request; if no response is received, a second and final request for medical records is forwarded to the provider. If the provider fails to respond to the second and final request for medical records, or if services for which claims have been paid are not documented in the medical record, Ambetter will recover all amounts paid for the services in question.

Ambetter auditors review cases for common FWA practices including:

- Unbundling of codes.
- Up-coding services.
- Add-on codes billed without primary CPT.
- Diagnosis and/or procedure code not consistent with the member's age/gender.
- Use of exclusion codes.
- Excessive use of units.

- Misuse of benefits.
- Claims for services not rendered.

Ambetter auditors consider state and federal laws and regulations, provider contracts, billing histories, and fee schedules in making determinations of claims payment appropriateness. If necessary, a clinician of like specialty may also review specific cases to determine if billing is appropriate. Auditors issue an audit results letter to each provider upon completion of the audit, which includes a claims report identifying all records reviewed during the audit. If the auditor determines that clinical documentation does not support the claims payment in some or all circumstances, Ambetter will seek recovery of all overpayments. Depending on the number of services provided during the review period, Ambetter may calculate the overpayment using an extrapolation methodology. Extrapolation is the use of statistical sampling to calculate and project overpayment amounts. It is used by Medicare Program Safeguard Contractors, CMS Recovery Audit Contractors, and Medicaid Fraud Control Units in calculating overpayments, and is recommended by the OIG in its Provider Self-Disclosure Protocol (63 Fed. Reg. 58,399; Oct. 30, 1998).

False Claims Act

The False Claims Act establishes liability when any person or entity improperly receives or avoids payment to the Federal government. The Act prohibits:

- Knowingly presenting, or causing to be presented a false claim for payment or approval.
- Knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim.
- Conspiring to commit any violation of the False Claims Act.
- Falsely certifying the type or amount of property to be used by the government.
- Certifying receipt of property on a document without completely knowing that the information is true.
- Knowingly buying government property from an unauthorized officer of the government.
- Knowingly making, using, or causing to be made or used a false record to avoid or decrease an obligation to pay or transmit property to the government.

For more information regarding the False Claims act, please visit www.cms.hhs.gov.

Physician Incentive Programs

On an annual basis and in accordance with federal regulations, Ambetter must disclose to the Centers for Medicare and Medicaid Services, any Physician Incentive Programs that could potentially influence a physician's care decisions. The information that must be disclosed includes the following:

- Effective date of the Physician Incentive Program.
- Type of Incentive Arrangement.
- Amount and type of stop-loss protection.

- Patient panel size.
- Description of the pooling method, if applicable.
- For capitation arrangements, provide the amount of the capitation payment that is broken down by percentage for primary care, referral, and other services.
- The calculation of Substantial Financial Risk (SFR).
- Whether Ambetter does or does not have a Physician Incentive Program.
- The name, address, and other contact information of the person at Ambetter who may be contacted with questions regarding Physician Incentive Programs.

Physician Incentive Programs may not include any direct or indirect payments to providers/provider groups that create inducements to limit or reduce the provision of necessary services. In addition, Physician Incentive Programs that place providers/provider groups at SFR may not operate unless there is adequate stop-loss protection, member satisfaction surveys, and satisfaction of disclosure requirements satisfying the Physician Incentive Program regulations.

Substantial financial risk occurs when the incentive arrangement places the provider/provider group at risk beyond the risk threshold, which is the maximum risk if the risk is based upon the use or cost of referral services. The risk threshold is set at 25% and does not include amounts based solely on factors other than a provider/provider group's referral levels. Bonuses, capitation, and referrals may be considered incentive arrangements that result in SFR.

If you have questions regarding the Physician Incentive Program regulations, please contact your Provider Relations Representative.

CULTURAL COMPETENCY

Ambetter views Cultural Competency as the measure of a person or organization's willingness and ability to learn about, understand, and provide excellent customer service across all segments of the population. It is the active implementation of a system-wide philosophy that values differences among individuals and is responsive to diversity at all levels in the community and within an organization and at all service levels the organization engages in outside of the organization. A sincere and successful Cultural Competency program is evolutionary and ever-changing to address the continual changes occurring within communities and families. In the context of healthcare delivery, Cultural Competency is the promotion of sensitivity to the needs of patients and incorporates cultural considerations that include, but are not limited to the following: race, ethnicity, primary language, age, geographic location, gender identity, sexual orientation, English proficiency, physical abilities/limitations, spiritual beliefs and practices, economic status, family roles, literacy, diverse populations. It accommodates the patient's culturally based attitudes, beliefs and needs within the framework of access to healthcare services and the development of diagnostic and treatment plans and communication methods to fully support the delivery of competent care to the patient. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions, and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner.

Ambetter is committed to the development, strengthening, and sustaining of healthy provider/member relationships. Members are entitled to dignified, appropriate care. Provider services should meet the unique needs of every member regardless of race, ethnicity, culture, language proficiency, or disability. In all interactions, providers are expected to act in a manner that is sensitive to the ways in which the member experiences the world. When healthcare services are delivered without regard for cultural differences, members are at risk for sub-optimal care. Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process.

As part of Ambetter's Cultural Competency Program, providers must:

- Facilitate member access to Cultural and Linguistic Services, including informing members of their right to access free, quality medical interpreters, and signers, accessible transportation, and TDD/TTY services.
- To support informing members of their right to access free language services, it is recommended that providers post nondiscrimination notices and language assistance taglines in lobbies and on websites. Language assistance taglines notify individuals of the availability of language assistance, the top 15 languages utilized in the state as identified by the ACA 1557 and include at least one tagline in 18-point font.
- Provide medical care with consideration of the members' primary language, race ethnicity and culture.
- Participate in cultural competency training annually and ensure that office staff routinely interacting with members have also been given the opportunity to participate in, and have participated in, cultural competency training.

- Ensure that treatment plans are developed with consideration of the member's race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, gender identity, sexual orientation, and other characteristics that may influence the member's perspective on healthcare.
- Ensure an appropriate mechanism is established to fulfill the provider's obligations under the Americans with Disabilities Act including that all facilities providing services to members must be accessible to persons with disabilities. Additionally, no member with a disability may be excluded from participation in or be denied the benefits of services, programs, or activities of a public facility, or be subjected to discrimination by any such facility.

Ambetter considers mainstreaming of members an important component of the delivery of care and expects providers to treat members without regard to race, color, creed, sex, gender identity, religion, age, national origin ancestry, marital status, sexual orientation, health status, income status, program membership, physical or behavioral disabilities except where medically indicated. Examples of prohibited practices include:

- Denying a member, a covered service or availability of a facility; and
- Providing an Ambetter member a covered service that is different or in a different manner, or at a different time or at a different location than to other "public" or private pay members (examples: separate waiting rooms, delayed appointment times).

CLAS-related educational opportunities are available for providers via the secure Provider Portal. Providers are able to participate in available Cultural Competency Health Literacy Training, as well as participate in training opportunities administered by the State or nationally recognized organizations, found at SuperiorHealthPlan.com. Providers are able to participate in training opportunities administered by the state, nationally recognized organizations, or other healthcare organizations in order to meet annual cultural competency training requirements. For additional information regarding resources and trainings, including a link to the training "A Physician's Practical Guide to Culturally Competent Care" which offers CME credits and contact hours, visit the U.S Department of Health and Human Services Office of Minority Health website at https://thinkculturalhealth.hhs.gov/. This website also offers trainings for other clinicians as well as guides and tools to assist you in providing culturally appropriate care, such as:

- The Agency for Healthcare Research and Quality website, which offers a toolkit as a way for primary care practices to assess their services for health literacy considerations, raise awareness of their entire staff, and work on specific areas. The toolkit can be found at www.ahrq.gov.
- The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) website at www.hrsa.gov/. Providers can find free online courses on topics such as addressing health literacy, cultural competency, and limited English proficiency.

Americans With Disabilities Act (ADA)

The Provider Accessibility Initiative (PAI) is committed to providing equal access to quality health care and services that are physically and programmatically accessible for members living with disabilities

and their companions. “Physical access” also known as “architectural access” refers to a person with a disability’s ability to access buildings, structures, and the environment. “Programmatic access” refers to a person with a disability’s ability to access goods, services, activities, and equipment. The goal of PAI is to increase the percentage of practitioner locations within our network that meet minimum federal and state disability access standards.

PAI covers people with physical, mental, cognitive, or intellectual limitations such as difficulty walking, balancing, climbing, seeing, hearing, reading, understanding, or remembering.

As Ambetter moves closer to full inclusion of people with disabilities through policy and practice integration, provider directory accessibility information display, and architecture barrier removal, it is important to understand that disability is just one aspect of a person’s full complex life and each person should be seen as an individual, not a disability. The key to creating an acceptable environment for providing health for people living with disabilities is to treat everyone with respect and equality.

- Do not be overly friendly or condescending toward individuals with disabilities.
- Use appropriate greetings, such as shaking hands.
- Challenge derogatory language and jokes.
- Take ownership for making everyone feel welcome and accepted.

When assisting the member:

- First, ask if help is needed.
- Be sure to understand what is needed and offer only what is needed.
- Don’t take over; just help.
- Speak directly to the person rather than through someone else, such as a sign language interpreter.
- Don’t be afraid to make a mistake.
- Made a mistake? Apologize, correct, learn, and move on.
- Use common sense and a positive attitude.
- Always think of the person first.
- Be generous with yourself.
- Unsure of what to do or say? Ask!

Important Points to Remember

Word Choice: Avoid words with negative connotations like “handicapped,” “afflicted,” “crippled,” “victim,” “sufferer,” etc. Do not refer to individuals by their disability. A person is not a condition.

Emphasize “person first” terminology:

- Handicapped = A PERSON with a disability.

- Deaf = A PERSON who is deaf.
- Mute = A PERSON without speech.
- Confined/Wheelchair-Bound = A PERSON who uses a wheelchair.

If you happen to not have a disability currently in your life, that DOES NOT make you “normal” or “able-bodied.” It makes you “non-disabled.”

Call your Provider Relations Representative for Ambetter at 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989) or Ambetter Health (Solutions) at 1-833-543-3145 (TTY:711) for more information.

The term "disability" means, with respect to an individual is any substantial limitation of one or more of a person’s daily life activities and may be present from birth or may occur during a person’s lifetime. Any individual meeting any of these conditions is an individual with a disability for purposes of coverage under the Americans with Disabilities Act.

Programmatic access to healthcare means that policies and practices that are part of the delivery of healthcare do not hinder the ability of members with disabilities to receive the same quality of care as other persons.

Common Methods to Ensure Equal Communication and Access to Information:

- Provisions for intake forms to be completed by persons who are blind or with a low visual disability with the same confidentiality afforded by other members.
- Use of large print forms, electronic or online web-based forms, or in-person staff assistance in a private location.
- Provision for the presence of sign language interpreters to enable full communication with deaf or hard of hearing members who use sign language.
- Provision for making auditory information (E.G., automated messages) available via alternative means.
- Written communication or secure web-based methods may be used as possible substitutes.
- Provision for communicating with deaf or hard of hearing members by telephone.
- Use of telephone relay services (TRS), video relay services (VRS), a TDD, or use of secure electronic means.

Policies for Scheduling and Waiting for Appointments

- Policies that allow additional time scheduling for the duration of appointments for members with disabilities who may require it.
- Members may require more time than the standard because of multiple complexities. More time may be needed to conduct the examination or for communication through an interpreter as well as other communication issues.
- Policies to enable members who may not be able to tolerate waiting in a reception area to be seen immediately upon arrival.
- Members with cognitive, intellectual, or some psychiatric disability may be unable to wait in a crowded reception area without becoming agitated or anxious.
- Policies to allow flexibility in appointment times for members who use paratransit.
- Members may arrive late at appointments because of delays or other problems with

paratransit scheduling or reliability.

- Policies to enable compliance with federal law that guarantee access to provider offices for people with disabilities who use service animals .
- Members with service animals expect the animal to accompany them into the waiting and examination rooms. This is protected under the Americans with Disabilities Act. This policy statement simply prepares staff to respond accordingly.

Policies for Conducting the Examination:

- Training of healthcare providers in operation of accessible equipment
- Staff must know how to operate accessible equipment, such as adjustable height exam tables and scales so they can be regularly and easily utilized.

Policies for Follow-up or Referral:

- Current and prospective members, including people with disabilities, should be referred to as another provider only for established medical reasons or specialized expertise is necessary.
- Referrals result in a delay of treatment and subject members to additional time, expenses, and reduce the member's choice of providers.
- Knowledge and/or attention to the accessibility of laboratories, testing facilities, specialists, or other healthcare delivery venues to which members are referred.
- Members may be unable to comply with medical referrals if the referred location is not accessible and/or not prepared to provide the recommended service.

General Prohibitions Against Discrimination

Except as may be otherwise provided by applicable law, the following prohibitions against discrimination binding upon public entities also apply to Providers:

- No qualified individual with a disability shall, based on disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any public entity.
- A public entity, in providing any aid, benefit, or service, may not, directly or through contractual, licensing, or other arrangements, based on disability –
- Deny a qualified individual with a disability the opportunity to participate in or benefit from the aid, benefit, or service;
- Afford a qualified individual with a disability an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others;
- Provide a qualified individual with a disability with an aid, benefit, or service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others;

- Provide different or separate aids, benefits, or services to individuals with disabilities or to any class of individuals with disabilities than is provided to others unless such action is necessary to provide qualified individuals with disabilities with aids, benefits, or services that are as effective as those provided to others;
- Aid or perpetuate discrimination against a qualified individual with a disability by providing significant assistance to an agency, organization, or person that discriminates based on disability in providing any aid, benefit, or service to beneficiaries of the public entity's program;
- Deny a qualified individual with a disability the opportunity to participate as a member of planning or advisory boards;
- Otherwise limit a qualified individual with a disability in the enjoyment of any right, privilege, Ambetter, or opportunity enjoyed by others receiving the aid, benefit, or service.
- A public entity may not deny a qualified individual with a disability the opportunity to participate in services, programs, or activities that are not separate or different, despite the existence of permissibly separate or different programs or activities.
- A public entity may not, directly or through contractual or other arrangements, utilize criteria or methods of administration:
    - That has the effect of subjecting qualified individuals with disabilities to discrimination based on disability;
    - That has the purpose or effect of defeating or
    - substantially impairing accomplishment of the objectives of the public entity's program with respect to individuals with disabilities; or
    - That perpetuates the discrimination of another public entity if both public entities are subject to common administrative control and are agencies of the same State.
- A public entity may not, in determining the site or location of a facility, make selections --
    - That has the effect of excluding individuals with disabilities from, denying them the benefits of, or otherwise subjecting them to discrimination; or
    - That has the purpose or effect of defeating or substantially impairing the accomplishment of the objectives of the service, program, or activity with respect to individuals with disabilities.
- A public entity, in the selection of procurement contractors, may not use criteria that subject qualified individuals with disabilities to discrimination based on disability.

- A public entity may not administer a licensing or certification program in a manner that subjects qualified individuals with disabilities to discrimination based on disability, nor may a public entity establish requirements for the programs or activities of licensees or certified entities that subject qualified individuals with disabilities to discrimination based on disability. The programs or activities of entities that are licensed or certified by a public entity are not, themselves, covered by this part.
- A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination based on disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.
- A public entity shall not impose or apply eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any service, program, or activity, unless such criteria can be shown to be necessary for the provision of the service, program, or activity being offered.
- Nothing in this part prohibits a public entity from providing benefits, services, or advantages to individuals with disabilities, or to a particular class of individuals with disabilities beyond those required by this part.
- A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.
- Nothing in this part shall be construed to require an individual with a disability to accept accommodations, aid, service, opportunity, or benefit provided under the ADA or this part which such an individual chooses not to accept.
- Nothing in the Act or this part authorizes the representative or guardian of an individual with a disability to decline food, water, medical treatment, or medical services for that individual.
- A public entity may not place a surcharge on a particular individual with a disability or any group of individuals with disabilities to cover the costs of measures, such as the provision of auxiliary aids or program accessibility, which are required to provide that individual or group with the nondiscriminatory treatment required by the Act or this part.
- A public entity shall not exclude or otherwise deny equal services, programs, or activities to an individual or entity because of the known disability of an individual with whom the individual or entity is known to have a relationship or association.
- Providers must ensure their websites meet compliance with Section 508 Accessibility Standards. Section 508 is a federal law that requires agencies to provide people with disabilities equal access to electronic information and data comparable to those who do not have disabilities.

Provider Accessibility Initiative

Ambetter is committed to providing equal access to quality health care and services that are physically and programmatically accessible for our members with disabilities. In May of 2017, our parent company, Centene, launched a Provider Accessibility Initiative (PAI) to increase the percentage of Centene's providers that meet minimum federal and state disability access standards. One of the goals of the PAI is to improve the accuracy, completeness, and transparency of the provider's self-reported disability access data in Provider Directories so that members with disabilities have the most accurate, accessible, and up-to-date information possible related to a provider's disability access. To accomplish this, providers are asked to complete a self-report of disability access that will be verified by Ambetter through an onsite Accessibility Site Review (ASR).

Ambetter's expectation, as communicated through the provider contract, is full compliance with all federal and state disability access laws and regulations (including, but not limited to, the Medicaid/CHIP Managed Care final rule provisions, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and Section 1557 of the Affordable Care Act). "Minimum accessibility," as defined in the ASR Tool, is not to be confused with, nor is intended to replace, the obligation of full compliance with all federal and state disability access laws and regulations, which remains the legal responsibility of Ambetter providers.

Language Services

In accordance with Title VI of the Civil Rights Act, Prohibition Against National Origin Discriminations, the President's Executive Order 131166, section 1557 of the Patient Protection and Affordable Care Act, The Health Plan and its providers must make language assistance available to persons with Limited English Proficiency (LEP) at all points of contact during all hours of operation. Language services are available at no cost to Ambetter members and providers without unreasonable delay at all medical points of contact. The member has the right to file a complaint or grievance if cultural and linguistic needs are not met.

Language services include:

- Telephonic interpretation.
- Oral translation (reading of English material in a members preferred language).
- Face to Face non-English interpretation.
- American Sign language.
- Auxiliary aids including alternate formats such as large print and braille.
- Written translations for materials that are critical for obtaining health insurance coverage and access to health care services in non-English prevalent languages.

Information is deemed to be critical for obtaining health insurance coverage or access to health care services if the material is required by law or regulation to provide the document to an individual.

To obtain language services for a member, contact Ambetter provider services. For Face to Face and American Sign Language requests, contact Ambetter provider services as soon as possible, or at least 5 business days before the appointment. All providers (Medical, Behavioral, Pharmacy, etc.) can request language services by calling our Provider Customer Contact Center for Ambetter at

1-877-687-1196 (Relay Texas/TTY 1-800-735-2989) or Ambetter Health (Solutions) at 1-833-543-3145 (TTY:711).

Restrictions Related to Interpretation or Facilitation of Communication

- Providers may not request or require an individual with limited English proficiency to provide their own interpreter.
- Providers may not rely on staff other than qualified bilingual/multilingual staff to communicate directly with individuals with limited English proficiency.
- Providers may not use an accompanying adult or minor child to interpreter or facilitate communication.

Exceptions to these expectations include:

- In an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available;
- Accompanying adults (minors are excluded) where the individual with limited English proficiency specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances for minimal needs.
- Providers are encouraged to document in the member's medical record any member denial of professional interpreters and the circumstances that resulted in the use of a minor or accompanying adult as an interpreter.

988 SUICIDE & CRISIS LIFELINE

Individuals experiencing mental health or substance use-related distress - including thoughts of suicide or other emotional crises - can contact the 988 Suicide & Crisis Lifeline by calling or texting **988**, or via online chat at www.988lifeline.org. The no-cost service is confidential and available 24/7.

The 988 Lifeline is led by the Substance Abuse and Mental Health Services Administration (SAMHSA) in coordination with the Federal Communications Commission (FCC) and the Department of Veterans Affairs (VA). It builds on the existing National Suicide Prevention Lifeline infrastructure and is designed to improve access to compassionate, evidence-based crisis support.

Key Information for Providers:

- Scope of Services: The Lifeline provides immediate support to individuals experiencing mental health, suicide, or substance use-related crises.
- Access: Callers can reach the Lifeline by dialing or texting 988 or the original 10-digit number **1-800-273-TALK (8255)**, both of which remain active.
- Languages Supported: Voice services are available in multiple languages. Text and chat support are currently offered in English. For TTY Users: Use your preferred relay service or dial 711 then 988.
- Distinction from 911: The 988 Lifeline is a mental health crisis resource. Unlike 911, which dispatches emergency responders, 988 connects individuals with trained crisis counselors and community-based services. 988 can activate 911 in situations that also require emergency services.
- Substance Use Support: The Lifeline accepts calls related to substance use crises and provides appropriate referrals and support.

Providers are encouraged to share this information with Ambetter members who may benefit from mental health crisis resources and to coordinate care with appropriate behavioral health professionals when necessary.

For more information, visit www.samhsa.gov/find-help/988.

QUALITY IMPROVEMENT PLAN

Overview

Ambetter's culture, systems, and processes are structured around its mission to improve the health of all enrolled members. The Quality Assessment and Performance Improvement (QAPI) Program utilizes a systematic approach to quality improvement initiatives applying reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of healthcare provided to all members, including those with special needs. This system provides a continuous cycle for assessing the level of care and service among health plan initiatives, including preventive health, acute and chronic care, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services. This includes the implementation of appropriate interventions and designation of adequate resources to support the interventions. Ambetter requires all practitioners and providers to cooperate with all quality improvement activities and allows Ambetter to use practitioner and/or provider performance data to ensure success of the

QAPI Program.

Ambetter is accredited by the National Committee for Quality Assurance (NCQA), an independent, nonprofit organization dedicated to improving health care quality. The NCQA seal is a widely recognized symbol of quality. NCQA Health Plan Accreditation surveys include rigorous on-site and off-site evaluation of standards, with a national oversight committee of physicians who analyze the survey team's findings and assign an accreditation level based on the performance level of each health plan as evaluated against NCQA's standards. This recognition is the result of Ambetter's long-standing dedication to providing quality health care service and programs to our members.

Ambetter promotes the delivery of appropriate care with the primary goal to improve the health status of its members. Where the member's condition is not amenable to improvement, Ambetter implements measures to prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the member. This includes the identification of members at risk of developing conditions, the implementation of appropriate interventions, and designation of adequate resources to support the interventions. Whenever possible, the Ambetter QAPI Program supports these processes and activities that are designed to achieve demonstrable and sustainable improvement in the health status of its members.

QAPI Program Structure

The Ambetter Board of Directors has the ultimate oversight for the care and service provided to members. The Board of Directors oversees the QAPI Program and has established various committees and ad-hoc committees to monitor and support the QAPI Program.

The Quality Improvement Committee (QIC) is a senior management committee with physician representation that is directly accountable to the Board of Directors. The purpose of the QIC is:

- to enhance and improve quality of care;
- to provide oversight and direction regarding policies, procedures, and protocols for member care and services; and
- to offer guidelines based on recommendations for appropriateness of care and services.

This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems; the identification of opportunities to improve member outcomes; and the education of members, providers, and staff regarding the Quality Improvement, Utilization Management, Pharmacy and Credentialing Programs.

The following standard sub-committees report directly to the QIC:

- Credentialing Committee.
- Utilization Management Committee.
- Performance Improvement Team.
- HEDIS® Steering Committee.
- Pharmacy and Therapeutics Committee.
- Delegate Vendor Oversight/Joint Operations Committee.
- Peer Review Committee (ad hoc).
- Subcommittees may also include a Grievance and Appeals Committee, Cultural Competence Committee, Member Advisory Committee, Physician Advisory Committee, Hospital Advisory Committee, and the Community Advisory Committee, based on health plan needs and state requirements.

Practitioner Involvement

Ambetter recognizes the integral role practitioner plays in the success of the QAPI Program. Practitioner involvement in various levels of the process is highly encouraged through network provider representation. Ambetter encourages primary care, behavioral health, specialty, and OB/GYN representation on key quality committees such as, but not limited to, the QIC, Credentialing Committee, and select ad-hoc committees.

Network practitioners and providers are contractually required to cooperate with all quality improvement activities to improve the quality of care and services and member experience. This includes the collection and evaluation of performance data and participation in Ambetter's QI programs and use of performance data for quality improvement activities.

Quality Assessment and Performance Improvement Program Scope and Goals

The scope of the QAPI Program is comprehensive and addresses both the level of clinical care and the level of service provided to Ambetter members. The Ambetter QAPI Program incorporates all demographic groups and ages, benefit packages, care settings, providers, and services in quality improvement activities. This includes services for the following: preventive care, primary care, specialty care, acute care, short-term care, long-term care, ancillary services, and operations, among others.

To that end, the Ambetter QAPI Program scope encompasses the following:

- Acute and chronic care management.

- Behavioral health care.
- Compliance with member confidentiality laws and regulation.
- Compliance with preventive health guidelines and clinical practice guidelines.
- Continuity and coordination of care.
- Delegated entity oversight.
- Department performance and service.
- Employee and provider cultural competency.
- Marketing practices.
- Member enrollment and disenrollment.
- Member grievance system.
- Member experience.
- Patient safety.
- Primary care provider changes.
- Pharmacy.
- Provider and plan after-hours telephone accessibility.
- Provider appointment availability.
- Provider Complaint System.
- Provider network adequacy and capacity.
- Provider experience.
- Selection and retention of providers (credentialing and recredentialing).
- Utilization of services, including under-and over-utilization.

Ambetter's primary quality improvement goal is to improve members' health status through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving quality of care and services delivered.

Quality improvement goals include but are not limited to the following:

- A high level of health status and quality of life will be experienced by Ambetter members;
- Network quality of care and service will meet industry-accepted standards of performance;
- Ambetter services will meet industry-accepted standards of performance;
- Fragmentation and/or duplications of services will be minimized through integration of quality improvement activities across plan functional areas;

- Member satisfaction will meet the plan's established performance targets;
- Preventive and clinical practice guideline compliance will meet established performance targets. This includes, but is not limited to, compliance with immunizations, prenatal care, diabetes, asthma, early detection of chronic kidney disease and well child visits.
- Compliance with all applicable regulatory requirements and accreditation standards will be maintained.

Ambetter's QAPI Program objectives include, but are not limited to, the following:

- To establish and maintain a health system that promotes continuous quality improvement.
- To adopt evidence-based clinical indicators and practice guidelines as a means for identifying and addressing variations in medical practice.
- To select areas of study based on demonstration of need and relevance to the population served.
- To develop standardized performance measures that are clearly defined, objective, measurable, and allow tracking over time.
- To utilize management information systems in data collection, integration, tracking, analysis, and reporting of data that reflects performance on standardized measures of health outcomes.
- To allocate personnel and resources necessary to:
    - support the QAPI Program, including data analysis and reporting
    - meet the educational needs of members, providers, and staff relevant to quality improvement efforts
- To seek input and work with members, providers, and community resources to improve quality of care.
- To oversee peer review procedures that will address deviations in medical management and health care practices, and devise action plans to improve services.
- To establish a system to provide frequent, periodic quality improvement information to participating providers to support them in their efforts to provide high quality health care.
- To recommend and institute "focused" quality studies in clinical and non-clinical areas, where appropriate.
- To conduct and report annual QHP/CAHPS surveys and certified HEDIS® results for Ambetter members.
- To achieve and maintain NCQA accreditation.
- To monitor ongoing compliance with regulatory and NCQA requirements .

Practice Guidelines

Evidence based preventive health and clinical practice guidelines are provided to assist providers in making decisions regarding health care in specific clinical situations. Guidelines are adopted from national recognized sources, in consultation with network providers (including behavioral health as indicated) and based on the health needs and opportunities for improvement identified as part of the QAPI Program, valid and reliable clinical evidence, or a consensus of health care professionals in the particular field and needs of the members.

Preventive health and clinical practice guidelines are reviewed annually and updated upon significant new scientific evidence or change in national standards or at least every two years. Ambetter distributes updated guidelines to all affected providers and makes all current preventive health and clinical practice guidelines available online via the Ambetter website and/or secure provider portal.

A complete listing of approved preventive health and clinical practice guidelines is available at www.AmbetterHealth.com/en/tx.

Patient Safety and Quality of Care

Patient safety is a key focus of the Ambetter QAPI program. Monitoring and promoting member safety is integrated throughout activities across the health plan, primarily through the identification of potential and/or actual quality of care events. A potential quality of care issue is any alleged act or behavior that may be detrimental to the quality or safety of member care, is not compliant with evidence-based standard practices of care, or that signals a potential sentinel event, up to and including death of a member. Ambetter employees (medical management staff, member services staff, provider services, complaint coordinators, etc.), panel practitioners, facilities or ancillary providers, members or member representatives, Medical Directors, or the board of directors may advise the QI department of potential quality of care issues. Adverse events may also be identified through claims-based reporting and analyses. A potential quality of care issue requires investigation of the factors surrounding the event to determine if the severity and need for corrective action up to and including review by an Ambetter Medical Director or the Peer Review Committee, as indicated. Potential quality of care issues are tracked and monitored for trends in occurrence, based on the Severity Level Definitions and Actions one-pager that attaches to policy CC.QI.17.

Performance Improvement Process

The Ambetter QIC reviews and adopts an annual QAPI Program Description and Work Plan based on managed care appropriate industry and accreditation standards. The QIC adopts traditional quality/risk/utilization management approaches to identify problems, issues, and trends with the objective of developing and implementing improvement opportunities. Initiatives are selected based on data that indicates the need for improvement in a particular clinical or non-clinical area and includes targeted interventions that have the greatest potential for improving health outcomes or service standards.

Performance improvement projects, focus studies, and other QI initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness and level of care and

services delivered against established standards and guidelines for the provision of that care or service. Each QI initiative is also designed to allow Ambetter to monitor improvement over time.

Annually, Ambetter completes an evaluation of the QAPI Program and develops a QAPI Work Plan for the upcoming year based on the evaluation. The QAPI Work Plan serves as a working document to guide quality improvement efforts on a continuous basis. The Work Plan integrates QIC activities, reporting, and studies from all areas of the organization (clinical and service) and includes timelines for completion and reporting to the QIC as well as requirements for external reporting. Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QAPI Work Plan.

Ambetter providers may request additional information on the health plan programs, including a description of the QAPI Program and a report on Ambetter's progress in meeting QAPI Program goals, by contacting the QI Department.

Quality Rating System

Healthcare Effectiveness Data and Information Set (HEDIS®)

HEDIS® is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA), which allows comparison across health plans. HEDIS® gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences.

As Federal and State governments move toward a health care industry that is driven by quality, HEDIS® rates are becoming more and more important, not only to the health plan, but to the individual provider. Purchasers of health care may use the aggregated HEDIS® rates to evaluate the effectiveness of a health insurance company's ability to demonstrate the clinical management of its members. Physician-specific scores are being used as evidence of preventive care from primary care office practices.

HEDIS® Rate Calculations

HEDIS® rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim and encounter data submitted to the health plan. Measures typically calculated using administrative data include annual mammogram, annual chlamydia screening, appropriate treatment of asthma, cholesterol management, antidepressant medication management, access to PCP services, and utilization of acute and behavioral health services.

Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of medical records to extract data regarding services rendered but not reported to the health plan through claims or encounter data. Accurate and timely claim submission, including encounter data, and appropriate CPT, ICD-10, and HCPCS codes can reduce the necessity of medical record reviews.

HEDIS® measures typically requiring medical record review include childhood immunizations, well child visits, diabetic HbA1c values, LDL, eye exam and nephropathy, controlling high-blood pressure, cervical cancer screening, and prenatal care and postpartum care.

Who Conducts Medical Record Reviews (MRR) for HEDIS®?

Ambetter may contract with an independent national MRR vendor to conduct the HEDIS® MRR on its behalf. Medical record review audits for HEDIS® are conducted on an ongoing basis with a particular focus from January through May each year. At that time, a sample of your patient's medical records may be selected for review; you will receive a call and/or a letter from a medical record review representative. Your prompt cooperation with the representative is greatly needed and appreciated.

As a reminder, sharing of protected health information (PHI) that is used or disclosed for purposes of treatment, payment, or health care operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with Ambetter, which allows them to collect PHI on our behalf.

How can providers improve their HEDIS® scores?

- Understand the specifications established for each HEDIS® measure.
- Submit claims and encounter data for each and every service rendered. All providers must bill (or submit encounter data) for services delivered, regardless of their contract status with Ambetter. Claims and encounter data is a clean and efficient way to report HEDIS®.
- Submit claims and encounter data correctly, accurately, and on time. If services rendered are not filed or billed accurately, then they cannot be captured and included in the scoring calculation. Accurate and timely submission of claims and encounter data will reduce the number of medical record reviews required for HEDIS® rate calculation.
- Ensure the chart documentation reflects all the services provided. Keep accurate chart/medical record documentation of each member service, and document conversation/services.
- Submit claims and encounter data using CPT codes related to HEDIS® measures such as diabetes, eye exam, and blood pressure, where appropriate.

If you have any questions, comments, or concerns related to the annual HEDIS® project or medical record reviews, please contact the Quality Improvement Department at 1-877-684-1169.

Provider Satisfaction Survey

Ambetter conducts an annual provider satisfaction survey, which includes questions to evaluate the provider's experience with our services such as claims, communications, utilization management, and provider services. Behavioral health providers receive a provider survey specific to the provision of behavioral health services in the Ambetter network. The survey is conducted by an external vendor. Participants are randomly selected by the vendor, meeting specific requirements outlined by Ambetter. If selected by the vendor, we encourage you to respond timely to the survey as the results of the survey are analyzed and used as a basis for forming provider-related quality improvement initiatives.

Qualified Health Plan (QHP) Enrollee Survey

The QHP Enrollee survey is a tool that measures the member experience and is integral to support CMS's ongoing administration of the Health Insurance Marketplace as well as a requirement for NCQA accreditation. It is a standardized survey administered annually to members by an NCQA-certified survey vendor. The survey provides information on the experiences of members with health plan and practitioner services. It gives a general indication of how well the plan meets the members' expectations. Member responses to the QHP survey are used in various aspects of the quality program, including, but not limited to, monitoring member perception of practitioner access and availability and care coordination. This survey is similar to the NCQA survey tool CAHPS (Consumer Assessment of Healthcare Provider Systems) used for other lines of business. Members receiving behavioral health services have the opportunity to respond to the Experience of Care Health Outcomes (ECHO) survey to provide feedback and input into the quality oversight of the behavioral health program.

Provider Performance Monitoring and Incentive Programs

It is nationally recognized that pay-for-performance (P4P) programs, which include provider profiling, are a promising strategy to improve the level and cost-effectiveness of care. Ambetter will manage a provider performance monitoring program to capture data relating to healthcare access, costs, and level of care that Ambetter members receive.

The Ambetter Provider Profiling Program is designed to analyze utilization data to identify provider utilization and care issues. Ambetter will use provider profiling data to identify opportunities to improve communications to providers regarding preventive health and clinical practice guidelines. Provider profiling is a highly effective tool that compares individual provider practices to normative data, so that providers can improve their practice patterns, processes, and level of care in alignment with evidence-based clinical practice guidelines. The Ambetter Program and Provider Overview Reports will increase provider awareness of performance, identify opportunities for improvement, and facilitate plan-provider collaboration in the development of clinical improvement initiatives. Ambetter's Profiling Program incorporates the latest advances in this evolving area.

Process For Submitting Medical Records

Ambetter requires members' medical record data for a wide variety of operational and analytical processes that help to improve quality, reduce risk, and lower costs of care for the members being served. These processes include but are not limited to quality (e.g., HEDIS®) and risk adjustment data tracking, clinical and population health stratification and prioritization, and continuity of care and care planning purposes. In addition, Ambetter requires medical record data relating to its members for purposes of complying with a wide array of regulatory and statutory data reporting requirements. Making these data available to Ambetter in the form of Electronic Medical Record (EMR) data reduces costs for both the provider and Ambetter.

At Ambetter's request, Provider will make commercially reasonable efforts to make EMR data relating to Ambetter's members available and accessible to Ambetter within a reasonable time frame requested by Ambetter via 1) electronic access to APIs (Application Programming Interfaces), 2) use of HL7 and FHIR data transfer protocols, and/or 3) data-formatted content delivered via Continuity of Care Document (CCD) data specifications. Alternatively, at Ambetter's request or authorization, Provider may provide EMR data to Ambetter by other means, including but not limited to text file, image, or PDF, which may be transferred through SFTP (Secured File Transfer Protocol) or available for

download via a secure web portal.

Ambetter reserves the right to assess a penalty of up to $30.00 per unmet medical record request on providers that fail to provide medical records as reasonably requested by Health Plan.

Medical Record Documentation and Review

Complete, accurate, and timely medical record documentation is an important part of providing high-quality care. It also helps ensure that services delivered to members are appropriately captured for quality measurement and reporting.

Medical records may occasionally be reviewed to support quality improvement activities and confirm that documentation reflects the care provided. These reviews may include Medical Record Review Validation (MRRV), which is a required component of the HEDIS® audit processes. The goal of these activities is to confirm that clinical documentation supports reported information, in alignment with NCQA technical specifications.

REGULATORY MATTERS

Medical Records

Ambetter providers must keep accurate and complete patient medical records which are consistent with 45 CFR 156, financial, and other records pertinent to Ambetter members. Such records enable providers to render the most appropriate level of health care service to members. They will also enable Ambetter to review the level and appropriateness of the services rendered. To ensure the member's privacy, medical records should be kept in a secure location. Ambetter requires providers to maintain all records for members for at least 10 years after the final date of service unless a longer period is required by applicable state law.

Healthcare providers can charge fees for providing medical records, but there are maximum limits set by Texas law. For paper records, the maximum is $25 for the first 20 pages and $0.50 per page thereafter. For electronic records, the fee is capped at $25 for 500 pages or less and $50 for over 500 pages. These fees must be reasonable and cost-based, covering labor, supplies, and mailing, not including retrieval fees. Members can usually access their records electronically through a patient portal at no cost.

Required Information

To be considered a complete and comprehensive medical record, the member's medical record (file) should include, at a minimum: provider notes regarding examinations, office visits, referrals made, tests ordered, and results of diagnostic tests ordered (i.e., x-rays, laboratory tests). Medical records should be accessible at the site of the member's participating primary care provider. All medical services received by the member, including inpatient, ambulatory, ancillary, and emergency care, should be documented, and prepared in accordance with all applicable state rules and regulations and signed by the medical professional rendering the services.

Providers must maintain complete medical records for members in accordance with the standards set forth below:

- The member's name, and/or medical record number must be on all chart pages.
- Personal/biographical data is present (i.e., employer, home telephone number, spouse, next of kin, legal guardianship, primary language, etc.).
- Prominent notation of any spoken language translation or communication assistance must be included.
- All entries must be legible and maintained in detail.
- All entries must be dated and signed or dictated by the provider rendering the care.
- Significant illnesses and/or medical conditions are documented on the problem list and all past and current diagnoses.
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA or NKDA are documented.

- An up-to-date immunization record is established for pediatric members, or an appropriate history is made in chart for adults.
- Evidence that preventive screening and services are offered in accordance with Ambetter practice guidelines.
- Appropriate subjective and objective information pertinent to the members' presenting complaints is documented in the history and physical.
- Past medical history (for members seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters; for children and adolescents (18 years and younger) past medical history relating to prenatal care, birth, any operations and/or childhood illnesses.
- Working diagnosis is consistent with findings.
- Treatment plan is appropriate for diagnosis.
- Documented treatment prescribed, therapy prescribed, and drug administered or dispensed, including instructions to the member.
- Documentation of prenatal risk assessment for pregnant members or infant risk assessment for newborns.
- Required consent forms are signed and dated.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Laboratory and other studies ordered as appropriate are documented.
- Abnormal lab and imaging study results have explicit notations in the record for follow-up plans; all entries should be initialed by the primary care provider (PCP) to signify review.
- Referrals to specialists and ancillary providers are documented, including follow up of outcomes and summaries of treatment rendered elsewhere, including family planning services, preventive services, and services for the treatment of sexually transmitted diseases.
- Health teaching and/or counseling is documented.
- For members over 10 years and over, appropriate notations concerning use of tobacco, alcohol, and substance use (for members seen three or more times substance abuse history should be queried).
- Documentation of the members failure to keep an appointment.
- Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months, or as needed.
- Evidence that the member is not placed at inappropriate risk by a diagnostic or therapeutic problem.

- Confidentiality of member information and records are protected.
- Evidence that an Advance Directive has been offered to adults 18 years of age and older.

Access to Records and Audits by Superior HealthPlan

Subject only to applicable state and federal confidentiality or privacy laws, the provider shall permit Superior HealthPlan or its designated representative access to provider's records, at provider's place of business in this state during normal business hours, or remote access of such records, to audit, inspect, review, perform chart reviews, and duplicate such records. If performed on site, access to records for the purpose of an audit will be scheduled at mutually agreed upon times, at least 30 business days prior written notice by Superior HealthPlan or its designated representative, but not more than 60 days following such written notice.

Electronic Medical Record (EMR) Access

Providers will grant Superior HealthPlan access to the provider's Electronic Medical Record (EMR) system to effectively case manage members and capture medical record data for risk adjustment and quality reporting. There will be no other fees charged to the Superior HealthPlan for this access.

Medical Records Release

All member medical records are confidential and must not be released without the written authorization of the member or their parent/legal guardian, in accordance with state and federal law and regulation. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need-to-know basis.

All release of specific clinical or medical records for substance use disorders must meet federal guidelines at 42 CFR Part 2 and any applicable state laws.

Medical Records Transfer for New Members

All Providers are required to document in the member's medical record attempts to obtain historical medical records for all newly assigned Ambetter members. If the member or member's parent/legal guardian is unable to remember where they obtained medical care, or they are unable to provide addresses of the previous providers, then this should also be noted in the medical record.

Federal And State Laws Governing The Release Of Information

The release of certain information is governed by a myriad of federal and/or state laws.

These laws often place restrictions on how specific types of information may be disclosed, including, but not limited to, behavioral health, alcohol /substance abuse treatment, and communicable disease records.

For example, HIPAA requires that covered entities, such as health plans and providers, release protected health information only when permitted under the law, such as for treatment, payment, and operations activities, including care management and coordination.

However, a different set of federal rules place more stringent restrictions on the use and disclosure of alcohol and substance abuse treatment records (42 CFR Part 2 or "Part 2"). These records generally may not be released without consent from the individual whose information is subject to the release.

Still other laws at the state level place further restrictions on the release of certain information, such as behavioral health, communicable disease, etc.

For more information about any of these laws, refer to the following:

- HIPAA - please visit the Centers for Medicare & Medicaid Services (CMS) website at: www.cms.hhs.gov, and then select “Regulations and Guidance” and “HIPAA – General Information;”
- 42 CFR Part 2 regulations - please visit the Substance Abuse and Mental Health Services Administration (within the U.S. Department of Health and Human Services) at: www.samhsa.gov;
- State laws - consult applicable statutes to determine how they may impact the release of information on patients whose care you provide.

Contracted providers within the Ambetter network are independently obligated to know, understand, and comply with these laws.

Ambetter takes privacy and confidentiality seriously. We have established processes, policies, and procedures to comply with HIPAA and other applicable federal and/or State confidentiality and privacy laws.

Please contact the Ambetter Compliance Officer by phone at 1-877-687-1196 or Ambetter Health (Solutions) at 1-833-543-3145 (TTY:711) or in writing (refer to address below) with any questions about our privacy practices.

Ambetter Health
5900 E. Ben White Blvd.
Austin, TX 78741

National Network

Ambetter is a national network where providers may provide covered services to members in accordance with the Ambetter Health Provider Manual. Providers must follow all provisions required by state or federal law, which may be included in the provider’s agreement with Ambetter with respect to the Commercial-Exchange/Qualified Health Plan Product and Direct Individual Product. Any additional regulatory requirements that may apply to the coverage agreements or members enrolled in or covered by this Product may be set forth in the Provider Manual or other attachment(s). Providers may provide services to members who are enrolled with Ambetter in a state that differs from the state where the Provider is contracted. Care provided to out-of-state members should follow rules outlined in the *Product & Network Descriptions* section above. In these cases, the covered services of the members domiciled state would govern. Providers should confirm that the services provided to the member are covered services. To the extent that a coverage agreement, or a member, is subject to the law cited in parenthetical at the end of a provision on the Schedules, such provision will apply to the provision of covered services to a member with such coverage agreement, or to such member, as applicable.

If a provider renders services to an Ambetter Health member from a different state, the member’s insurance card should display one of the following Ambetter health plans:

(Arkansas)	Ambetter from Arkansas Health & Wellness
(Arizona)	Ambetter from Arizona Complete Health
(Alabama)	Ambetter of Alabama
(Delaware)	Ambetter Health
(Florida)	Ambetter Health
(Georgia)	Ambetter Health
(Illinois)	Ambetter of Illinois
(Indiana)	Ambetter Health of Indiana
(Iowa)	Ambetter Health of Iowa
(Kansas)	Ambetter from Sunflower Health Plan
(Kentucky)	Ambetter from WellCare of Kentucky
(Louisiana)	Ambetter from Louisiana Healthcare Connections
(Michigan)	Ambetter from Meridian
(Mississippi)	Ambetter Health
(Missouri)	Ambetter Health
(Nebraska)	Ambetter Health
(Nevada)	Ambetter from SilverSummit Healthplan
(New Hampshire)	Ambetter from NH Healthy Families
(New Jersey)	Ambetter from WellCare of New Jersey
(North Carolina)	Ambetter of North Carolina
(Ohio)	Ambetter from Buckeye Health Plan
(Oklahoma)	Ambetter of Oklahoma
(Pennsylvania)	Ambetter Health
(South Carolina)	Ambetter from Absolute Total Care
(Tennessee)	Ambetter of Tennessee
(Texas)	Ambetter from Superior HealthPlan or Ambetter Health
(Washington)	Ambetter from Coordinated Care

APPENDIX

Appendix I: Common Causes for Upfront Rejections

Common causes for upfront rejections include, but are not limited to:

- Unreadable Information - The ink is faded, too light, or too bold (bleeding into other characters or beyond the box), or the font is too small.
- Member date of birth is missing or does not match the Ambetter record.
- Member Name or Identification Number is missing or does not match the Ambetter record.
- Provider Name, Taxpayer Identification Number (TIN), or National Practitioner Identification (NPI) Number is missing.
- Attending Provider information missing from Loop 2310A on Institutional claims when CLM05-1 (Bill Type) is 11, 12, 21, 22, or 72 or missing from box 48 on the paper UB claim form.
- Date of Service is not prior to the received date of the claim (future date of service).
- Date of Service or Date Span is missing from the required fields. Example: "Statement From" or “Service From" dates.
- Type of Bill is invalid.
- Diagnosis Code is missing, invalid, or incomplete.
- Service Line Detail is missing.
- Date of Service is prior to the member’s effective date.
- Admission Type is missing (Inpatient Facility Claims – CMS 1450 (UB-04), field 14).
- Patient Status is missing (Inpatient Facility Claims – CMS 1450 (UB-04), field 17).
- Occurrence Code/Date is missing or invalid.
- Revenue Code is missing or invalid.
- CPT/Procedure Code is missing or invalid.
- A missing CLIA Number in box 23 or a CMS 1500 for CLIA or CLIA waived service.
- Incorrect form type used.
- A missing taxonomy code and qualifier in box 24 I, 24 J, or Box 33b on the CMS 1500 form or box 81 CC on the CMS 1450 (UB04) form (see further requirements in this manual).

Appendix II: Common Cause of Claims Processing Delays and Denials

- Procedure or Modifier Codes entered are invalid or missing, including GN, GO, or GP modifiers for therapy services.
- Diagnosis Code is missing the 4th or 5th digit.
- DRG code is missing or invalid.
- Explanation of Benefits (EOB) from the primary insurer is missing or incomplete.
- Third Party Liability (TPL) information is missing or incomplete.
- Member ID is invalid.
- Place of Service code is invalid.
- Provider TIN and NPI do not match the Ambetter provider's record.
- Revenue Code is invalid.
- Dates of Service span do not match the listed days/units.
- Tax Identification Number (TIN) is invalid.

Appendix III: Common EOP Denial Codes and Descriptions

An updated and complete description of all explanation codes associated with the provider's claim is located on the bottom of the paper Explanation of Payment (EOP). Electronic EOP uses standard HIPAA explanation and denial codes.

EX Code	Description
18	Deny: Duplicate claim service
28	Deny: Coverage not in effect when service provided
29	Deny: The time limit for filing has expired
46	Deny: This service is not covered
0B	Adjust: Claim to be re-processed corrected under new claim number
A1	Deny: No authorization on file that matches service (s) billed
AB	Ace line-item rejection
AQ	Ace claim level return to provider must call provider services for more detail
AT	Ace claim level rejection
fq	Deny: Resubmit claim under FQHC RHC clinic NPI number
IM	Deny: Modifier missing or invalid
M3	Deny: No associated facility claim received
w1	Co-surgeon/team surgeon disallowed per CMS surgical billing guidelines
w2	Assistant & primary surgeon procedure codes must match per CMS

EX Code	Description
w3	Assistant, co-surgeon, or team surgeons not typically required per CMS
w4	Inappropriate level of E/M service billed per AMA guidelines
w5	Primary service is denied; therefore, add-on service is denied per AMA
w6	State-Specific Guideline: Procedure code to Revenue code mismatch
x3	Procedure code unbundled from global procedure code
x8	Modifier invalid for procedure or modifier not reported
x9	Procedure code pairs incidental, mutually exclusively or unbundled
xE	Procedure code is disallowed with this diagnosis code(s) per plan policy
xf	Maximum allowance exceeded
y1	Deny: Service rendered by non-authorized non plan provider
ya	Denied after review of patient's claim history
yf	HCI partially approved units; Claim needs manual pricing
yq	Duplicate claims or multiple providers billing same/similar code(s)
yr	Incorrect procedure code for diagnosis per NCD/CMS
ys	Reimbursement included in another code per CMS/AMA/Medical Guidelines
yt	Incorrect Procedure code for member age or sex per CMS/AMA/Plan
yu	Incorrect CPT/HCPCS/REV/Modifier or unlisted code based on CPT/CMS guidelines
yv	Outpatient services included in inpatient admit per CMS/Plan Guidelines
yw	Not covered or eligible service per CMS or Plan Guidelines
yx	Included in global surgical or maternity package per CMS or ACOG
yy	Reimbursement reduction based on CPT and/or CMS
yz	Incorrect use of modifier -26 or -TC based on CMS
Za	Deny: Provider billing error
ZW	After review, previous decision upheld; See provider handbook for appeal process

Appendix IV: Instructions for Supplemental Information

CMS 1500 (02/12) FORM, SHADED FIELD 24A-G

The following types of supplemental information are accepted in a shaded claim line of the CMS 1500 (02/12) Claim Form field 24-A-G:

- National Drug Code (NDC)
- Narrative description of unspecified/miscellaneous/unlisted codes
- Contract Rate

The following qualifiers are to be used when reporting these services:

- ZZ - Narrative description of unspecified/miscellaneous/unlisted codes

- N4 - National Drug Code (NDC)
- CTR - Contract Rate

If required to report other supplemental information not listed above, follow payer instructions for the use of a qualifier for the information being reported. When reporting a service that does not have a qualifier, enter two blank spaces before entering the information.

To enter supplemental information, begin at 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the number/code/information. Do not enter hyphens or spaces within the number/code.

More than one supplemental item can be reported in the shaded lines of item number 24. Enter the first qualifier and number/code/information at 24A. After the first item, enter three blank spaces and then the next qualifier and number/code/information.

For reporting dollar amounts in the shaded area, always enter the dollar amount, a decimal point, and the cents. Use 00 for cents if the amount is a whole number. Do not use commas. Do not enter dollars signs (Correct entry examples: 1000.00; 123.45).

Additional Information for Reporting NDC

When adding supplemental information for NDC, enter the information in the following order:

- Qualifier
- NDC Code
- One space
- Unit/basis of measurement qualifier
- F2 – International Unit
- ME – Milligram
- UN – Unit
- GR – Gram
- ML – Milliliter
- Quantity
- The number of digits for the quantity is limited to eight digits before the decimal and three digits after the decimal (ex. 99999999.999).
- When entering a whole number, do not use a decimal.
- Do not use commas.

Unspecified/Miscellaneous/Unlisted Codes

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
ZZLaparoscopic Ventral Hernia Repair Op Note Attached															
														NPI	

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
ZZKaye Walker													N	G2	12345678901
10	01	05	10	01	05	11		E1399		12	165 00	1	N	NPI	0123456789

NDC Codes

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N459148001665 UN1													N	G2	12345678901
10	01	05	10	01	05	11		J0400		1	250 00	40	N	NPI	0123456789

Appendix V: Common Business EDI Rejection Codes

The codes on the following page are the Standard National Rejection Codes for EDI submissions. All errors indicated for the code must be corrected before the claim is resubmitted.

...	Error Description
01	Invalid Mbr DOB
02	Invalid Mbr
06	Invalid Prv
07	Invalid Mbr DOB & Prv
08	Invalid Mbr & Prv
09	Mbr not valid at DOS
10	Invalid Mbr DOB; Mbr not valid at DOS
12	Prv not valid at DOS
13	Invalid Mbr DOB; Prv not valid at DOS
14	Invalid Mbr; Prv not valid at DOS
15	Mbr not valid at DOS; Invalid Prv
16	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv
17	Invalid Diag
18	Invalid Mbr DOB; Invalid Diag
19	Invalid Mbr; Invalid Diag
21	Mbr not valid at DOS; Prv not valid at DOS
22	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS
23	Invalid Prv; Invalid Diag
24	Invalid Mbr DOB; Invalid Prv; Invalid Diag
25	Invalid Mbr; Invalid Prv; Invalid Diag
26	Mbr not valid at DOS; Invalid Diag

...	Error Description
27	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag
29	Prv not valid at DOS; Invalid Diag
30	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag
31	Invalid Mbr; Prv not valid at DOS; Invalid Diag
32	Mbr not valid at DOS; Prv not valid; Invalid Diag
33	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid; Invalid Diag
34	Invalid Proc
35	Invalid DOB; Invalid Proc
36	Invalid Mbr; Invalid Proc
37	Invalid or future date
38	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
39	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
40	Invalid Prv; Invalid Proc
41	Invalid Prv; Invalid Proc; Invalid Mbr DOB
42	Invalid Mbr; Invalid Prv; Invalid Proc
43	Mbr not valid at DOS; Invalid Proc
44	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Proc
46	Prv not valid at DOS; Invalid Proc
48	Invalid Mbr; Prv not valid at DOS, Invalid Proc
49	Invalid Proc; Invalid Prv; Mbr not valid at DOS
51	Invalid Diag; Invalid Proc
52	Invalid Mbr DOB; Invalid Diag; Invalid Proc
53	Invalid Mbr; Invalid Diag; Invalid Proc
55	Mbr not valid at DOS; Prv not valid at DOS, Invalid Proc
57	Invalid Prv; Invalid Diag; Invalid Proc
58	Invalid Mbr DOB; Invalid Prv; Invalid Diag; Invalid Proc
59	Invalid Mbr; Invalid Prv; Invalid Diag; Invalid Proc
60	Mbr not valid at DOS; Invalid Diag; Invalid Proc
61	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag; Invalid Proc
63	Prv not valid at DOS; Invalid Diag; Invalid Proc
64	Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag; Invalid Proc
65	Invalid Mbr; Prv not valid at DOS; Invalid Diag; Invalid Proc
66	Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
67	Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
72	Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
73	Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
74	Reject. DOS prior to 6/1/2006; OR Invalid DOS
75	Invalid Unit

...	Error Description
76	Original claim number required
77	Invalid claim type
81	Invalid Unit; Invalid Prv
83	Invalid Unit; Invalid Mbr & Prv
89	Invalid Prv; Mbr not valid at DOS; Invalid DOS
91	Missing or Invalid Taxonomy Code
A2	Diagnosis pointer invalid
A3	Claim exceeded the maximum 97 service line limit
B1	Rendering and Billing NPI are not tied on state file
B2	Not enrolled with MHS and/or State with rendering NPI/TIN on DOS. Enroll with MHS and resubmit claim
B5	Missing/incomplete/invalid CLIA certification number
H1	ICD9 is mandated for this date of service.
H2	Incorrect use of the ICD9/ICD10 codes.
HP	ICD10 is mandated for this date of service.
ZZ	Claim not processed

Appendix VI: Claim Form and Submission Guidance

Providers submitting paper claims must use the appropriate industry-standard claim form, including the CMS-1500 for professional services and the UB-04 (CMS-1450) for institutional services. For the most current claim form completion requirements and instructions, providers should refer to the Centers for Medicare & Medicaid Services (CMS) and the National Uniform Claim Committee (NUCC). Providers are responsible for ensuring claims are completed accurately and submitted in accordance with applicable CMS, NUCC, and Ambetter requirements. Ambetter-specific billing, claims submission, and reimbursement requirements are outlined throughout this provider manual.

Resources

- CMS Claim Forms and Instructions: www.cms.gov/medicare/forms-notices/cms-forms-list
- National Uniform Claim Committee (NUCC): National Uniform Claim Committee - 1500 Instructions

Claim Type Hints

Professional Billing is responsible for billing claims generated for outpatient and inpatient services provided by providers, suppliers, and non-institutional providers.

Forms Used: Professional charges are billed on a CMS-1500 form. The CMS-1500 form, in red ink on white paper, is the standard billing form used by providers and suppliers.

While some claims are currently billed on paper, Medicare, Medicaid, and most other insurance companies accept electronic claims as the primary billing method. The electronic version of the CMS-1500 is called the 837-P, the P indicating the professional format.

Institutional Billing is responsible for the billing of work performed by hospitals, skilled nursing facilities, and other institutions for outpatient and inpatient services, including equipment and supply use, laboratory services, radiology services, and other charges.

Forms Used: Institutional charges are billed on a UB-04 form. The UB-04 form, in red ink on white paper, is the standard claim form used by institutional providers for claim billing. The electronic version of the UB-04 is called the 837-I, the I indicating the institutional format.

Medicaid is always the payer of last resort. This simply means that Medicaid always pays last where other health insurance plans are present, such as Ambetter.

Providers are also responsible for notifying Medicaid of any third-party insurance they become aware of, informing Medicaid of any third-party payments they receive on behalf of the recipient, and billing any primary payer, such as Ambetter, prior to billing Medicaid.

Electronic Data Interchange (EDI) Health Claims

EDI refers to the transfer of electronic data. Sending healthcare claims via EDI has many advantages. EDI claims are sent electronically from one computer to another, so there is no costly paperwork involved. By the time a paper claim is received by mail, an EDI claim can already be received and processed for payment/denial. Reducing printing and mailing costs, along with improved accuracy and faster claim payments, makes sending electronic claims extremely cost-effective. The claims are viewed the same way as paper claims in the AWD system.

Attachments

Overview

Claims may have attachments such as medical records, health records, medical charts, transportation records, explanation of benefits (EOB), explanation of payment (EOP), etc. The following section provides some examples of different types of attachments.

Medical Records

A medical record, health record, or medical chart is documentation of a member's medical history and care. It is a written transcript of information obtained from a member, guardian, or medical professional concerning their health history, diagnostic tests, diagnoses, treatments, and prognosis.

Explanation of Benefits (EOB)

An EOB is a statement listing services provided, amounts billed, and payment amounts. The statement also includes the name of the provider, date of service (DOS), and amount allowed. An EOB is required if a member has other insurance coverage (OIC), and the provider must bill the primary insurance company first and attach a copy of the primary's EOB for benefit coordination by Ambetter.

Explanation of Payment (EOP)

An EOP is a remittance statement sent to the rendering provider that explains the DOS payment or denial, the amount charged, the amount allowed, and the amount paid. If a provider disagrees with the payment or denial of a claim, an adjustment may be submitted with a copy of the original EOP attached.

Appendix VII: Billing Tips and Reminders

Acute General Hospitals

- Bill type for an outpatient APC claim is limited to 13X and 14X.
- Independent Labs owned/billed under Hospital will use bill type 14X.
- When updating the level of care from outpatient to inpatient, or vice versa, the provider should void the original claim and bill a first-time claim under the alternate bill type.... For example, if the provider used bill type 131 and identifies that the member was upgraded to Inpatient, the original claim should be rebilled with bill type 138, and a new claim with bill type 111 should then be billed.

Ambulance

- Must be billed in accordance with CMS billing guidelines.
- Appropriate modifiers must be billed with the Transportation Codes.
- Enter the ZIP code of the location where the ambulance picked up the member. This ZIP code is crucial for pricing and accurate claims processing.
- Enter the date the ambulance service was provided.
- Leave the Place of Service field blank.
- Indicate if the service was an emergency (9 or Y) or non-emergency (3 or N).
- Enter the appropriate HCPCS code for the ambulance service. For example, use A0427 for advanced life support, or A0429 for basic life support.

Ambulatory Surgery Center (ASC)

- Ambulatory Surgery Centers can bill on either a CMS-1500 or a CMS-1450. Refer to your contract for specific guidance if applicable.
- If billed on CMS-1500, must be billed in Place of Service 24.
- Ambetter uses the CMS surgical and ancillary fee schedule from the fiscal intermediary website. (Fee schedule per CBSA from primary practice ZIP code.)
- If billed on CMS-1450, must be billed using the appropriate revenue code and HCPCS codes.
- Invoice must be billed with Corneal Transplants.
- Most surgical extractions are billable only under the ASC.

Anesthesia

- Bill the total number of minutes in box 24G of the CMS-1500. Form must be submitted with the appropriate modifier.
- Failure to bill the total number of minutes may result in incorrect reimbursement or claim denial.
- Anesthesia claims may not be billed if they contain both modifier QK (medical direction by a physician) *and* modifier QX (qualified non-physician anesthetist with medical direction by a physician).

APC Billing Rules

- Refer to Medicare billing guidelines.
- Bill type for an APC claim is limited to 13x-14x.
- Independently owned labs that bill under Hospital should submit claims with bill type 14x.
- Late charge claims are not allowed, only replacement claims. A claim with late charges will be denied for resubmission.
- Revenue codes and HCPCS codes are required for APC claims.
- Can only be billed on a CMS-1450 claim form.
- Acceptable modifiers.
- CMS Maximum Unit Edits (MUEs) will be applied per line, per claim.
- Claim lines exceeding the MUE value will be denied.

Critical Access Hospitals (CAH)

- Critical Access Hospitals (CAHs) are required to bill with the appropriate bill type.

- Allowed bill types: 11x, 14x, 18x, 85x.
- Bill type 13x is not allowed.

DME/Supplies/Prosthetics and Orthotics

- Must be billed with an appropriate modifier.
- Purchase-only services must be billed with modifier NU.
- Rental services must be billed with modifier RR.

Hearing Aids

- Must be billed with the appropriate modifier LT or RT.

Home Health

- When using Medicare methodology, it must be billed on a CMS-1450.
- Bill type must be 32X for Current, or 34X for Payor.
- Must be billed with location 12 within the CMS-1500 form.
- Both Rev and CPT codes are required within the CMS-1450 form.
- Must bill procedure code Q.
- Each visit must be billed individually on a separate service line.
- Therapy services must be billed with the appropriate modifier(s).
- Nursing services must be billed with the appropriate modifier(s).
- Must bill with occurrence code 50.
- Must bill with 61 and 85 value codes.
- Must bill with appropriate HIPPS code.

Long Term Acute Care Facilities (LTACs)

- Long Term Acute Care Facilities (LTACs) must submit Functional Status Indicators on claim submissions.

Maternity Services

- Providers must use correct coding for Maternity Services.
- Use appropriate value codes as well as birth weight when billing for delivery services.
- Services provided to members prior to their Ambetter effective date should be correctly coded and

submitted to the responsible payor.

- Services provided to the member on or after their Ambetter effective date should be correctly coded and submitted to Ambetter.

Modifiers

- Review the appropriate uses of 25, 26, 96, 97, CO, CQ, 73, 74, TC, 50, GN, GO, GP, TD, and TE codes. Inappropriate use of modifiers may result in a claim denial/rejection.
- Modifier 25 should be used when a significant and separately identifiable E&M service is performed by the same provider on the same day as another procedure (e.g., 99381 and 99211-25).
- Modifier 25 is subject to the code edit and audit process. Appending a modifier 25 is not a guarantee of automatic payment and may require the submission of medical records.
- Use modifier 25 when a well child and sick visit is performed on the same day by the same provider.
- 25 modifiers are not appended to non-E&M procedure codes (e.g., lab).
- Modifier 26 should never be appended to an office visit CPT code.
- Use modifier 26 to indicate that the professional component of a test or study is performed using the 70000 (radiology) or 80000 (pathology) series of CPT codes.
- The correlating facility or institutional claim should have a Technical Component (TC) modifier.
- Modifier 96/97 – used for all habilitative services and rehabilitative services.
- Must be billed in addition to the GN, GO, GP modifier in the secondary position.
- Modifier CQ/CO – used for assistant therapist.
- Must be billed in addition to the GN, GO, GP (Primary Modifier) and 96/97. (Secondary Modifier) in the third position.
- Modifier TC – used to indicate that the technical component of a test or study is performed.
- Modifier 50 – indicates a procedure performed on a bilateral anatomical site.
- Procedure must be billed on a single claim line with the 50 modifier and quantity of one.
- RT and LT modifiers and quantities greater than one should not be billed when using modifier 50.
- Modifier GN, GO, GP– rehabilitative therapy modifiers required for speech, occupational, and physical therapy.
- This must be billed in the primary modifier position.
- Modifier TD and TE – nursing modifiers required for nursing services.

- Modifier 73 and 74 – cancelled procedure before and after anesthesia administered (ASC facilities only).

Present on Admission (POA)

- POA indicator is required on all inpatient facility claims.
- Failure to include the POA may result in a claim denial/rejection.

Rehabilitation Services – Inpatient Services

- Functional status indicators must be submitted for inpatient Rehabilitation Services.
- Must bill with occurrence code 50.
- Must bill with appropriate HIPPS code.

Reproductive Health Services

Claims will be adjudicated in accordance with state and federal laws. The following tables provide additional detail on how providers should bill for reproductive services.

Reproductive Health Procedure Codes				
59414	59812	59820	59821	59840
59841	59850	59851	59852	59855
59856	59857	59866	59870	59830
S0190	S0199	S2260	S2265	S2266
S2267				

Claims for these services must be presented with a condition code.

Hyde Procedures[5]	
Condition Code	Description
AA	Rape
AB	Incest
AD	Life Endangerment
AF	Due to Emotional/Physical Health of Mother
Non Hyde Futile Pregnancy Procedures	
AC	Due to serious fetal genetic defect, deformity, abnormality.

[5] Hyde Procedures are cases involving rape, incest, or when the continuation of the pregnancy would endanger the mother's life.

Claims for these services must be presented with a modifier code (Hyde Procedures Only).

Modifier	Description
G7	Pregnancy resulted from rape or incest, or pregnancy certified by a physician as life-threatening.

Fetal Viability Review will be conducted for Hyde and Non-Hyde Procedures.

Non-Hyde Procedures[6]	
Gestational Age	Medical Records Required
23 weeks or greater	Yes

Note: Procedures that are performed at 13 weeks or greater will not be covered.

Residential Treatment Centers (TOB 86x)

Purpose

To clarify appropriate billing practices for claims submitted using Type of Bill (TOB) 86X and to reduce the occurrence of duplicate denials and underpayments associated with incorrect billing constructs.

Scope

This guidance applies to:

- All participating providers submitting outpatient facility claims using TOB 86X.
- All Marketplace products and applicable state-specific requirements.

Background

A claims issue identified revealed inconsistencies in provider billing practices related to Type of Bill (TOB) 86X, specifically involving misalignment between bill type and date of service. As a result, variability in how providers submit TOB 86X claims has led to increased rework, operational inefficiencies, and elevated risk in certain markets. This update is part of a broader effort to ensure consistent application of billing guidelines across all Marketplace products.

To address these issues, a provider manual update is being implemented to:

- Standardize billing expectations for TOB 86X across markets.
- Reduce denial rates, underpayments, and administrative burden.

Billing Requirements for TOB 86X

Providers should adhere to the following requirements when submitting claims under TOB 86X:

- Date of Service and Billing Alignment

[6] Non-Hyde procedures are cases involving an elective procedure or cases not included as a Hyde procedure.

- Claims should accurately reflect the date of service (DOS) in alignment with the applicable billing period and service delivery.
- When submitting claims under Type of Bill (TOB) 86X, providers should bill services using an in-patient style construct as follows:
- Submit one service line per claim.
- Report on the full date span of services on the claim.
- Bill total units on a single line, reflecting the entire service period.
- Failure to follow this billing structure may result in claim denials or payment delays.

Supplies

- Providers may bill for supplies and materials in addition to an office visit if these supplies are over and above those usually included with the office visit.
- Supplies such as gowns, drapes, gloves, specula, pelvic supplies, urine cups, swabs, jelly, etc., are included in the office visit and may not be billed separately. Providers may not bill for any reusable supplies.

Telemedicine

- Providers at the distant site may bill for telemedicine services and *must* use the appropriate modifier to identify that the service was provided via telemedicine.
- E&M CPT plus the appropriate modifier.
- Via interactive audio and video telecommunication systems.
- Location must be billed with 02 or 10.
- For telehealth services billed with a Place of Service 02 or 10, providers will be reimbursed at the facility rate unless otherwise required per state guidelines.

Appendix VIII: Reimbursement Policies

Ambetter payments follow reimbursement policies that include, but are not limited to, those set forth below.

Admissions for Same or Related Diagnoses

Inpatient admissions for the same or a related diagnosis occurring within 30 days following a discharge in connection with a previous admission shall be considered part of the previous admission and are not separately reimbursable.

Calculating Anesthesia

Anesthesia time is defined as the period during which an anesthesia practitioner is present with the member. It starts when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room (or an equivalent area) and ends when the anesthesia practitioner is no

longer furnishing anesthesia services to the patient (that is, when the patient may be placed safely under postoperative care). Anesthesia time is a continuous time from the start of anesthesia to the end of the anesthesia service.

Consent for Sterilization

Ambetter requires providers to submit a Consent for Sterilization form for any service that may render the member sterile, including hysterectomies. The following information should be submitted in addition to the UB-04:

- Consent for Sterilization form – available under the Claims and Claim Payment page of the Ambetter website.
- Consent for Sterilization form – required on any procedure during which the beneficiary elects to become sterile.
- Consent for Sterilization form – required when a hysterectomy is performed on a member who is not already sterile.

If the member is sterile prior to the hysterectomy, the provider can note this on the claim. Documentation must be kept on file - A signed statement from the physician, certifying the individual was already sterile and stating the cause of sterility. This documentation must be available upon request.

EKG Payment

EKG Interpretation is separately billable and payable in addition to the actual test. However, the first provider to bill receives payment for services.

Professional modifier 26 and Technical modifier TC can be billed and paid separately for all radiology and some laboratory/pathology services.

Physician Site of Service

Physicians will be paid at the physician rate only at the following Sites of Service:

- Office
- Home
- Assisted living facility
- Mobile unit
- Walk-in retail health clinic
- Urgent care facility
- Birthing center
- Nursing facility
- Skilled nursing facility
- Independent clinic or lab
- FQHC
- Intermediate HC facility
- Comprehensive OP rehab facility
- ESRD facility
- State or local health clinic
- RHC

Other Place of Service: Diagnostic Testing of Implants

Charges and payments for diagnostic testing of implants following surgery are not included in the global fee for surgery and are reimbursable if the testing is outside the global timeframe. If it is inside the global timeframe, it is not reimbursable.

Hospice SIA Payment

Payments for hospice services do not include Service Intensity Add-on payments.

Hospital-Acquired Conditions and Provider Preventable Conditions

Provider payment shall comply with state and federal laws that require a reduction in payment or non-payment for “hospital-acquired conditions” and for “provider preventable conditions” as such terms (or the reasonable equivalents thereof) are defined under applicable state and federal laws.

Lesser Of Language

Ambetter will pay the provider the lesser of the provider’s allowable charges or the contracted rate.

Multiple Procedure Rules

When multiple procedures are performed for members during a single occasion, reimbursement will be as follows:

- Multiple procedure Surgical and Endoscopic codes follow Multiple Procedure reimbursement guidelines: 100%/50%/50%, max three surgical codes.
- Multiple procedure Radiology codes follow Multiple Procedure reimbursement guidelines: 100%/ /50%/50%, max three radiology codes.

Physician Assistant (PA) Payment Rules

- PA services furnished during a global surgical period shall be paid at 85% of what a physician is paid under the Ambetter Physician Fee Schedule.
- PA assistant-at-surgery services shall be paid at 85% of what a physician is paid under the Medicare Physician Fee Schedule. Since physicians are paid at 16% of the surgical payment amount under the Medicare Physician Fee Schedule for assistant-at-surgery services, the actual payment amount that PAs receive for assistant-at-surgery services is 13.6% of the amount paid to physicians. The AS modifier must be used.

Provider-Based Billing

Provider-based billing will not be reimbursed, as it is included in the professional fee compensation. Neither the payor nor the member shall be responsible for such provider-based billing. Provider-based billing is the amount charged by a clinic or facility as a technical component, or for overhead, in connection with professional services rendered in a clinic or facility and includes, but is not limited to, services billed using Revenue Codes 510-519.

Non-Physician Payment Reduction Rule

As applicable, the Allowed Amount on the claim may be reduced based on the non-physician Contracted Provider's specialty, provider type, licensing/certifications, or education.

Qualifying APM Participants

Payment for covered services is not augmented for "Qualifying APM Participants" under Medicare Alternative Payment Models.

Surgical Physician Payment Rules

For surgeries billed with these modifiers, pay the appropriate percentage of the fee schedule payment as identified by the modifier and procedure code used: 22, 52, 54, 55, 56, 62, 66, AS, 80, 81, 82.

Injection Services

Injection service codes must be paid separately if no other provider service is paid and when not billed with an office visit. If an office visit is billed, then no injection is payable because it is covered in the office charge.

Unpriced Codes

If the CMS/Medicare schedule does not contain a published fee amount, an alternate “gap fill” source is utilized to determine the fee amount. Unlisted codes are subject to the code edit and audit process and require submission of medical records.

Rental or Purchase Decisions

Rental or purchase decisions are made at the discretion of Medical Management.

Payment for Capped Rental Items During Period of Continuous Use

When no purchase options have been exercised, rental payments may not exceed a period of continuous use longer than 13 months. For the month of death or discontinuance of use, contractors pay the full month's rental. After 13 months of rental is paid, the supplier must continue to provide the item without any charge, other than for the maintenance and servicing fees, until medical necessity ends or Ambetter coverage ceases. For this purpose, unless there is a break in need of at least 60 days, medical necessity is presumed to continue. Any lapse greater than 60 days triggers a new medical necessity.

If the member changes suppliers during or after the 13-month rental period, this does not result in a new rental episode. The supplier that provides the item in the 13th month of the rental period is responsible for supplying the equipment and for maintenance and servicing after the 13-month period. If the supplier changes after the 10th month, there is no purchase option.

Percutaneous Electrical Nerve Stimulator (PENS) Rent Status While Hospitalized

An entire month's rent may not be paid when a member is hospitalized during the month. The rent will be prorated to allow for the time not hospitalized.

Transcutaneous Electrical Nerve Stimulator (TENS)

To permit an attending physician time to determine whether the purchase of a TENS is medically appropriate for a particular member, contractors pay 10% of the purchase price of the item for each of two months. The purchase price and payment for maintenance and servicing are determined under the same rules as any other frequently purchased item. There is a reduction in the allowed amount for purchase due to the two-month rental.

Appendix IX: EDI Companion Guide Overview

The Companion Guide provides Ambetter trading partners with guidelines for submitting the ASC X12N/005010x222 Healthcare Claim: Professional (837-P), and ASC X12N/005010x223 Healthcare Claim: Institutional (837-I). The Ambetter Companion Guide documents any assumptions, conventions, or data issues that may be specific to Ambetter business processes when implementing the HIPAA ASC X12N 5010A Technical Reports Type 3 (TR3). As such, this Companion Guide is unique to Ambetter and its affiliates.

This document does NOT replace the HIPAA ASC X12N 5010A Technical Reports Type 3 (TR3) for electronic transactions, nor does it attempt to amend any of the rules therein or impose any mandates on any trading partners of Ambetter. This document provides information on Ambetter-specific code handling and situation handling that is within the parameters of the HIPAA administrative Simplification rules. Readers of this Companion Guide should be acquainted with the HIPAA Technical Reports Type 3, their structure and content. Information contained within the HIPAA TR3s is not repeated here, although the TR3s have been referenced when necessary. The HIPAA ASC X12N 5010A Technical Reports Type 3 (TR3) can be purchased at https://x12.org/products.

The Companion Guide provides supplemental information to the Trading Partner Agreement (TPA) that exists between Ambetter and its trading partners. Refer to the TPA for guidelines pertaining to Ambetter legal conditions surrounding the implementations of EDI transactions and code sets. Refer to the Companion Guide for information on Ambetter business rules or technical requirements regarding the implementation of HIPAA-compliant EDI transactions and code sets.

Nothing contained in this guide is intended to amend, revoke, contradict, or otherwise alter the terms and conditions of the Trading Partner Agreement. If there is an inconsistency with the terms of this guide and the terms of the Trading Partner Agreement, the terms of the Trading Partner Agreement shall govern.

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Rules of Exchange

The Rules of Exchange section details the responsibilities of trading partners in submitting or receiving electronic transactions with Ambetter.

Transmission Confirmation

Transmission confirmation may be received through one of two possible transactions: the ASC X12C/005010X231 Implementation Acknowledgment for Healthcare Insurance (TA1, 999). A TA1 Acknowledgement is used at the ISA level of the transmission envelope structure, to confirm a positive transmission or indicate an error at the ISA level of the transmission. The 999 Acknowledgement may be used to verify a successful transmission or to indicate various types of errors.

Confirmations of transmissions, in the form of TA1 or 999 transactions, should be received within 24 hours of batch submissions, and usually sooner. Senders of transmissions should check for confirmations within this time frame.

Batch Matching

Senders of batch transmissions should note that transactions are unbundled during processing, and rebundled so that the original bundle is not replicated. Trace numbers or patient account numbers should be used for batch matching or batch balancing.

TA1 Interchange Acknowledgment

The TA1 Interchange Acknowledgment provides senders a positive or negative confirmation of the transmission of the ISA/IEA Interchange Control.

999 Functional Acknowledgment

The 999 Functional Acknowledgment reports on all Implementation Guide edits from the Functional Group and transaction Sets.

277CA Healthcare Claim Acknowledgment

The X12N005010X214 Healthcare Claim Acknowledgment (277CA) provides a more detailed explanation of the transaction set. Ambetter also provides the Pre-Adjudication rejection reason of the claim within the STC12 segment of the 2220D loop. **NOTE:** The STC03 – Action Code will only be a "U" if the claim failed on HIPAA validation errors, NOT Pre-Adjudication errors.

Duplicate Batch Check

To ensure that duplicate transmissions have not been sent, Ambetter checks five values for redundancy within the ISA: ISA06, ISA08, ISA09, ISA10, ISA13.

- Collectively, these numbers should be unique for each transmission. A duplicate ISA/IEA receives a TA1 response of "025" (Duplicate Interchange Control Number).
- To ensure that Transaction Sets (ST/SE) have not been duplicated within a transmission, Ambetter checks the ST02 value (Transaction Set Control Number), which should be a unique ST02 within the Functional Group transmitted.
- ISA08 & GS03 could also be the Single Payer ID.

Claims Processing

Acknowledgments

Senders receive four types of acknowledgment transactions:

- TA1 transaction – to acknowledge the Interchange Control Envelope (ISA/IEA) of a transaction.
- 999 transaction – to acknowledge the Functional Group (GS/GE) and Transaction Set (ST/SE).
- 277CA transaction – to acknowledge healthcare claims.
- Ambetter Audit Report. At the claim level of a transaction, the only acknowledgment of receipt is the return of the Claim Audit Report and/or a 277CA.

Coordination of Benefits (COB) Processing

To ensure the proper processing of claims requiring coordination of benefits, Ambetter recommends that providers validate the member's membership number and supplementary or primary carrier information for every claim.

Code Sets

Only standard codes, valid at the time of the date(s) of service, should be used.

Corrections and Reversals

The 837 defines what values submitters must use to signal payers that the Inbound 837 contains a reversal or correction to a claim that has previously been submitted for processing. For both Professional and Institutional 837 claims, 2300 CLM05-3 (Claim Frequency Code) must contain a value for the National UB Data Element Specification type list, Type of Bill position 3.

Data Format/Content

Ambetter accepts all compliant data elements on the 837 Professional Claim. The following points outline consistent data format and content issues that should be followed for submission.

Dates

The following statements apply to any dates within an 837 transaction:

- All dates should be formatted according to Year 2000 compliance (CCYYMMDD), except for ISA segments, where the date format is YYMMDD.
- The only values acceptable for "CC" (century) for date of birth are 18, 19, or 20.
- Dates that include hours should use the following format: CCYYMMDDHHMM.
- Use military format, or numbers from 0 to 23, to indicate hours. For example, an admission date of 201006262115 defines the date and time of June 26, 2010, at 9:15 PM.
- No spaces or character delimiters should be used in presenting dates or times.
- Dates that are logically invalid (e.g., 20011301) are rejected.
- Dates must be valid within the context of the transaction. For example, a member's date of birth cannot be after their service date.

Decimals

- All percentages should be presented in decimal format. For example, a 12.5% value should be presented as .125.
- Dollar amounts should be presented with decimals to indicate portions of a dollar. However, no more than two positions should follow the decimal point. Dollar amounts containing more than two positions after the decimal point are rejected.

Monetary and Unit Amount Values

Ambetter accepts all compliant data elements in the 837 Professional Claim, but negative monetary or unit amounts are rejected.

Delimiters

Delimiters are characters used to separate data elements within a data string. Delimiters suggested for use by Ambetter are specified in the Interchange Header segment (the ISA level) of a transmission and include the tilde (~) for segment separation, the asterisk (*) for element separation, and the colon (:) for component separation.

Phone Numbers

Phone numbers should be presented as contiguous number strings without dashes or parenthesis markers. For example, the phone number (336) 555-1212 should be presented as 3365551212. Area codes should always be included. Ambetter requires the phone number to be AAABBBCCCC where AAA is the Area code, BBB is the telephone number prefix, and CCCC is the telephone number.

Additional Items

- Ambetter will not accept more than 50 service lines per CMS-1500 claim.
- Ambetter will only accept single-digit diagnosis pointers in the SV107 of the 837-P.
- The Value-Added Network Trace Number (2300-REF02) is limited to 30 characters.

Identification Codes and Numbers

General Identifiers

Federal Tax Identifiers

Any federal tax identifier (employer ID or Social Security Number, etc.) used in a transmission should omit dashes and hyphens. Ambetter sends and receives only numeric values for all tax identifiers.

Provider Identifiers

National Provider Identifiers (NPI)

HIPAA regulations require providers to use their NPI for electronic claims submission. The NPI is used at the record level of HIPAA transactions. For 837 claims, it is placed in the 2010AA loop. See the 837 Professional Data Element table for specific instructions about where to place the NPI within the 837 Professional file. The table also clarifies what other elements must be submitted when the NPI is used.

Billing Provider

The Billing Provider Primary Identifier should be the group/organization ID of the billing entity, filed only at 2010AA. This will be a Type 2 (Group) NPI unless the billing provider is a sole proprietor and processes all claims and remittances with a Type 1 (Individual) NPI.

Rendering Provider

When providers perform services for a subscriber/patient, the service must be reported in the Rendering Provider Loop (2310B or 2420A). Only use 2420A when it differs from Loop 2310B/NM1*82.

Referring Provider

Ambetter has no specific requirements for Referring Provider information.

Atypical Provider

Atypical Providers are not always assigned an NPI; however, if an Atypical Provider has been assigned an NPI, they must follow the same requirements as a medical provider. An Atypical Provider which provides non-medical services is not required to have an NPI (e.g., carpenters, transportation, etc.). Existing Atypical Providers need only send the Provider Tax ID in the REF segment of the Billing Provider loop. **If an NPI is billed in any part of the claim, it will not follow the Atypical Provider Logic.**

Subscriber Identifiers

Submitters must use the entire identification code **as it appears on the subscriber's card** in the 2010BA element.

Claim Identifiers

Ambetter issues a claim identification number upon receipt of any submitted claim. The ASC X12 Technical Reports (Type 3) may refer to this number as the Internal Control Number (ICN), Document Control Number (DCN), or the Claim Control Number (CCN). It is provided to senders in the Claim Audit Report and in the CLP segment of an 835 transaction. Ambetter returns the submitter's Patient Account Number (2300, CLM01) on the Claims Audit Report and the 835 Claim Payment/Advice (CLP01).

Connectivity Media for Batch Transactions

Direct Submission

Ambetter also allows posting an 837-batch file directly on the secure provider portal for processing.

Edits and Reports

Incoming claims are reviewed first for HIPAA compliance and then for Ambetter business rules requirements. The business rules that define these requirements are identified in the 837 Professional Data Element Table below and are also available as a comprehensive list in the 837 Professional Claims – Ambetter Business Edits Table. HIPAA TR3 implementation guide errors may be returned on either the TA1 or 999 while Ambetter business edit errors are returned on the Ambetter Claims Audit Report.

Reporting

The following table indicates which transaction or report to review for problem data found within the 837 Professional Claim Transaction.

Transaction Structure Level	Type of Error or Problem	Transaction or Report Returned
ISA/IEA Interchange Control		TA1
GS/GE Functional Group ST/SE Segment Detail Segments	HIPAA Implementation Guide violations	999 Ambetter Claims Audit Report (a proprietary confirmation and error report)
Detail Segments	Ambetter Business Edits (See audit report rejection reason codes and explanation.)	Ambetter Claims Audit Report (a proprietary confirmation and error report)
Detail Segments	HIPAA Implementation Guide violations and Ambetter Business Edits	277CA

STATE MANDATED REGULATORY REQUIREMENTS

This Appendix applies to the following Products:

- Individual Marketplace (also known, or previously known, in some markets as Commercial-Exchange, Exchange, Individual, Individual Market or Health Benefit Exchange, among others)
- Direct Individual

As relating to any agreement between you and Ambetter from Superior HealthPlan under which you participate in any of the Products listed above, for each state listed below, the following requirements apply to you as well as any Centene-affiliated health plan in that state, to the extent that such Centene-affiliated health plan (i) offers such Product in that state, and (ii) has access as an affiliate or is a party to your agreement with Ambetter from Superior HealthPlan, pursuant to the terms of that agreement.

Alabama

STATE REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

Arizona

STATE REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

AZ-1 No Gag Clause. Neither the Payor nor HMO shall restrict or prohibit a Participating Provider's good faith communication with the Participating Provider's patients concerning any such patient's health care or medical needs, treatment options, health care risks or benefits. HMO shall not terminate or refuse to renew the Agreement, or a Participating Provider's participation in this Product Attachment, solely because the Participating Provider in good faith does any of the following: (a) advocates in private or in public on behalf of a patient; (b) assists a patient in seeking

reconsideration of a decision made by the Payor to deny coverage for a health care service; or (c) reports a violation of law to an appropriate authority. (ARIZ. REV. STAT. §§ 20-118; 20-1061).

AZ-2 Hold Harmless. If the Payor fails to pay for Covered Services as set forth in the Covered Person's Coverage Agreement, the Covered Person is not liable to the Participating Provider for any amounts owed by the Payor and the Participating Provider shall not bill or otherwise attempt to collect from the Covered Person the amount owed by the Payor. (ARIZ. REV. STAT. § 20-1072).

AZ-3 Continuation of Care After Insolvency. Each Participating Provider shall provide Covered Services to Covered Persons at the same rates and subject to the same terms and conditions established in the Agreement for the duration of the period after the Payor is declared insolvent, until the earliest of the following: (a) the expiration of the period during which the Payor is required to continue benefits as described in ARIZ. REV. STAT. § 20-1069(A); (b) notification from the receiver pursuant to ARIZ. REV. STAT. § 20-1069(F) or a determination by the court that the Payor cannot provide adequate assurance it will be able to pay the Participating Provider's claims for Covered Services that were rendered after the Payor is declared insolvent; (c) a determination by the court that the insolvent Payor is unable to pay the Participating Provider's claims for health care services that were rendered after the Payor is declared insolvent; (d) a determination by the court that continuation of the Agreement would constitute undue hardship to the Participating Provider; or (e) a determination by the court that the Payor has satisfied its obligations to all Covered Persons under the applicable Coverage Agreements. (ARIZ. REV. STAT. § 20-1074(B)).

Arkansas

STATE REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

AR-1 Continuity of Care. If the Payor becomes insolvent, each Participating Provider shall continue to provide services to Covered Persons for the duration of the period after the Payor's insolvency for which the premium payment has been made and until any Covered Persons that are inpatients at the time of the Payor's insolvency are discharged from the inpatient facilities. (ARK. CODE ANN. § 23-76-118(c)(2)).

AR-2 Hold Harmless. In the event the Payor fails to pay for Covered Services as set forth in the Agreement, each Participating Provider agrees that no Covered Person is liable to the Participating Provider for any sums owed by the Payor. In addition, the Participating Provider agrees that the Participating Provider and any agent, trustee, or assignee of the Participating Provider shall not

maintain an action at law against a Covered Person to collect sums owed to them by the Payor nor shall they make any statement, either written or oral, to any Covered Persons that makes demand for, or would lead a reasonable person to believe that a demand is being made for, payment of any amounts owed by the Payor. (ARK. CODE ANN. §§ 23-76-119(c)(1), 23-76-119(c)(3), 23-76-118(b)).

AR-3 Network Access. Each Participating Provider authorizes Company to sell, lease, assign, convey, and otherwise grant access to Company's network and related contracted reimbursement rates to other entities, including, without limitation, Payors. (ARK. CODE ANN. § 23-63-113(b)(1)).

Florida

STATE REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

FL-1 Orders of the OIR. Pursuant to State law, the Agreement will be canceled upon issuance of an order by the Office of Insurance Regulation ("*OIR*"). (Fla. Stat. § 641.234(3)).

FL-2 Notice of Termination. Provider shall give sixty (60) days' advance written notice to Health Plan and the OIR before canceling the Agreement for any reason. Provider agrees that nonpayment for goods or services rendered by the Provider to the Health Plan is not a valid reason for avoiding the 60-day advance notice of cancellation. Health Plan will provide 60 days' advance written notice to the Provider and the OIR before canceling, without cause, the Agreement, except in a case in which a patient's health is subject to imminent danger or a physician's ability to practice medicine is effectively impaired by an action by the Board of Medicine or another governmental agency. (Fla. Stat. § 641.315(2)).

FL-3 Notice of Consumer Assistance. Each Participating Provider shall post a consumer assistance notice prominently displayed in the reception area of the Participating Provider and clearly noticeable by all patients. The consumer assistance notice must state the addresses and toll-free telephone numbers of AHCA, the Subscriber Assistance Program, and the Department of Financial Services. The consumer assistance notice must also clearly state that the address and toll-free telephone number of Health Plan's grievance department shall be provided upon request. (Fla. Stat. § 641.511(11)).

FL-4 Covered Person Hold Harmless. If Health Plan is liable for services rendered to a Covered Person by a Participating Provider, Health Plan is liable for payment of fees to the Participating Provider and the Covered Person is not liable for payment of fees to the Participating Provider. For purposes of this Section, Health Plan is liable for services rendered to a Covered Person by a Participating Provider if the Participating Provider follows Health Plan's authorization procedures and receives authorization for a Covered Service for a Covered Person, unless the Participating Provider provided information to Health Plan with the willful intention to misinform Health Plan. A Participating Provider or any representative of a Participating Provider may not collect or attempt to collect money from, maintain any action at law against, or report to a credit agency a subscriber of Health Plan or a Payor for payment of services for which Health Plan or the Payor is liable, if the Participating Provider in good faith knows or should know that Health Plan or the Payor is liable. This prohibition applies during the pendency of any claim for payment made by the Participating Provider to Health Plan or the Payor for payment of the services and any legal proceedings or dispute resolution process to determine whether Health Plan or the Payor is liable for the services if the Participating Provider is informed that such proceedings are taking place. It is presumed that a Participating Provider does not know and should not know that Health Plan or a Payor is liable unless: (a) the Participating Provider is informed by Health Plan or the Payor that it accepts liability; (b) a court of competent jurisdiction determines that Health Plan or a Payor is liable; (c) the OIR or Agency for Health Care Administration ("***AHCA***") makes a final determination that Health Plan or a Payor is required to pay for such services subsequent to a recommendation made by the Subscriber Assistance Panel pursuant to Fla. Stat. § 408.7056; or (d) AHCA issues a final order that Health Plan or a Payor is required to pay for such services subsequent to a recommendation made by a resolution organization pursuant to Fla. Stat. § 408.7057. (Fla. Stat. §§ 641.315(1); 641.3154) Sunshine State Health Plan, Inc. - PPA – All Products 5/20/16 Page 156 of 343.

Georgia

STATE REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

GA-1 Physician Specific Provisions. If a Participating Provider is a physician, the following apply.

GA-1.1 If the Agreement or a Participating Provider's participation is terminated by Health Plan thereby affecting any Covered Person's opportunity to continue receiving health care services from the Participating Provider under the Coverage Agreement, any such Covered Person

who is suffering from and receiving active health care services for a chronic or terminal illness or who is an inpatient shall have the right to continue to receive health care services from the Participating Provider for a period of up to sixty (60) days from the date of the termination of the Agreement. Any Covered Person who is pregnant and receiving treatment in connection with that pregnancy at the time of the termination of that Covered Person's Participating Provider's Agreement shall have the right to continue receiving health care services from the Participating Provider throughout the remainder of that pregnancy, including six (6) weeks' post-delivery care. During such continuation of coverage period, the Participating Provider shall continue providing such services in accordance with the terms of the Agreement applicable at the time of the termination, and Health Plan or Payor, as applicable, shall continue to meet all obligations of such Participating Provider's Agreement. The Covered Person shall not have the right to the continuation provisions provided in this Section if the Participating Provider's Agreement is terminated because of the suspension or revocation of the Participating Provider's license or if Health Plan determines that the Participating Provider poses a threat to the health, safety, or welfare of Covered Persons. (GA. CODE ANN. § 33-20A-61(a)).

GA-1.2 Notwithstanding the foregoing, if a Participating Provider terminates their Agreement thereby affecting any Covered Person's opportunity to continue receiving health care services from that Participating Provider under the Coverage Agreement, any such Covered Person who is suffering from and receiving active health care services for a chronic or terminal illness or who is an inpatient shall have the right to receive health care services from that Participating Provider for a period of up to sixty (60) days from the date of the termination of the Participating Provider's Agreement. Any Covered Person who is pregnant and receiving health care services in connection with that pregnancy at the time of the termination of that Covered Person's Participating Provider's Agreement shall have the right to continue receiving health care services from that Participating Provider throughout the remainder of that pregnancy, including six (6) weeks' post-delivery care. During such continuation of coverage period, the Participating Provider shall continue providing such services in accordance with the terms of the Agreement applicable at the time of the termination, and Health Plan and Payor, as applicable, shall continue to meet all obligations of such Participating Provider's Agreement. The Covered Person shall not have the right to the continuation provisions provided in this Section if the Participating Provider terminates their Agreement because of the suspension or revocation of the Participating Provider's license or for reasons related to the quality of health care services rendered or issues related to the health, safety, or welfare of Covered Persons. (GA. CODE ANN. § 33-20A-61(b)).

Illinois

REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this

Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

IL-1 Hold Harmless. If the Participating Provider is a hospital, the Participating Provider agrees that in no event, including but not limited to nonpayment by the Payor of amounts due the Participating Provider under the Agreement or this Product Attachment, insolvency of the Payor any breach of the Agreement or this Product Attachment by the Payor, shall the Participating Provider or its assignees or subcontractors have a right to seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against, the Covered Person, persons acting on the Covered Person's behalf (other than the Payor), the employer or group contract holder for Covered Services provided pursuant to the Agreement or this Product Attachment except for the payment of applicable co-payments or deductibles for Covered Service or fees for services not covered by the Payor. The requirements of this clause will survive any termination of the Agreement or this Product Attachment for services rendered prior to such termination, regardless of the cause of such termination. The Covered Persons, the persons acting on the Covered Person's behalf (other than the Payor) and the employer or group contract holder will be third party beneficiaries of this Section. This Section supersedes any oral or written agreement now existing or hereafter entered between the Participating Provider and the Covered Person, persons acting on the Covered Person's behalf (other than the Payor) and the employer or group contract holder. (215 ILL. COMP. STAT. 125/2-8(a); ILL. ADMIN. CODE § 5421.50(e)).

IL-2 Quality Assurance. Each Participating Provider (and any of their or its subcontractors) shall provide, arrange for, or participate in the quality assurance programs mandated by the Health Maintenance Organization Act, as may be amended. (215 ILL. COMP. STAT. 125/2-8(b)).

IL-3 Examination by the Director. Each Participating Provider agrees that the Director of Public Health may make an examination concerning the quality of health care services provided under the Agreement and this Product Attachment as often as the Director deems it necessary for the protection of the interest of the people of the State, but not less frequently than once every three (3) years. Each Participating Provider shall submit his, hers or its books and records relating to Health Plan and the Payor to examination and in every way facilitate them. Each Participating Provider acknowledges that, for the purpose of examinations, the Director of Insurance and the Director of Public Health may administer oaths to and examine the principals of the Participating Provider concerning their or its business. (215 ILL. COMP. STAT. 125/5-4).

IL-4 Termination.

IL-4.1 Each Participating Provider shall provide at least sixty (60) days' notice to Health Plan for termination of the Agreement or the termination of its, their participation under this Product Attachment with cause, as may be defined in the Agreement or Provider Manual, and at least ninety (90) days' notice to Health Plan for termination of the Agreement or the termination of its, their participation under this Product Attachment without cause. (ILL. ADMIN. CODE § 5421.50(a)(5)).

IL-4.2 Health Plan shall provide at least sixty (60) days' notice to the Participating Provider of the nonrenewal or termination of the Agreement or its, their participation under this Product Attachment. Notwithstanding the foregoing, immediate written notice of non-renewal or termination may be provided by Health Plan without sixty (60) days' notice if the Participating Provider's license has been disciplined by a state licensing board. (215 ILL. COMP. STAT. 134/20).

IL-4.3 Each Participating Provider acknowledges that notification procedures for termination of the Agreement or this Product Attachment are set forth in the Agreement, this Product Attachment, and the Provider Manual. Each Participating Provider agrees that such termination provisions require: (a) not less than thirty (30) days prior written notice by either party who wishes to terminate the Agreement without cause; (b) Health Plan may immediately terminate the Agreement for cause (except as otherwise expressly required by IL-4.1); and (c) if the Participating Provider acts as a primary care physician under a Coverage Agreement requiring a gatekeeper option, the Participating Provider must provide the Payor with a list of all Covered Persons using such Participating Provider as a gatekeeper within five (5) working days after the date that the Participating Provider either gives or receives notice of termination. (ILL. ADMIN. CODE § 2051.290(f)).

IL-5 Provider Responsibility. Each Participating Provider acknowledges that the specific Covered Services for which the Participating Provider will be responsible, including any discount services, copayments, benefit maximums, limitations, and exclusions, as well as any discount amount or discounted fee schedule reflecting discounted rates, are set forth in the Agreement (which includes the Provider Manual and all Attachments). (ILL. ADMIN. CODE § 2051.290(a)).

IL-6 Administrative Policies. Each Participating Provider shall comply with applicable administrative policies and procedures of Health Plan and the Payor including, but not limited to credentialing or recredentialing requirements, utilization review requirements and referral procedures. (ILL. ADMIN. CODE § 2051.290(b)).

IL-7 Records. When payments are due to the Participating Provider for services rendered to a Covered Person, the Participating Provider must maintain and make medical records available: (a) to the Payor for the purpose of determining, on a concurrent or retrospective basis, the medical necessity and appropriateness of care provided to Covered Persons; (b) to appropriate State and federal authorities and their agents involved in assessing the accessibility and availability of care or investigating member grievances or complaints; and (c) to show compliance with the applicable State and federal laws related to privacy and confidentiality of medical records. (ILL. ADMIN. CODE § 2051.290(c)).

IL-8 Licensure. Each Participating Provider shall be licensed by the State and notify Health Plan immediately whenever there is a change in licensure or certification status. (ILL. ADMIN. CODE § 2051.290(d)).

IL-9 Admitting Privileges. If the Participating Provider is a physician, the Participating Provider shall have admitting privileges in at least one hospital with which Health Plan has a written provider

contract. Health Plan shall be notified immediately of any changes in privileges at any hospital or admitting facility. Each Participating Provider acknowledges that Health Plan may make reasonable exceptions for a Participating Provider who, because of the type of clinical specialty, or location or type of practice, does not customarily have admitting privileges. (ILL. ADMIN. CODE § 2051.290(e)).

IL-10 Continuity of Care.

IL-10-1 Each Participating Provider agrees to accept the responsibilities for continuation of Covered Services in the event of termination of the Agreement, to the extent that an extension of benefits is required by law or regulation, or that continuation is voluntarily provided by the Payor. (ILL. ADMIN. CODE § 2051.290(g)).

IL-10-2 Except in situations involving imminent harm to a patient or a final disciplinary action by a State licensing board, each Participating Provider shall continue to provide Covered Services to Covered Persons in an ongoing course of treatment with that Participating Provider for a transitional period following termination or non-renewal of the Agreement or the termination of the Participating Provider's participation under this Product Attachment: (a) for ninety (90) days from the date of the notice to the Covered Person of the termination or non-renewal of the Agreement or the termination of the Participating Provider's participation under this Product Attachment if the Covered Person has an ongoing course of treatment; or (b) if the Covered Person has entered the third trimester of pregnancy at the time of the termination or non-renewal, through delivery and the provision of postpartum care directly related to the delivery. For transitional periods exceeding thirty (30) days, each Participating Provider agrees: (a) to continue to accept reimbursement from the Payor at the rates applicable prior to the start of the transitional period; (b) to adhere to the Payor's quality assurance requirements and to provide to the Payor necessary medical information related to such care; and (c) to otherwise adhere to the Payor's policies and procedures, including but not limited to procedures regarding referrals and obtaining preauthorization's for treatment. (215 ILL. COMP. STAT. 134/25).

IL-11 Assignment. The rights and responsibilities under the Agreement or this Product Attachment cannot be sold, leased, assigned, assumed, or otherwise delegated by either party without the prior written consent of the other party. By participating under this Product Attachment, Provider and each Participating Provider is hereby deemed to consent to any assignment or assumption of the Agreement or this Product Attachment by Health Plan, including any assignment or assumption in connection with any purchase of Health Plan by another administrator or insurer. The parties acknowledge that any assignee must comply with all the terms and conditions of the documents being assigned, including all appendices, policies, and fee schedules. (ILL. ADMIN. CODE § 2051.290(h)).

IL-12 Insurance. Each Participating Provider has and will maintain adequate professional liability and malpractice coverage, through insurance, self-funding, or other means satisfactory to Health Plan. The Participating Provider shall give Health Plan at least fifteen (15) days advance notice of cancellation of such insurance and shall notify Health Plan within no less than ten (10) days after

the Participating Provider's receipt of notice of any reduction or cancellation of the required coverage. (ILL. ADMIN. CODE §§ 5421.50(a)(7); 2051.290(i)).

IL-13 Non-Discrimination. Each Participating Provider shall provide health care services without discrimination against any beneficiary based on participation in a Coverage Agreement, source of payment, age, sex, ethnicity, religion, sexual, health status or disability. (ILL. ADMIN. CODE § 2051.290(j)).

IL-14 Financial Responsibility. Each Participating Provider shall collect applicable copayments, coinsurance and/or deductibles (if any) from Covered Persons as provided by the Covered Person's Coverage Agreement and shall provide notice to Covered Persons of their personal financial obligations for services that are not Covered Services including any amount of applicable discounts or, alternatively, a fee schedule that reflects any discounted rates. (ILL. ADMIN. CODE § 2051.290(k)).

IL-15 Availability. Except as otherwise provided in the Provider Manual, each Participating Provider shall provide Covered Services on a twenty-four (24) hour per day, seven (7) day per week basis. (ILL. ADMIN. CODE § 2051.290(l)).

IL-16 Payment. Each Participating Provider acknowledges that a clear description of the Payor's payment obligations to the Participating Provider are set forth in the Agreement and this Product Attachment, which includes the Compensation Schedule attached at Exhibit 1. (ILL. ADMIN. CODE § 2051.290(m)).

IL-17 Information. Each Participating Provider acknowledges that the Agreement (which includes the Provider Manual and all Attachments) provides a description of the administrative services, if any, the Health Plan or Payor will perform and the types of information (e.g., financial, enrollment, utilization) that will be submitted to the Participating Provider, as well as other information that is accessible to the Participating Provider. (ILL. ADMIN. CODE § 2051.290(n)).

IL-18 Benefit Information. Each Participating Provider acknowledges that the Agreement (which includes the Provider Manual and all Attachments) identifies the method that Participating Providers may use to access Health Plan, each Payor, or their designees to obtain benefit information and adequate notice of change in benefits and copayments. Health Plan will arrange for each Payor's operational policies to be accessible to the Participating Provider. (ILL. ADMIN. CODE § 2051.290(o)).

IL-19 Dispute Resolution. Each Participating Provider acknowledges that the Agreement (which includes the Provider Manual and all Attachments) sets forth the applicable internal appeal or arbitration procedures for settling contractual disputes or disagreements between the Participating Provider and the Health Plan. (ILL. ADMIN. CODE § 2051.290(p)).

Indiana

STATE REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

IN-1 Continuation of Care. Upon the request of a Covered Person, the Participating Provider shall continue to treat and provide Covered Services to the Covered Persons for up to sixty (60) days following the termination of the Agreement or, in the case of a pregnant Covered Person in the third trimester of pregnancy, throughout the term of the pregnancy. If Participating Provider is a hospital, the Participating Provider shall provide continue to treat and provide Covered Services to Covered Persons until the earlier of: (i) the sixtieth (60th) day following the termination of the Agreement or (ii) the Covered Person is released from inpatient status at the Participating Provider. During a continuation period under this Section, the Participating Provider (i) shall continue accepting the terms and conditions of the Agreement, together with applicable deductibles and copayments, as payment in full; and (ii) is prohibited from billing the Covered Person for any amounts more than the Covered Person's applicable deductible or copayment. This Section does not apply if the Agreement is terminated by Health Plan due to a quality-of-care issue. (IND. CODE § 27-13-36-6).

IN-2 Hold Harmless. In the event the Payor fails to pay for health care services as specified by the Agreement, the Covered Person is not liable to the Participating Provider for any sums owed by the Payor. Each Participating Provider (and any trustee, agent, representative, or an assignee of a Participating Provider) may not bring or maintain any legal action against a Covered Person to collect sums owed by the Payor. Except as provided below in this Section, if Participating Provider brings or maintains a legal action against a Covered Person for an amount owed to the Participating Provider by the Payor, the Participating Provider is liable to the subscriber or enrollee for costs and attorney's fees incurred by the Covered Person in defending the legal action. The Participating Provider shall not be liable to the Covered Person for costs and attorney's fees described in the preceding sentence if the Participating Provider can demonstrate a reasonable basis for believing at the time the legal action was brought and while the legal action was maintained that the Payor did not owe the sums the Participating Provider sought to collect from the Covered Person. (IND. CODE §§ 27-13-15-1(a)(4); 27-13-15-3).

IN-3 Termination. Provider and each Participating Provider shall give the Health Plan at least sixty (60) days advance written notice of its, their termination of the Agreement; provided, however, that if Provider or the Participating Provider provide thirty percent (30%) or more of the Payor's services, then Provider and each Participating Provider shall give at least one hundred twenty (120) days advance written notice of its, their termination of the Agreement. (IND. CODE §§ 27-13-17-1).

IN-4 Third Party Access. The Agreement applies to network rental arrangements. One purpose of the Agreement is selling, renting or giving Health Plan rights to the services of the Participating Provider, and the third party accessing the Participating Provider's services is any of the following: (i) a Payor or a third-party administrator or other entity responsible for administering claims on behalf of the Payor; (ii) a preferred provider organization or preferred provider network, including a physician-hospital organization, (iii) an entity engaged in the electronic claims transport between Health Plan and the Payor. Any third party that is granted access is obligated to comply with all the applicable terms of Health Plan's contract with the Participating Provider. In addition, any of the following third parties may be granted access to the Participating Provider's services: (A) an employer or another entity providing coverage for health care services to the employer's or entity's employees or members and the entity has a contract with Health Plan or Health Plan's Affiliate for the administration or processing of claims for payment or service provided under the Agreement; or (B) an Affiliate of Health Plan or an entity providing administrative IN PPA – Confidential and Proprietary Page 137 of 278 PPA base agreement 01.29.15.

Iowa

STATE REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

IA-1 Provider contracts. In all instances, all provider contracts shall include the following provision: (Provider), or its assignee or subcontractor, hereby agrees that in no event, including, but not limited to nonpayment by the HMO, HMO insolvency or breach of this agreement, shall (Provider), or its assignee or subcontractor, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against subscriber/enrollee or persons other than the HMO acting on their behalf for services provided pursuant to this Agreement. This provision shall not prohibit collection of supplemental charges or copayments on HMO's behalf made in accordance with terms of (applicable Agreement) between HMO and subscriber/enrollee. (Provider), or its assignee or subcontractor, further agrees that (1) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the HMO subscriber/enrollee and that (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between (Provider) and subscriber/enrollee or persons acting on their behalf. (Iowa Administrative Code 191—40.18(514B)).

IA-2 Post delivery benefits. Every person issuing contracts under the scope of this chapter providing maternity benefits, which are not limited to complications of pregnancy, or newborn care benefits,

shall not terminate inpatient benefits or require discharge of a mother or the newborn from a hospital following delivery earlier than determined to be medically appropriate by the attending physician after consultation with the mother and in accordance with the most recent edition of the Guidelines for Perinatal Care, by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, which provide that when complications are not present, the postpartum hospital stay ranges from a minimum of 48 hours for a vaginal delivery to a minimum of 96 hours for a Cesarean birth, excluding the day of delivery. In accordance with those guidelines, in the event of a discharge from the hospital prior to the minimum stay established in the guidelines, a post discharge follow-up visit shall be provided to the mother and newborn by providers competent in postpartum care and newborn assessment if determined medically appropriate as directed by the attending physician. Copies of this publication may be obtained through the Iowa Insurance Division, 1963 Bell Avenue, Suite 100, Des Moines, Iowa 50315, telephone (515)654-6600. (Iowa Administrative Code 191—81.3(514C)).

IA-3 Appointment Availability. Iowa Total Care's Medicaid contract with the State of Iowa requires them to: (ii) Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid FFS, if the provider serves only Medicaid enrollees. (42 CFR § 438.206(c)(1)(ii), Contract E.5.01(b)).

Our Iowa **Medicaid** contractual requirements include the following appointment availability standards:

TYPE OF APPOINTMENT	SCHEDULING REQUIREMENT
Primary Care Providers	Timeframe
Emergency Medical Condition	Immediately upon presentation, twenty-four (24) hours a day, seven (7) days a week.
Urgent Medical Condition	Within twenty-four (24) hours.
Non-Urgent Sick Visits (w/persistent symptoms)	Within thirty (30) days.
Routine Appointments	Not to exceed four (4) to six (6) weeks.
Specialists	Timeframe
Specialty Providers – Urgent	Within Twenty-four (24) hours.
Specialty Providers – Routine	Within thirty (30) days.
Hospitals – Emergency	Twenty-four (24) hours a day, seven (7) days a week.
Behavioral Health – Emergency	Immediately upon presentation, twenty-four (24) hours a day, seven (7) days a week.
Behavioral Health – Mobile Crisis	Within one (1) hour of presentation or request.
Behavioral Health – Urgent	Within one (1) hour of presentation at a service delivery site or within twenty-four (24) hours of telephone contact with provider or Iowa Total Care.
Behavioral Health – Persistent Symptoms	Within forty-eight (48) hours of seeking treatment.
Substance Use Disorder & Pregnancy	Members who are pregnant women in need of routine substance use disorder services must be admitted within forty-eight (48) hours of seeking treatment.

TYPE OF APPOINTMENT	SCHEDULING REQUIREMENT
Intravenous Drug Use	Admitted no later than fourteen (14) days after making the request for admission, or one-hundred and twenty (120) days after the date of such request if no program has the capacity to admit the individual on the date of such request and if interim services are made available to the individual no later than forty-eight (48) hours after such request.
Labs and X-Ray Services – Non-Urgent	Not to exceed three (3) weeks.
Labs and X-Ray Services – Urgent	Within forty-eight (48) hours.
General Optometry – Routine	Not to exceed three (3) weeks.
General Optometry – Urgent	Within forty-eight (48) hours.

Kansas

STATE REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

KS-1 Hold Harmless. Provider and each Contracted Provider agree that a Covered Person is not liable to Provider or any Contracted Provider for any amounts owed by the Payor for Covered Services under the applicable Coverage Agreement that are not paid by the Payor. Any action by Provider or Contracted Provider to collect or attempt to collect from a Covered Person any sum owed by the Payor to Provider, or a Contracted Provider is deemed to be an unconscionable act within the meaning of KAN. STAT. ANN. § 50-627, and any amendments thereto. (KAN. STAT. ANN. § 40-3209(b)).

KS-2 Examination by Insurance Commissioner. Provider and each Contracted Provider shall provide access to their respective affairs, books and records to the State insurance commissioner including any delegate or duly authorized agent thereof for examination in accordance with State law. (KAN. STAT. ANN. § 40-3211).

KS-3 Emergency Services. To the extent that a Coverage Agreement requires prior authorization before receiving payment for treatment of an emergency medical condition, neither Provider nor any Contracted Provider shall hold a Covered Person under such Coverage Agreement financially responsible for payment for such services if such prior authorization is not sought or received. (KAN. STAT. ANN. § 40-3229(c)).

KS-4 Treatment Decisions. The parties acknowledge and agree that nothing in the Agreement or this Attachment prohibits or restricts a Contracted Provider from discussing or disclosing to any Covered Person any medically appropriate health care information that such Contracted Provider deems appropriate regarding the nature of treatment options, the risks or alternatives thereto, the process used or the decision made by a Company or Payor to approve or deny health care services, the availability of alternate therapies, consultations, or tests, or from advocating on behalf of the Covered Person within any utilization review or grievance processes established by a Company or Payor. (KAN. STAT. ANN. § 40-4604).

KS-5 Financial Incentives. The parties acknowledge and agree that nothing in the Agreement or this Attachment, including but not limited to the Compensation Schedule, serves as a direct or indirect inducement to reduce, or limit the delivery of medically necessary services to a Covered Person. (KAN. STAT. ANN. § 40-4605).

KS-6 Use of Name. Provider and each Contracted Provider hereby authorize each Company and Payor to use their respective names, telephone numbers, addresses, availability, and a description of services in listings of Participating Providers. (KAN. STAT. ANN. §§ 40-3214, 40-4606(c)).

KS-7 Grievance Procedures. Provider and each Contracted Provider shall participate in the grievance procedures established under or in connection with the applicable Coverage Agreement. (KAN. STAT. ANN. § 40-3229(d)).

Michigan

STATE REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

Required Provisions.

500.3529 Affiliated provider contracts; collection of payments from enrollees; contract provisions; waiver of requirement under subsection (2); contract format; evidence of sufficient number of providers.

(4) An affiliated provider contract shall contain provisions assuring all the following:

(a) The provider meets applicable licensure or certification requirements.

(b) Appropriate access by the health maintenance organization to records or reports concerning services to its enrollees.

(c) The provider cooperates with the health maintenance organization's quality assurance activities.

500.3531 Contracts with health care providers to become affiliated providers; requirements; standards; filing; duplicative standards; notice procedures; provider application period; approval or rejection as affiliated provider; termination of contract; providing information to insurer.

(1) This section applies if a health maintenance organization contracts with health care providers to become affiliated providers or offers a prudent purchaser contract.

(4) A contract shall be based upon the following written standards which shall be filed by the health maintenance organization with the commissioner on a form and in a manner that is uniformly developed and applied by the commissioner:

(a) Standards for maintaining quality health care.

(b) Standards for controlling health care costs.

(c) Standards for assuring appropriate utilization of health care services.

(d) Standards for assuring reasonable levels of access to health care services.

(e) Other standards considered appropriate by the health maintenance organization.

Continuation of Benefits.

500.3561 Insolvency; continuation of benefits.

(c) A contract between the health maintenance organization and its affiliated providers that provides for the continuation of provider services in the event of the health maintenance organization's insolvency. A health maintenance organization shall include in a contract under this subdivision a mechanism for appropriate sharing by the health maintenance organization of the continuation of provider services as approved by the director and shall not include a provision that continuation of provider services is solely the responsibility of the affiliated providers.

Fee Schedule Changes.

500.3525 Proposal to revise contract or rate; approval of commissioner; approval with modifications; hearing; disposition; exception; notice.

(3) Except as provided in this subsection with respect to health maintenance contracts issued in connection with state and federal health programs under section 3571, not less than 30 days before the effective date of a proposed change in a health maintenance contract or the rate charged, the health maintenance organization shall issue to each subscriber or group of subscribers who will be affected by the proposed change a clear written statement stating the extent and nature of the

proposed change. With respect to health maintenance contracts issued in connection with state and federal health programs under section 3571, advance notice is not required if the change in a health maintenance contract or rate arises from a change in the law, a state or federal administrative order, or an executive order and the change does not provide for a reasonable period for a health maintenance organization to give the required notice. In that case, the health maintenance organization shall provide notice within 30 days after the effective date of the change. If the commissioner has approved a proposed change in a contract or rate in writing before the expiration of 60 days after the date of filing, the organization immediately shall notify each subscriber or group of subscribers who will be affected by the proposed change.

Hold Harmless.

500.3529 Affiliated provider contracts; collection of payments from enrollees; contract provisions; waiver of requirement under subsection (2); contract format; evidence of sufficient number of providers.

(3) An affiliated provider contract shall prohibit the provider from seeking payment from the enrollee for services provided pursuant to the provider contract, except that the contract may allow affiliated providers to collect copayments, coinsurances, and deductibles directly from enrollees.

Most Favored Nation Clause Prohibited.

500.3405a Use of most favored nation clause.

(3) Beginning January 1, 2014, an insurer or a health maintenance organization shall not use a most favored nation clause in any provider contract, including a provider contract in effect on January 1, 2014.

(4) As used in this section, "most favored nation clause" means a clause that does any of the following:

(a) Prohibits or grants a contracting insurer or health maintenance organization an option to prohibit, a provider from contracting with another party to provide health care services at a lower rate than the payment or reimbursement rate specified in the contract with the insurer or health maintenance organization.

(b) Requires or grants a contracting insurer or health maintenance organization an option to require, a provider to accept a lower payment or reimbursement rate if the provider agrees to provide health care services to any other party at a lower rate than the payment or reimbursement rate specified in the contract with the insurer or health maintenance organization.

(c) Requires or grants a contracting insurer or health maintenance organization an option to require, termination or renegotiation of an existing provider contract if a provider agrees to provide health care services to any other party at a lower rate than the payment or reimbursement rate specified in the contract with the insurer or health maintenance organization.

(d) Requires a provider to disclose, to the insurer or health maintenance organization or the insurers or health maintenance organizations designee, the provider's contractual payment or reimbursement rates with other parties.

Termination.

500.2212b Policy issued under MCL 550.3405 and to health maintenance organization contract; applicability; termination of affiliation or participation between primary care physician and insurer; notice to insured; effect of termination; definitions.

(3) If affiliation or participation between an insured's current physician and an insurer terminates, the insurer shall permit the insured to continue an ongoing course of treatment with that physician as follows:

(a) For 90 days after the date of notice to the insured by the physician of the physician's termination with the insurer.

(b) If the insured is in her second or third trimester of pregnancy at the time of the physician's termination, through postpartum care directly related to the pregnancy.

(c) If the insured is determined to have an advanced illness before a physician's termination or knowledge of the termination and the physician was treating the advanced illness before the date of termination or knowledge of the termination, for the remainder of the insured's life for care directly related to the treatment of the advanced illness.

(4) Subsection (3) applies only if the physician agrees to all the following:

(a) To continue to accept as payment in full reimbursement from the insurer at the rates applicable before the termination.

(b) (b) To adhere to the insurer's standards for maintaining quality health care and to provide to the insurer necessary medical information related to the care.

(c) (c) To otherwise adhere to the insurer's policies and procedures, including, but not limited to, those concerning utilization review, referrals, preauthorization’s, and treatment plans.

(d) (5) An insurer shall provide written notice to each affiliated or participating physician that if affiliation or participation between the physician and the insurer terminates, the physician may do both of the following:

(e) (a) Notify the insurer's insureds under the care of the physician of the termination if the physician does so within 15 days after the physician becomes aware of the termination.

(f) (b) Include in the notice under subdivision (a) a description of the procedures for continuing care under subsections (3) and (4).

(6) This section does not create an obligation for an insurer to provide to an insured coverage beyond the maximum coverage limits permitted by the insurer's policy or certificate with the insured. This section does not create an obligation for an insurer to expand who may be a primary care physician under a policy or certificate.

500.3531 Contracts with health care providers to become affiliated providers; requirements; standards; filing; duplicative standards; notice procedures; provider application period; approval or rejection as affiliated provider; termination of contract; providing information to insurer.

(8) A health care provider whose contract as an affiliated provider is terminated shall be provided upon request with a written explanation by the organization of the reasons for the termination.

Assumption of Financial Risk.

500.3569 Assumption of financial risk.

(2) If the health maintenance organization requires an affiliated provider to assume financial risk under the terms of its contract, the contract must require both of the following:

(a) The health maintenance organization to pay the affiliated provider, including a subcontracted provider, directly or through a licensed third-party administrator for health services provided to its enrollees.

(b) The health maintenance organization to keep all pooled funds and withhold amounts and account for them on its financial books and records and reconcile them at year end pursuant to the contract.

Financial Incentives.

500.3477 Use of financial incentive or payment to act as inducement to deny, reduce, limit, or delay services; prohibition; exception.

(1) An insurer shall not use any financial incentive or make any payment to a health professional that acts directly or indirectly as an inducement to deny, reduce, limit, or delay specific medically necessary and appropriate services.

(2) Subsection (1) does not prohibit payment arrangements that are not tied to specific medical decisions or prohibit the use of risk sharing as otherwise authorized in this chapter.

Provider Licensure.

500.3501 Definitions.

As used in this chapter:

(a) "Affiliated provider" means a health professional, licensed hospital, licensed pharmacy, or any other institution, organization, or person that has entered a participating provider contract, directly or indirectly, with a health maintenance organization to render 1 or more health services to an enrollee.

Affiliated provider includes a person described in this subdivision that has entered a written arrangement with another person, including, but not limited to, a physician hospital organization or physician organization, that contracts directly with a health maintenance organization.

(f) "Health professional" means an individual licensed, certified, or authorized in accordance with state law to practice a health profession in his or her respective state.

500.3529 Affiliated provider contracts; collection of payments from enrollees; contract provisions; waiver of requirement under subsection (2); contract format; evidence of sufficient number of providers.

(4) An affiliated provider contract shall contain provisions assuring all the following:

(a) The provider meets applicable licensure or certification requirements.

500.2212d National or regional certification of physician; condition of payment or reimbursement by insurer or health maintenance organization; prohibited.

An insurer that delivers, issues for delivery, or renews in this state a health insurance policy issued under chapter 34 or a health maintenance organization that issues a health maintenance contract under chapter 35 shall not require as the sole condition precedent to the payment or reimbursement of a claim under the policy or contract that an allopathic or osteopathic physician in the medical specialties of family practice, internal medicine, or pediatrics maintain a national or regional certification not otherwise specifically required for licensure under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.

Records.

500.3529 Affiliated provider contracts; collection of payments from enrollees; contract provisions; waiver of requirement under subsection (2); contract format; evidence of sufficient number of providers.

(4) An affiliated provider contract shall contain provisions assuring all the following:

(b) Appropriate access by the health maintenance organization to records or reports concerning services to its enrollees.

500.3547 Health care service operations; visitation or examination by director; consultation with enrollees; authority; access to information relating to delivery of services; submission of information regarding proposed contract.

(4) At the request of the director, a health maintenance organization shall submit information regarding a proposed contract between the health maintenance organization and an affiliated provider that the director considers necessary to ensure that the contract follows this act.

Mississippi

STATE REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

MS-1 Hold Harmless. Each Participating Provider agrees that if the Payor fails to pay for health care services as set forth in the Agreement, the Covered Person shall not be liable to the Participating Provider for any sums owed by the Payor. Each Participating Provider agrees that the Participating Provider, and any agent, trustee or assignee of the Participating Provider shall not maintain any action at law against a Covered Person to collect sums owed by the Payor. (MISS CODE ANN. §§ 83-41-325(13), 83-41-325(15)).

MS-2 Continuity of Care. Each Participating Provider agrees that in the event of insolvency of the Payor, the Participating Provider will continue to provide services to Covered Persons for the duration of the period after the Payor's insolvency for which premium payment has been made and until the Covered Persons' discharge from inpatient facilities. (MISS CODE ANN. § 83-41-325(16)(b)).

MS-3 Termination. If the Participating Provider terminates the Agreement or their or its participation under the Product Attachment, the Participating Provider shall give Health Plan at least sixty (60) days' advance written notice of termination. (MISS CODE ANN. § 83-41-325(17)).

MS-4 Examination. Each Participating Provider agrees that (a) the Commissioner of Insurance may make an examination of the affairs of the Participating Provider as often as is reasonably necessary for the protection of the interests of the people of this State; and (b) the State Health Officer may make an examination concerning the quality assurance shall make an examination of the affairs of the Participating Provider as often as is reasonably necessary for the protection of the interests of the people of this State. Each Participating Provider shall submit their or its books and records for such examination and in every way facilitate the completion of the examination. Each Participating Provider agrees that, for the purpose of examinations, the Commissioner of Insurance and the State Health Officer may administer oaths to and examine the principles of the Participating Provider concerning its, their business in accordance with existing insurance laws, rules, and regulations. (MISS CODE ANN. § 83-41-337).

Missouri

STATE REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

MO-1 Intermediary Defined. For purposes of this Schedule, the term "Intermediary" has the meaning given such term in Missouri Revised Statutes § 354.600(13), which as of the Effective Date, means a person authorized to negotiate and execute provider contracts with a Payor on behalf of health care providers or on behalf of a network.

MO-2 Limitations. No Payor or other entity shall restrict a Participating Provider from discussing or disclosing to any Covered Person any information that the Participating Provider deems appropriate regarding the nature of treatment, risks or alternatives thereto, the availability of other therapy, consultation or test, the decision of a Payor or its delegate to authorize or deny services, or the process that a Payor or any person contracting with the Payor uses or proposes to use to authorize or deny health care services or benefits. (MO. REV. STAT. § 354.441).

MO-3 Hold Harmless. Each Participating Provider agrees that in no event, including but not limited to nonpayment by a Payor or any Intermediary, insolvency of a Payor or any Intermediary, or breach of the Agreement, shall the Participating Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person or other person, other than Payor or an Intermediary, if any, acting on behalf of the Covered Person for services provided pursuant to this Product Attachment. This Product Attachment does not prohibit Participating Provider from collecting coinsurance, deductibles, or co-payments, as specifically provided in the Coverage Agreement, or fees for non-covered services delivered on a fee-for-service basis to Covered Persons. This Product Attachment does not prohibit the Participating Provider, except for a health care professional who is employed full time on the staff of a Payor and has agreed to provide service exclusively to the Payor's Covered Persons and no others, and a Covered Person from agreeing to continue services solely at the expense of the Covered Person, as long as the Participating Provider has clearly informed the Covered Persons that the Payor may not cover or continue to cover a specific service or services. Except as provided herein, this Product Attachment does not prohibit the Participating Provider from pursuing any available legal remedy, including, but not limited to, collecting from any insurance carrier providing coverage to a Covered Person. This provision survives the termination of the Agreement or this Product Attachment regardless of the reason for termination. (MO. REV. STAT. § 354.606.2).

MO-4 Continuation of Services. In the event of a Payor's or Intermediary's insolvency or other cessation of operations, each Participating Provider shall continue to provide Covered Services to the

affected Covered Person through the period for which premiums have been paid to the Payor on behalf of such Covered Person or until such Covered Person's discharge from an inpatient facility, whichever time is greater. (MO. REV. STAT. § 354.606.3).

MO-5 Independent Contractor Relationship. The relationship among the parties is that of independent contractors. (MO. CODE REGS. TIT. 20, § 400-7.080).

MO-6 Assignment. The Agreement may not be assigned, sublet, delegated, or transferred by the Participating Provider without the prior written consent of Health Plan. (MO. REV. STAT. § 354.606.13).

MO-7 Non-Discrimination in Enrollment Status. Each Participating Provider shall provide Covered Services to Covered Persons without regard to the Covered Person's status as a private purchaser or as a participant in a publicly financed program. (MO. REV. STAT. § 354.606.14).
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MO-8 Notice of Termination, List of Covered Persons. The parties agree that any notice of termination of the Agreement or this Product Attachment given by a party, or a Participating Provider must state the reason for the termination. The Agreement or a Participating Provider's participation in this Product may only be terminated by a party or the Participating Provider without cause by giving the others the minimum amount of prior written notice set forth in the Agreement, which in no event can be less than sixty (60) days prior written notice for a termination without cause. Within fifteen (15) business days of the date that a Participating Provider either gives or receives notice of termination, the Participating Provider shall provide the Payor with a list of all Covered Persons who are patients of the Participating Provider. Upon a termination of the Agreement or this Product Attachment by Health Plan, the Participating Provider will provide with an opportunity for a review or hearing as required by Missouri law and in accordance with the Payor's applicable procedures. For purposes of this Section MO-8 only, a "termination" of the Agreement or a "termination" of a Participating Provider's participation in this Product is different than a "non-renewal" of the Agreement or a "non-renewal" of a Participating Provider's participation in this Product. (MO. REV. STAT. §§ 354.609.1, 354.609.2).

MO-9 Continue Care upon Termination. Upon termination of a Participating Provider's participation in this Product, the Participating Provider shall (a) continue to provide Covered Services to each Covered Person in such Product for up to ninety (90) days following the date of termination and in accordance with the dictates of medical prudence, including circumstances such as disability, pregnancy, or life-threatening illness, and (b) continue to comply with and abide by all of the terms and conditions of the Agreement and this Product Attachment, including, but not limited to, Section MO-3 above, in connection with the provision of such Covered Services during such continuation period. During the continuation period, the Participating Provider shall be compensated in accordance with this Product Attachment for Covered Services rendered to a Covered Person after termination and shall accept such compensation as payment in full. This provision survives the

termination of the Participating Provider's participation in this Product. (MO. REV. STAT. §§ 354.612, 354.606.2).

MO-10 Records.

MO-10.1 Compel to Furnish Records. Each Participating Provider shall furnish to the Payor all documentation required by them to monitor, on an ongoing basis, the ability, clinical capacity, and legal authority of the Participating Provider to provide all Covered Services to Covered Persons in this Product. (MO. REV. STAT. § 354.603.1(3)).

MO-10.2 Access to Records. Each Participating Provider shall make health records available to appropriate State and federal authorities involved in assessing the quality of care but shall not disclose individual identities, or investigating the grievances or complaints of Covered Persons, and to comply with the applicable State and federal laws related to the confidentiality of medical or health records. (MO. REV. STAT. § 354.606.12).

MO-11 Access to Entire Network. A Payor shall not act in a manner that unreasonably restricts a Covered Person's access to the Payor's entire contracted provider network, unless otherwise provided in or contemplated by the Coverage Agreement or Payor Contract. (MO. REV. STAT. § 354.603).

MO-12 Provider Notification. Each Participating Provider acknowledges that the Agreement and the Provider Manual informs the Participating Provider of the mechanism by which the Participating Provider may timely determine an enrollee's eligibility, and describes the mechanisms by which the Participating Provider will be notified of the Payor's administrative procedures, and on an ongoing basis of specific Covered Services for which the Participating Provider is responsible, including limitations or conditions on services. Each Participating Provider is responsible for collecting applicable coinsurance, co-payments, and deductibles, if any, from Covered Persons. (MO. REV. STAT. §§ 354.606.1, 354.606.8, 354.606.15, 354.606.17).

MO-13 Dispute Resolution. Each Participating Provider acknowledges that the Agreement and the Provider Manual establish procedures for resolution of administrative, payment and other disputes between the Participating Provider and Payor. (MO. REV. STAT. § 354.606.19).
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MO-14 Contract Review. Each Participating Provider hereby acknowledges that the Participating Provider was allowed at least thirty (30) days to review the Agreement and its Attachments (including this Schedule A) prior to the Participating Provider's execution. (MO. REV. STAT. § 354.609.6).

MO-15 Intermediaries. If Provider is an Intermediary, the provisions set forth below apply.

MO-15.1 Provider and each of its Participating Providers shall comply with the Agreement and its Attachments (including this Schedule A), and applicable law, including but not limited to Sections 354.600 to 354.636 of the Missouri Revised Statutes, as amended. (MO. REV. STAT. § 354.621.1).

MO-15.2 If required by the Payor, the Provider shall transmit utilization documentation and claims paid documentation to the Payor. (MO. REV. STAT. § 354.621.3).

MO-15.3 Provider shall maintain all books, records, financial information, and documentation of services provided to Covered Persons at its principal place of business within Missouri and preserve them for no less than five (5) years in a manner that facilitates regulatory review. (MO. REV. STAT. § 354.621.4).

MO-15.4 Provider shall allow the Payor and regulatory authority's access to the books, records, financial information, and any documentation of services provided to Covered Persons, as necessary to determine compliance with Sections 354.600 to 354.636 of the Missouri Revised Statutes, as amended. (MO. REV. STAT. § 354.621.5).

MO-15.5 Provider agrees that the Payor has the right, in the event of Provider's insolvency, to require assignment to the Payor of the provisions of a Participating Provider's contract with Provider addressing the Participating Provider's obligation to furnish Covered Services. (MO. REV. STAT. § 354.621.6).

Nebraska

STATE REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

NE-1 Notice of Termination. Company, Provider, and each Participating Provider may not terminate the Agreement or, with respect to a Participating Provider, his, her or its participation under the Agreement, without cause unless he, she or it provides at least sixty days' advance written notice of termination. (NEB. REV. STAT. § 44-32,142, § 44-7106(2)(k)).

NE-2 Continuation of Care.

A. In the event of a Payor's insolvency, Provider and each Contracted Provider agree to continue to provide services to Covered Persons for the duration of the period for which premiums have been paid

and to any Covered Person who is an inpatient on the date of insolvency until his or her discharge. (NEB. REV. STAT. § 44-32,143).

B. In the event of the insolvency or other cessation of operations of Company, Payor, or Intermediary (as defined below), Provider and each Participating Provider agree to continue to provide services to Covered Persons through the period for which premiums have been paid on behalf of the Covered Persons or until the Covered Person is discharged from an inpatient facility, whichever time is greater. Covered Services to Covered Persons confined to an inpatient facility on the date of insolvency or other cessation of operations will continue until their continued confinement in an inpatient facility is no longer Medically Necessary. This Section will be construed in favor of the Covered Person, survives termination of the Agreement for any reason, and supersedes any oral or written contrary agreement between Provider or a Participating Provider and a Covered Person or representative of a Covered Person if the contrary agreement is inconsistent with this Section. (NEB. REV. STAT. § 44-7106(2)(c), § 44-7106(2)(d)).

NE-3 Hold Harmless. Provider and each Participating Provider agree that in no event, including, but not limited to, nonpayment by a Payor or Intermediary, insolvency of a Payor or Intermediary, or breach of the Agreement, shall the Provider or a Participating Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a Covered Person or a person, other than the Payor or Intermediary, acting on behalf of the Covered Person for health care services provided pursuant to the Agreement. The Agreement does not prohibit the Provider from collecting coinsurance, deductibles, or copayments, as specifically provided in the evidence of coverage, or fees for non-Covered Services delivered on a fee-for-service basis to Covered Persons. Nor does the Agreement prohibit Provider or a Participating Provider, except for a health care professional who is employed full time on the staff of Company and has agreed to provide health care services exclusively to that Company's Covered Persons and no others, and a Covered Person from agreeing to continue health care services solely at the expense of the Covered Person, as long as Provider or the Participating Provider has clearly informed the Covered Person that Company may not cover or continue to cover a specific health care service or health care services. No Provider or Participating Provider, or agent, trustee, or assignee of Provider or a Participating Provider, may maintain any action at law against a Covered Person to collect sums owed by the Payor. Except as provided herein, the Agreement does not prohibit the Provider from pursuing any available legal remedy. This Section will be construed in favor of the Covered Person, survives termination of the Agreement for any reason, and supersedes any oral or written contrary agreement between Provider or a Participating Provider and a Covered Person or representative of a Covered Person if the contrary agreement is inconsistent with this Section. (NEB. REV. STAT. § 44-7106(2)(b), § 44-7106(2)(d), § 44-32,141).

NE-4 Amounts owed by Payor. In no event will Provider or a Participating Provider collect or attempt to collect from a Covered Person any money owed to Provider by a Payor. (NEB. REV. STAT. § 44-7106(2)(e)).

NE-5 Records. Provider and each Participating Provider will make available health records to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of Covered Persons, and to comply with the applicable state and federal laws related to the confidentiality of medical or health records. (NEB. REV. STAT. § 44-7106(2)(j); § 44-32,175).

NE-6 Assignment. The rights and responsibilities set forth in the Agreement may not be assigned or delegated by the Provider or any Participating Provider without the prior written consent of Company. (NEB. REV. STAT. § 44-7106(2)(l)).

NE-7 No Discrimination. Provider and each Participating Provider will furnish Covered Services to all Covered Persons without regard to a Covered Person's enrollment under a Coverage.

Agreement whether it is entered, issued, or agreed to by a Payor that is a private purchaser or a participant in a publicly financed program of health care services. (NEB. REV. STAT. § 44-7106(2)(m)).

NE-8 Coinsurance. Participating Providers will collect the applicable coinsurance, copayments, or deductibles, if any, from Covered Persons pursuant to the Coverage Agreement and will notify Covered Persons of their personal financial obligations for non-Covered Services. (NEB. REV. STAT. § 44-7106(2)(n)).

NE-9 Consistency with Law. The parties acknowledge and agree that the Agreement and this Exhibit do not conflict with the definitions or provisions specified by applicable law. The parties acknowledge and agree that any term in the Agreement or Exhibit that conflicts with applicable law will to the extent possible and allowable be read to comply with existing law. (NEB. REV. STAT. § 44-7106(2)(r)).

NE-10 Intermediaries. "Intermediary" has the definition set forth at NEB. REV. STAT. § 44-7103(13), which, as of the Effective Date, means a person authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers or on behalf of a network. If Provider is an Intermediary, this Section applies. (NEB. REV. STAT. § 44-7107).

A. Provider and Participating Providers with whom Provider contracts will comply with all the applicable requirements of NEB. REV. STAT. § 44-7106.

B. Company's or Payor's responsibility to monitor the offering of Covered Services to Covered Persons is not delegated or assigned to Provider.

C. Company and Payor each have the right to approve or disapprove participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering Covered Services to Covered Persons.

D. Company and Payor each have access to all Provider subcontracts, and the right to make copies to facilitate regulatory review, upon twenty days' prior written notice from Company or Payor.

E. If applicable, Provider will transmit utilization documentation and claims paid documentation to Company or Payor.

F. If applicable, Provider will maintain the books, records, financial information, and documentation of health care services provided to Covered Persons at its principal place of business in the State of Nebraska and preserve them for at least five (5) years in a manner that facilitates regulatory review.

G. Provider will allow the Director of Insurance and the Department of Health and Human Services access to Provider's books, records, financial information, and any documentation of health care

services provided to Covered Persons, as necessary to determine compliance with the Nebraska Managed Care Plan Network Adequacy Act.

H. Company has the right, in the event of the Provider's insolvency, to require the assignment to Company of the provisions of a Participating Provider's contract addressing the Participating Provider's obligation to furnish.

Nevada

STATE REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

NV-1 Parties' Responsibilities. The parties agree that the Agreement, together with its Attachments and the Provider Manual, adequately and completely describes the responsibilities of Health Plan, Provider, and each Participating Provider. (NEV. ADMIN. CODE § 695C.190.1).

NV-2 Hold Harmless. Provider and each Participating Provider release Covered Persons from liability for the cost of Covered Services rendered pursuant to the Coverage Agreement, except for any nominal payment made by the Covered Person for a service that is not covered under the Coverage Agreement. (NEV. ADMIN. CODE § 695C.190.2).

NV-3 Term. As set forth in the "Term and Termination" Article of the Agreement, the term of the Agreement is for not less than one year, subject to any right of termination stated in the Agreement. (NEV. ADMIN. CODE § 695C.190.3).

NV-4 Quality Assurance Program. Each Participating Provider shall participate in the programs of Company and Payor to assure the quality of health care provided to Covered Persons by Participating Providers. (NEV. ADMIN. CODE § 695C.190.4).

NV-5 Provision of Services. Each Participating Provider shall provide all Medically Necessary services required by the Coverage Agreement and the Agreement to each Covered Person for the period for which a premium has been paid to Payor. (NEV. ADMIN. CODE § 695C.190.5).

NV-6 Insurance. Each Participating Provider shall provide evidence of a contract of insurance against loss resulting from injuries resulting to third persons from the practice of their profession or a reasonable substitute for it as determined by Health Plan. (NEV. ADMIN. CODE § 695C.190.6).

NV-7 Records. Each Participating Provider, who is a physician, shall transfer or otherwise arrange for the maintenance of the records of Covered Persons who are their patients if the Participating Provider leaves the panel of physicians associated with Health Plan. (NEV. ADMIN. CODE § 695C.190.7).

NV-8 Schedule for Claims Payment. Payors and each Participating Provider agree to the schedule for the payment of claims set forth in NEV. REV. STAT. § 695C.185. (NEV. REV. STAT. § 695C.187.1).

NV-9 Amendments. The Agreement may be modified at any time pursuant to a written amendment executed by both parties. Except as otherwise provided by this Section NV-9, the Agreement may be modified by Health Plan giving to Provider at least 45 days' written notice of the modification of the schedule of payments, including any changes to the Compensation Schedule applicable to the Participation Provider's practice. If the Provider fails to object in writing to the modification within the 45-day period, the modification becomes effective at the end of that period. If the Provider objects in writing to the modification within the 45-day period, the modification will not become effective unless agreed to by both parties in writing. (NEV. REV. STAT. §§ 689A.035; 689B.015; 689C.435; 695C.125; 695G.430).

NV-10 Continuation of Care. Subject to the conditions described in NEV. REV. STAT. §§ 689A.04036.2(a) and 689A.04036.4 (individual health insurance), those described in NEV. REV. STAT. §§ 689B.0303.2(a) and 689B.0303.4 (group health insurance), those described in NEV. REV. STAT. §§ 695C.1691.2(a) and 695C.1691.4 (coverage by a health maintenance organization), or those described in NEV. REV. STAT. §§ 695G.164.2(a) and 695G.164.4 (coverage by a managed care plan), as applicable, if a Covered Person is receiving medical treatment for a medical condition from a Participating Provider and the Agreement, or the Participating Provider's participation under the Agreement or in a particular Product, is terminated during the course of the medical treatment, each Participating Provider agrees: (a) to provide medical treatment with regard to the Covered Person under the terms of the Agreement, including, without limitation, the rates of payment for providing medical service, as those terms existed before such termination; and (b) to not to seek payment from the Covered Person for any medical service provided by the Participating Provider that the Participating Provider could not have received from the Covered Person were the provider still a Participating Provider; and (c) the coverage required by this Section NV-10 will be provided until the later of the 120th day after the date of termination or, if the medical condition is pregnancy, the 45th day after: (i) the date of delivery; or (ii) if the pregnancy does not end in delivery, the date of the end of the pregnancy. (NEV. REV. STAT. §§ 689A.04036; 689B.0303; 695C.1691; 695G.164).

NV-11 Notice of Termination. Either party must give the other party at least ninety (90) days' prior notice of termination of the Agreement. (NEV. ADMIN. CODE § 689B.160).

NV-12 Intermediary Contracts. If Provider is a Delivery System Intermediary that accepts risk and assumes financial liability from Health Plan for any Covered Services provided to Covered Persons, this Section NV-12 will apply. A "***Delivery System Intermediary***" has the definition set forth at NEV. ADMIN. CODE § 695C.025, which, as of the Effective Date, is as follows, with certain exclusions: a partnership, association, corporation or other legal entity which enters into a contract with a health maintenance organization to provide health care services, including an entity jointly owned and controlled by a hospital and a physician and an entity primarily owned and controlled by physicians. The health care providers with which the Delivery System Intermediary contracts to furnish health care services to Covered Persons of the health maintenance organization are referred to in this Section NV-12 as "***DSI Providers***".

a. Provider shall provide to the Health Plan a written report, at least quarterly, which identifies the total payments made or owed by Provider to DSI Providers in sufficient detail to enable Company or Payor and the Nevada Commissioner of Insurance to determine whether the payments have been made in a timely manner and in compliance with the applicable provisions of Nevada law. Health Plan will review such reports. (NEV. ADMIN. CODE §§ 695C.505.1 - 695C.505.2).

b. Company or Payor and the Nevada Commissioner of Insurance are authorized, upon reasonable prior notice, to audit, inspect and copy the Provider's books, records, and any other evidence of its operations to determine whether it has complied with the applicable provisions of Nevada law, including any regulations adopted pursuant thereto. (NEV. ADMIN. CODE §§ 695C.505.3- 695C.505.4).

c. Provider shall maintain working capital in the form of cash or equivalent liquid assets in an amount equal to at least the lesser of: (a) five hundred thousand dollars ($500,000); or (b) the operating expenses paid for two months calculated by using the monthly average of the operating expenses for the prior six months. As used in this subsection, "operating expenses" means the expenses of the Provider, except money paid or owed to DSI Providers for health services provided pursuant to the Agreement. (NEV. ADMIN. CODE § 695C.505.5).

d. Payor will assume financial responsibility for any Clean Claims that are presented for payment to the Provider by DSI Providers for Covered Services and not paid by the Provider as provided by law and the Agreement. (NEV. ADMIN. CODE § 695C.505.6).

e. Each contract with a Covered Person will be entered into directly with Company or Payor, and not with Provider. (NEV. ADMIN. CODE § 695C.505.7).
f. The responsibilities that Provider assumes are set forth in the Agreement. Provider shall comply with the requirements of the quality assurance programs established by Company or Payors pursuant to NEV. ADMIN. CODE § 695C.400. (NEV. ADMIN. CODE § 695C.505.8).

g. Health Plan shall review, not less than quarterly, Provider's compliance with the provisions of the Agreement. (NEV. ADMIN. CODE § 695C.505.9).

h. If the Provider provides health care services on behalf of more than one entity, Provider shall maintain separate records for each entity. (NEV. ADMIN. CODE § 695C.505.10).

i. Health Plan may terminate its relationship with any DSI Provider with appropriate notice as specified in the Agreement. (NEV. ADMIN. CODE § 695C.505.11).
j. Each contract between Provider and a DSI Provider will be assigned to Health Plan if the Provider fails to pay for Covered Services. (NEV. ADMIN. CODE § 695C.505.12).

k. Any DSI Provider who has a financial interest of more than 10 percent in Provider is prohibited from participating on a utilization review committee or taking any action to change an authorization made by the utilization review committee or an authorized physician. (NEV. ADMIN. CODE § 695C.505.13).

l. Provider shall provide Health Plan, the Commissioner, and the State Board of Health with a list of the names of those persons who have a financial interest in Provider and the amount of each person's financial interest. Any change in the financial interests of the Provider must be reported to Health Plan, the Commissioner, and the State Board of Health within ten (10) working days after the change. (NEV. ADMIN. CODE § 695C.505.14).

m. Provider is prohibited from assigning the Agreement to any other organization without the prior approval of Health Plan, which is subject to the filing of a material modification of operation pursuant to NEV. REV. STAT. § 695C. 140. (NEV. ADMIN. CODE § 695C.505.15).

n. If Provider hires a company to manage its affairs, Provider or that company shall provide Health Plan with a surety bond or deposit of cash or securities in the amount of $250,000 for the faithful performance of the obligations of the company. (NEV. ADMIN. CODE § 695C.505.16).

o. If, pursuant to the Agreement, Provider evaluates the credentials of Participating Providers, Provider shall comply with the requirements established by Health Plan for evaluating the credentials of providers. (NEV. ADMIN. CODE § 695C.540).

New Jersey

STATE REGULATORY REQUIREMENTS

This Exhibit sets forth the provisions that are required by State law to be included in the Agreement with respect to this Product. Any additional Regulatory Requirements that may apply to the Benefit Plans or Covered Persons enrolled in or covered by this Product are or will be set forth in the Provider Manual or another Attachment. To the extent that a Benefit Plan, or a Covered Person, is subject to

the law cited in parenthetical at the end of a provision on this Exhibit 1, such provision will apply to the rendering of Covered Services to a Covered Person with such Benefit Plan, or to such Covered Person, as applicable.

NJ-1 Agreement Terms.

Contracted Provider and each Provider acknowledge that the Agreement (including the Provider Manual) discloses in plain language the terms and conditions, including, but not limited to, the following: (i) compensation terms, including amount and timing of compensation, which are set forth on the Compensation Schedules that are attached as Exhibits to Attachment A (relating to the Medicaid Product) of this Agreement; the Compensation Schedules that are attached as Exhibits to Attachment B (relating to the Medicare Product); the Compensation Schedules that are attached as Exhibits to Attachment C (relating to the Commercial-Exchange Product); and the Compensation Schedules that are attached as Exhibits to Attachment G (relating to the Direct Individual Product); (ii) the specifics applicable to each product herein, which are set forth on various Product Attachments found at Attachment A (the Medicaid Product Attachment), Attachment B (the Medicare Product Attachment) , Attachment C (the Commercial-Exchange Product Attachment) and Attachment G (the Direct Individual Product Attachment) to this Agreement; (iii) the term of the Agreement, which is set forth in Section 7.1; (iv) the methods by which the Agreement may be amended, renewed, and terminated, which are set forth in Sections 8.7., 7.1 and 7.2, respectively; (v) Contracted Provider's obligation to participate in preauthorization programs, which is forth in Section 2.7; (vi) Contracted Provider's obligation to maintain liability insurance; (vii) a description of the internal dispute resolution mechanism, which is set forth in Article VI; (viii) claims submission and payment procedures, which are set forth in Sections 3.1 and 3.2; and (ix) confidentiality requirements that apply to various records including medical records, which are set forth in Sections 2.14 and 8.13. N.J. ADMIN. CODE § 11:24C-4.3(c)1; 11:24B-5.2; 11:24B-5.3(a); 11:24B-5.2(a).

NJ-2 Amendments.

(a) To the extent that the Agreement permits unilateral changes, any Adverse Changes will only be made with sufficient advance notice to permit termination in advance of the effective date of the change. To the extent that the terms of the Agreement have been the subject of negotiation, no changes will be made unilaterally to the administration of the contract materially impacting those terms. N.J. ADMIN. CODE § 11:24C-4.3(c)3 – 4.

(b) Any Adverse Change during the term of the Agreement may be made in accordance with the terms of the Agreement only upon 90 days' notice prior to the effective date of the Adverse Change. If Provider declines to accept the Adverse Change, Contracted Provider may terminate the Agreement upon written notice to Health Plan prior to the effective date of the Adverse Change as set forth in N.J. ADMIN. CODE § 11:24C-4.3(c)3. N.J. ADMIN. CODE § 11:24C-4.3(d).

(c) To the extent that the Agreement automatically renews, no Adverse Change may be made to the terms of the Agreement upon its automatic renewal. Any such Adverse Change may be made to the Agreement as set forth in (b) above either before or after its renewal. N.J. ADMIN. CODE § 11:24C-4.3(e).

NJ-3 Network Lease.

Health Plan may enter into agreements with third parties allowing the third parties to obtain the Health Plan's rights and responsibilities as if the third party were the contracting entity. For purposes of this Section, "third party" does not include any employer or other group for whom Health Plan provides administrative services, including at least the payment of claims. Health Plan shall provide Contracted Provider with a list of such third parties with access to the Agreement prior to execution of the Agreement. N.J. ADMIN. CODE § 11:24C-4.3(c)5.

NJ-4 Hold Harmless.

Contracted Provider agrees that in no event, including but not limited to nonpayment by the Health Plan, Payor or intermediary, payment by the Health Plan, Payor or intermediary that is other than what the Contracted Provider believed to be in accordance with the reimbursement provision of the Agreement or is otherwise inadequate, insolvency of the Health Plan, Payor or intermediary, or breach of this Agreement, shall Contracted Provider bill, charge or collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person or a person (other than the Health Plan, Payor or intermediary) acting on behalf of the Covered Person for services provided pursuant to the Agreement. Nothing in the Agreement (including this Attachment) prohibits Contracted Provider from collecting coinsurance, deductibles, or copayments, as specifically provided in the evidence of coverage. Nothing in the Agreement (including this Attachment) prohibits Contracted Provider (except for a health care professional who is employed full-time on the staff of a health carrier and has agreed to provide services exclusively to that health carrier's covered persons and no others) and a Covered Person from agreeing to continue services solely at the expense of the Covered Person, as long as Contracted Provider has clearly informed the Covered Person that Health Plan or Payor may not cover or continue to cover a specific service or services. N.J. ADMIN. CODE §§ 11:4-37.4(c)8; 11:24-15.2(b)7; 11:24B-5(a)10.

NJ-5 Compliance with Law.

(a) The Agreement is consistent, and the parties shall comply, with applicable laws, including those regarding confidentiality of information and those regarding licensure, certification, and adequate malpractice insurance. Contracted Provider agrees that the Agreement is not worded so that compliance with the terms of the Agreement would cause Contracted Provider to violate the statutes or rules governing licensure, such as his or her professional licensing standards, including, but not limited to, N.J. ADMIN. CODE § 45:14B–31 et seq. N.J. ADMIN. CODE §§ 11:24A-4.15(a); 11:24A-4.15(e); 11:24-15.2(a); 11:24-15.2 (b)10 and (e); 11:24B-5.2(a)12.

(b) Any sections of the Agreement that conflict with applicable State or federal law are hereby amended to conform with the requirements of the State or federal law. N.J. ADMIN. CODE § 11:24B-5.2(a)1.

(c) To the extent that the Payor is an organized delivery system, the Agreement is governed by New Jersey law. N.J. ADMIN. CODE § 11:24B-5.2(a)7.

NJ-6 Term and Termination.

(a) The term of the Agreement and reasons for which the Agreement may be terminated by one or more parties, including the procedures for notice and effectuation of such termination,

and opportunities, if any to cure any deficiencies prior to termination are set forth in the Term and Termination Section of the Agreement, subject to the below. N.J. ADMIN. CODE §§ 11:24A-4.15(b)1; 11:24-15.2(b)1; 11:24B-5.

(b) To the extent that the Agreement is terminated prior to the Agreement's renewal date, Health Plan shall give Contracted Provider at least 90 days' prior written notice, and Contracted Provider has a right to request a hearing following such notice except in enumerated circumstances consistent with N.J. ADMIN. CODE § 11:24A–4.9 or 11:24–3.5, as applicable. The contents of a notice of termination will contain: (i) a statement as to the right of Contracted Provider to obtain a reason for the termination in writing from Health Plan if the reason is not otherwise stated in the notice; (ii) the right of Contracted Provider to request a hearing, and any exceptions to that right; and (iii) the procedures for exercising either right. The procedures for requesting either are set forth in the Provider Manual and, with respect to a hearing, are consistent with the standards set forth at N.J. ADMIN. CODE §§ 11:24A–3.6 or 11:24A–4.9, to the extent applicable. Health Plan shall respond to a request from Contracted Provider for a reason for termination in writing. N.J. ADMIN. CODE §§ 11:24A-4.15(b)1; 11:24–3.5. Such written response will be provided within no more than 15 days of receipt of the request. N.J. ADMIN. CODE §§ 11:24–3.5; 11:24-15.2(b); 11:24B-5.3.

NJ-7 No Penalties.

(a) Contracted Provider's participation in the hearing process shall not be deemed to be an abrogation of Contracted Provider's legal rights. Contracted Provider will not be terminated or penalized because of filing a complaint or appeal as permitted by New Jersey rules. Contracted Provider may not be terminated or penalized for acting as an advocate for the patient in seeking appropriate, Medically Necessary health services. N.J. STAT. ANN. § 26:2S-9; N.J. ADMIN. CODE §§ 11:24A-4.15(b)2-3; 11:24-15.2(b); 11:24B-5.2(a)15.

(b) Contracted Provider has the right to communicate openly with a patient about all diagnostic testing and treatment options. N.J. STAT. ANN. § 26:2S-9; N.J. ADMIN. CODE §§ 11:24A-4.15(b)11; 11:24-15.2(b)13; 11:24B-5.2(a)14.

(c) Nothing in the Agreement will be construed as providing financial incentives to the Contracted Provider for withholding Covered Services that are Medically Necessary as determined in accordance with N.J. STAT. ANN. § 26:2S-6, except that nothing in this Subsection will be construed to limit the use of capitated payment arrangements between Health Plan and Provider. N.J. STAT. ANN. § 26:2S-9; N.J. ADMIN. CODE §§ 11:24A-4.15(b)5; 11:24-15.2(b)5. i.

NJ-8 Compensation.

The method of reimbursement, including the method, events, and timing of application of any penalties, bonuses, or other types of compensation arrangements, is set forth in the Agreement. To the extent that some portion of the compensation under the Agreement is tied to the occurrence of a predetermined event, or the nonoccurrence of a predetermined event, the event will be clearly specified in the Agreement along with: (i) the right of Contracted Provider to receive a periodic accounting (no less frequently than annually) of the funds held, and (ii) the process whereby

Contracted Provider may appeal a decision denying such additional compensation, in whole or in part, in accordance with any compensation arrangement tied to the occurrence or nonoccurrence of a pre-determined event. Notwithstanding the above, capitation will not be used as the sole method of reimbursement to a Contracted Provider that primarily provides supplies (e.g., prescription drugs or durable medical equipment) rather than services. N.J. ADMIN. CODE §§ 11:24A-4.15(b)5; 11:24-15.2(b)5; 11:24B-5.2(a)2. medical service corporation contract shall reimburse for orthotic and prosthetic appliances at the same rate as reimbursement for such appliances under the federal Medicare reimbursement schedule.

Where applicable, Health Plan shall reimburse for orthotic and prosthetic appliances at the same rate as reimbursement for such appliances under the federal Medicare reimbursement schedule. NJ Rev Stat § 26:2J-4.31.8(b); NJ Rev Stat § 17B:26-2.1z.4(b), et al.

NJ-9 Services.

The Agreement describes the services and/or supplies to be provided by Contracted Provider and the Providers and for which benefits will be paid by Payor. N.J. ADMIN. CODE §§ 11:24A-4.15(b)6; 11:24-15.2(b)6; 11:24B-5.2(a)13.

NJ-10 Non-Discrimination.

Neither Contracted Provider nor Providers shall discriminate in the treatment of Covered Persons. N.J. ADMIN. CODE §§ 11:24A-4.15(b)7; 11:24-15.2(b)8; 11:24B-5.2(a)16.

NJ-11 Program Participation.

Contracted Provider shall comply with the utilization review programs and quality assurance programs of Health Plan, each Payor, and, if applicable, Contracted Provider. Contracted Provider's activities and records relevant to the provision of health care services may be monitored from time to time by the Health Plan, a Payor, or the Contracted Provider, or another contractor acting on behalf of the foregoing in connection with the performance of quality assurance and continuous quality improvement functions. The Provider Manual specifies all information required to explain the programs including, without limitation: the entity that is responsible for the day-to-day administration of the programs, the entity with which complaints regarding the quality assurance program may be lodged, and the entity that, to the extent applicable, and how provider feedback regarding the operations of Health Plan, a Payor or Contracted Provider will be elicited, the rights and obligations when appealing decisions. N.J. ADMIN. CODE §§ 11:24A-4.15(b)8; 11:24-15.2(b)9; 11:24B-5.2.

NJ-12 Patient Information.

Contracted Provider and each Provider shall keep patient information confidential. However, Health Plan and/or Payor have a mutual right by law to a Covered Person's medical records, as well as timely and appropriate communication of patient information, so that both Contracted Provider and the Providers and the Health Plan and/or Payor may perform their respective duties efficiently and effectively for the benefit of the Covered Person. N.J. ADMIN. CODE §§ 11:24A-4.15(b)9; 11:24-15.2(b)11.

NJ-13 Complaints; Grievances.

The process for an internal provider complaint and grievance procedure to be used by Contracted Provider, which complies with N.J. ADMIN. CODE § 11:24A–4.6(b) or N.J. ADMIN. CODE § 11:24-3.7, as applicable, is set forth in the Provider Manual. N.J. ADMIN. CODE §§ 11:24A-4.15(b)10; 11:24-15.2(b)12; 11:24B-5.2(a)18.

NJ-14 PCPs and Specialists.

If Contracted Provider is a primary care provider or specialist, this Section applies to Contracted Provider. Contracted Provider shall acquire and maintain hospital admission privileges in accordance with the Provider Manual and/or the Health Plan's or Payor's credentialing criteria. It is the mutual responsibility of Contracted Provider and Health Plan or Payor to assure 24 hour, seven-day a week emergency and urgent care services and benefits therefor to Covered Persons, as appropriate to the Benefit Plan. The procedures to assure proper utilization of such coverage are set forth in the Agreement (including the Provider Manual). N.J. ADMIN. CODE §§ 11:24A-4.15(c); 11:24-15.2(c); 11:24B-5.5.

NJ-15 Facilities.

If Contracted Provider is a health care facility, this Section applies to Contracted Provider. Contracted Provider shall follow clear procedures for granting of admitting and attending privileges to physicians and will notify Health Plan when such procedures are no longer appropriate. The following are set forth in the Agreement (including the Provider Manual): (i) admission authorization procedures for Covered Persons, (ii) to the extent notice is necessary to assure payment of benefits (other than a screening fee), the procedures for notifying Health Plan or Payor when Covered Persons present at emergency departments, and (iii) the procedures for billing and payment, schedules, and any negotiated arrangements. N.J. ADMIN. CODE §§ 11:24A-4.15(d); 11:24-15.2(d); 11:24B-5.6.

NJ-16 Compensation Other Than Fee-For-Service.

If Contracted Provider is reimbursed on a basis other than fee-for-service (for example, capitation, per diem, or percent of charges), the Agreement specifies the dollar amount or methodology used by Health Plan or Payor to determine reimbursement, and identifies the services included in and excluded from the alternate reimbursement methodology. N.J. ADMIN. CODE § 11:24C–4.4.

NJ-17 Licensed Organized Delivery Systems. N.J. STAT. ANN. § 17:48H-18.

(a) To the extent that Payor is a licensed organized delivery system, this Subsection applies with respect to such Payor. If a Payor fails to pay or provide for comprehensive or limited health care services for any reason whatsoever, including, but not limited to, insolvency or breach of contract, neither the Health Plan nor the Covered Person will be liable to Contracted Provider or the Provider for any sums owed to Contracted Provider or the Provider under the Agreement. Contracted Provider may not, nor may any agent, trustee or assignee thereof maintain an action at law or attempt to collect from the Health Plan or the Covered Person sums owed to the Contracted Provider by the Payor, except that this Subsection shall not be construed to prohibit collection of uncovered charges consented to or lawfully owed to a Contracted Provider by Health Plan or a Covered Person.

(b) To the extent that Contracted Provider or Provider is a licensed organized delivery system, this Subsection applies. If Provider or, to the extent Contracted Provider is a licensed organized delivery system, Contracted Provider fails to pay or provide for comprehensive or limited health care services for any reason whatsoever, including, but not limited to, insolvency or breach of contract, neither the Health Plan, Payor nor the Covered Person will be liable to Contracted Provider for any sums owed to Contracted Provider under the Agreement. Contracted Provider may not, nor may any agent, trustee or assignee thereof maintain an action at law or attempt to collect from the Health Plan, Payor or the Covered Person sums owed to Provider by the Contracted Provider or, to the extent Contracted Provider is a licensed organized delivery system, such Contracted Provider, except that this Subsection shall not be construed to prohibit collection of uncovered charges consented to or lawfully owed to a Provider by Health Plan, Payor, Contracted Provider or a Covered Person.

NJ-18 Continuation of Care.

(a) Contracted Provider shall continue to provide services to Covered Persons at the contract price (i.e., in exchange for the compensation described in the Agreement as payment in full) following termination of the Agreement, in accordance with N.J. STAT. ANN. § 26:2S-9.1 or N.J. ADMIN. CODE § 11:24A–4.8, as applicable. N.J. STAT. ANN. § 26:2S-9.1; N.J. ADMIN. CODE § 11:24A-4.15(b)4.

(b) Contracted Provider shall continue to provide services to Covered Persons at the contract price (i.e., in exchange for the compensation described in the Agreement as payment in full) following termination of the Agreement for up to four (4) months in cases where it is Medically Necessary for the Covered Person to continue treatment with the terminated health care professional except as set forth below.

(i) In cases of the pregnancy of a Covered Person, Medical Necessity shall be deemed to have been demonstrated and coverage of services by the terminated Contracted Provider shall continue to the postpartum evaluation of the Covered Person, up to six (6) weeks after delivery.

(ii) In the case of care post-operative care, coverage of services by the terminated Contracted Provider shall continue for a period of up to six (6) months.

(iii) In the case of oncological treatment, coverage of services by the terminated Contracted Provider shall continue for a period up to one (1) year.

(iv) In the case of psychiatric treatment, coverage of services by the terminated Contracted Provider shall continue for a period of up to one (1) year.

(v) Health Plan or Payor is not required to continue coverage for services obtained through a terminated Contracted Provider in those instances in which the health care professional has been terminated based upon: the opinion of the Health Plan's or Payor's medical director that the health care professional is an imminent danger to a patient or the public health, safety and welfare, a determination of fraud, or a breach of Agreement by the health care professional, or the health care professional is the subject of disciplinary action by the State Board of Medical Examiners.

(vi) The determination as to the Medical Necessity of a Covered Person's continued treatment with a terminated Contracted Provider shall be subject to the appeal procedures set forth at N.J. ADMIN.

CODE § 11:24–8.5 through 8.7, if applicable. N.J. STAT. ANN. § 26:2S-9.1; N.J. ADMIN. CODE §§ 11:24-3.5(c); 11:24B-5.3.

(c) If Contracted Provider is not a hospital provider, this Subsection applies to Contracted Provider. Regardless of which party terminates the Agreement, or the reasons for the termination, Health Plan and the Contracted Provider shall abide by the terms of the Agreement, including reimbursement terms, for a minimum of four (4) months following the date of the termination, except as otherwise required or permitted by applicable law. However, Contracted Provider has no obligation under the Agreement to provide, and Health Plan or Payor has no obligation to reimburse at the contracted rate, services which are not Medically Necessary to be provided by the provider on and after the 31st day following the date of termination. N.J. STAT. ANN. § 26:2J-11.1; NJ ADMIN. CODE §§ 11:24-3.5(c)-(d); 11:24-15.2(b)4.

(d) If Contracted Provider is a hospital provider, this Subsection applies to Provider. If the Agreement is not renewed, or is terminated by either party, Contracted Provider and Health Plan or Payor shall continue to abide by the most current terms of the Agreement for a period of four (4) months from a severance date mutually agreed upon by both parties as required by N.J. STAT. ANN. § 26:2J–11.1. N.J. ADMIN. CODE §§ 11:24-3.5(e); 11:24-15.2(b)4; 11:24B-5.4(c).

NJ-19 Privity

If Health Plan or Payor is an HMO and Contracted Provider is a secondary contractor (as defined at N.J. ADMIN. CODE § 11:24-1.2, as may be amended), or if Contracted Provider is an organized delivery system, Health Plan or Payor is a third party beneficiary of Contracted Provider's contracts with its health care providers (including Providers), and Contracted Provider warrants and represents that such contracts will provide that Health Plan or Payor will have privity of contract with Contracted Provider's health care providers (including Providers) such that Health Plan or Company will have standing to enforce Contracted Provider's contract with the health care provider in the absence of enforcement by the Provider. N.J. ADMIN. CODE §§ 11:24-15.2(f); 11:24B-5.7.

NJ-20 Orthotic or Prosthetic Appliance Coverage

Coverage for an additional orthotic or prosthetic appliance from any licensed orthotist or prosthetist, licensed podiatrist, or any certified pedorthist must be provided if the covered person's physician determines that the additional appliance is necessary to enable the covered person to engage in physical or recreational activities. These provider types will be paid no less than 100% of Medicare rates when billing orthotic or prosthetic appliances that the physician determines are necessary to engage in physical or recreational activities in accordance with Senate Bill 1439.

North Carolina

STATE REGULATORY REQUIREMENTS

This section sets forth the provisions that are required by State law to be included in the Agreement with respect to this Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product are or will be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered

Person, or a Participation Provider is subject to the law cited in the parenthetical at the end of a provision in this section, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person or Participating Provider, as applicable.
The Parties shall comply with the State requirements set forth below.

NC-1 Entire Agreement. The Agreement and any attached or incorporated amendments, exhibits, or appendices constitute the entire contract between the parties in accordance with this Section NC-1 and the "Entire Agreement" provision of the Agreement. (11 N.C. ADMIN. CODE 20.0202(1)).

NC-2 Definitions. Except as set forth in this Section NC-2, the definitions of technical insurance
or managed care terms used in the Agreement are generally set forth in the "Definitions" Article of the Agreement. To the extent applicable, such definitions contain references to certain other documents distributed to providers (e.g., the Provider Manual), and are consistent with the definitions included in the evidence of coverage issued in connection with the Coverage Agreements. (11 N.C. ADMIN. CODE 20.0202(2)).

When appearing in this Product Attachment or the Agreement, the following quoted and bolded terms (and the plural thereof, when appropriate) have the meaning set forth below with respect to the Individual Market Product.

a. "***Emergency Medical Condition***" and "***Emergency Services***" or "***Emergency Care***" have the meaning set forth in N.C. GEN. STAT. § 58-3-190(g), which as of the Effective Date, "Emergence Services" (sometimes referred to herein as Emergency Care) means those health care items and services furnished or required to screen for or treat an emergency medical condition until the condition is stabilized, including prehospital care and ancillary services routinely available to the emergency department, and "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge
of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following: (a) placing the health of an individual, or with respect to a pregnant member, the health of the member or their unborn child, in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part.

b. "***Medical Necessity***" or "***Medically Necessary***" or "***Medically Necessary Services or Supplies***" has the definition set forth at N.C. GEN STAT. § 58-3-200(b), which, as of the Effective Date, is as follows: those Covered Services (or supplies) that are: (1) provided for the

diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease, and, except as allowed under N.C. GEN. STAT. § 58-3-255 (regarding coverage of clinical trials), not for experimental, investigational, or cosmetic purposes; (2) necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms; (3) within generally accepted standards of medical care in the community; and (4) not solely for the convenience of the insured (i.e., the Covered Person), the insured's family, or the provider.

For Medically Necessary services, nothing herein precludes a Payor from comparing the cost effectiveness of alternative services or supplies when determining which of the services or supplies will constitute Covered Services.

c. "*Intermediary*" has the definition set forth at 11 N.C. ADMIN. CODE 20.0101(b)(4), which, as of the Effective Date, is as follows: an entity that employs or contract with health care providers for the provision of health care services, and that also contracts with a network plan carrier, including the Company or a Payor, or its intermediary.

d. **"***Utilization Review"* or **"***utilization review"* means a set of formal techniques designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers, or facilities. These techniques may include: (a) ambulatory review - utilization review of services performed or provided in an outpatient setting; (b) case management - a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions; (c) certification - a determination by an insurer or its designated utilization review organization that an admission, availability of care, continued stay, or other service has been reviewed and, based on the information provided, satisfies the insurer's requirements for medically necessary services and supplies, appropriateness, health care setting, level of care, and effectiveness; (d) concurrent review - utilization review conducted during a patient's hospital stay or course of treatment; (e) discharge planning - the formal process for determining, before discharge from a provider facility, the coordination and management of the care that a patient receives after discharge from a provider facility; (f) prospective review - utilization review conducted before an admission or a course of treatment including any required preauthorization or precertification; (g) retrospective review - utilization review of medically necessary services and supplies that is conducted after services have been provided to a patient, but not the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment. Retrospective review includes the review of claims for emergency services to determine whether the prudent layperson standard in N.C. GEN. STAT. § 58-3-190 has been met; (h) second opinion - an opportunity or requirement to obtain a clinical evaluation by a provider other than the provider originally making a recommendation for a proposed service to assess the clinical necessity and appropriateness of the proposed service.

NC-3 Term. The term of the Agreement is set forth in the "Term" provision of the Agreement, and the term of this Product Attachment is set forth in Section 6 of this Product Attachment. (11 N.C. ADMIN. CODE 20.0202(3)).

NC-4 Written Notice of Termination; Grounds for Termination. The requirements for written notice of termination and each Party's grounds for termination are generally set forth in the "Term and Termination" Article of the Agreement. (11 N.C. ADMIN. CODE 20.0202(4)).

NC-5 Continuity of Care. Each Participating Provider shall continue to provide services to Covered Persons after termination of the Agreement or in the event of a Payor's or Intermediary's insolvency in accordance with the "Effect of Termination" provision of the Agreement and this Section NC-5, including, but not limited to, when inpatient care of a Covered Person is ongoing until patient is ready for discharge. In addition, in the event of a Payor's or Intermediary's insolvency, each Participating Provider shall continue to provide services to Covered Persons during the period for which premium has been paid. Each Participating Provider will cooperate with Company regarding the transition of administrative duties and records. To the extent that services are provided or arranged for on prepaid basis, each Participating Provider shall continue to provide inpatient care until the Covered Person is ready for discharge. (11 N.C. ADMIN. CODE 20.0202(5); N.C. GEN. STAT. § 58-67-120).

NC-6 Credentials. Each Participating Provider shall maintain licensure, accreditation, and credentials sufficient to meet Company's and/or Payor's credential verification program requirements, which are set forth in the Policies. Each Participating Provider shall notify Company of subsequent changes in status of any information relating to the Participating Provider's professional credentials in accordance with this Section NC-6 and the "Notice of Certain Events" provision of the Agreement. (11 N.C. ADMIN. CODE 20.0202(6)).

NC-7 Insurance. Each Participating Provider shall maintain professional liability insurance coverage in an amount acceptable to Health Plan and will inform Health Plan of subsequent changes in status of professional liability insurance on a timely basis in accordance with this Section NC-7 and the "Insurance" provision of the Agreement. (11 N.C. ADMIN. CODE 20.0202(7)).

NC-8 Hold Harmless.

a. No Participating Provider shall bill a Covered Person for Covered Services, except for specified coinsurance, copayments, and applicable deductibles. This provision shall not prohibit a Participating Provider and a Covered Person from agreeing to continue non-Covered Services at the Covered Person's own expense if the Participating Provider has notified the Covered Person in advance that the Payor may not cover or continue to cover specific services and the Covered Person chooses to

receive the service. This Section NC-8 survives termination of the Agreement for any reason, including Plan insolvency. Each Participating Provider is responsible for collecting any applicable deductibles, copayments, coinsurance, and fees for non-Covered Services from Covered Persons. (11 N.C. ADMIN. CODE 20.0202(8)).

b. In the event Payor fails to pay for Covered Services as set forth in the Agreement, the Covered Person shall not be liable to the Participating Provider for any sums owed by the Payor. No other provisions of the Agreement will, under any circumstances, change the effect of the foregoing. No Participating Provider, or agent, trustee, or assignee thereof, may maintain any action at law against a Covered Person to collect sums owed by the Payor. (N.C. GEN. STAT. § 58-67-115(a))

NC-9 Call Coverage. Each Participating Provider shall arrange for call coverage or other backup to provide service in accordance with the Payor's standards for provider accessibility, which are set forth in the Agreement, the Provider Manual, or the Policies. (11 N.C. ADMIN. CODE 20.0202(9)).

NC-10 Eligibility. A mechanism for Participating Providers to verify the eligibility of Covered Persons (based on current information held by Company or Payor, as applicable) before rendering health care services will be made available in accordance with the "Eligibility Determinations" section of the Agreement. (11 N.C. ADMIN. CODE 20.0202(10)).

NC-11 Records. Each Participating Provider shall: (a) maintain confidentiality of Covered Person medical records and personal information as required by N.C. Gen. Stat. Title 58, Article 39 and other health records as required by all applicable law; (b) maintain adequate medical and other health records according to industry and Company and/or Payor standards; and (c) make copies of such records available to Company, Payors and the North Carolina Department of Insurance in conjunction with its regulation of Company or Payor. (11 N.C. ADMIN. CODE 20.0202(11)).

NC-12 Grievance Procedures. Each Participating Provider shall cooperate with Covered Persons in grievance procedures in accordance with this Section NC-12, the Policies of Company or Payor, and the Agreement. (11 N.C. ADMIN. CODE 20.0202(12)).

NC-13 Discrimination Prohibition. Each Participating Provider shall not discriminate against any Covered Person based on race, color, national origin, gender, age, religion, marital status, health status, or health insurance coverage. (11 N.C. ADMIN. CODE 20.0202(13)).

NC-14 Compensation. The methodology to be used as a basis for payment (for example, Medicare DRG reimbursement, discounted fee for service, withhold arrangement, HMO provider capitation, or capitation with bonus) to the Participating Provider under the Agreement is set forth in the Compensation Schedule set forth or described in one or more Attachments to the Agreement. (11 N.C. ADMIN. CODE 20.0202(14))

NC-15 Data. Company will provide certain data and other information to the Participating Provider, if applicable, such as: (a) performance feedback reports or information, if compensation is related to efficiency criteria, or (b) information on benefit exclusions, administrative and utilization management requirements, credential verification programs, quality assessment programs, and provider sanction policies and/or program. Company will also provide advance notice of changes in such requirements in accordance with the Agreement to allow Participating Providers time to comply with such changes. (11 N.C.
ADMIN. CODE 20.0202(15)).

NC-16 Programs. Each Participating Provider shall comply with Company's or Payor's utilization management programs, credential verification programs, quality management programs, and provider sanctions programs. Notwithstanding the foregoing or any other provision of the Agreement, none of these programs override the professional or ethical responsibility of the Participating Provider or interfere with the Participating Provider's ability to provide information or assistance to their patients. (11 N.C. ADMIN.
CODE 20.0202(16)).

NC-17 Use of Name. Each Participating Provider authorizes Company or Payor to use of the name of the Participation Provider or the Participating Provider's group in the provider directory distributed to Covered Persons in accordance with this Section NC-17 and the "Use of Name" provision of the Agreement. Company or Payor, as applicable, will include the name of the Participating Provider or the Participating Provider's group in the provider directory. (11 N.C. ADMIN. CODE 20.0202(17)).

NC-18 Disputes. The process to be followed to resolve contractual differences between the Health Plan and/or Company, as applicable (including any Company acting as Payor), and a Participating Provider is set forth in the "Dispute Resolution" Article of the Agreement. (11 N.C. ADMIN. CODE 20.0202(18)).

NC-19 Assignment. The Participating Provider's duties and obligations under the Agreement may not be assigned, delegated, or transferred without the prior written consent of Health Plan. Health Plan shall notify the Participating Provider, in writing, of any duties or obligations that are to be delegated or transferred by Participating Provider, before the delegation or transfer (i.e., Health Plan will send prior written notice of the delegation or transfer to the Participating Provider). (11 N.C. ADMIN. CODE 20.0202(19)).

NC-20 Intermediary Contracts. If Provider is an Intermediary, the following apply. (11 N.C. ADMIN. CODE 20.0204(b))

a. Provider's contracts with health care providers will comply with and include the applicable provisions of 11 N.C. ADMIN. CODE 20.0202, which, as of the Effective Date, are set forth in this Exhibit.

b. Company and Payor each retain its legal responsibility to monitor and oversee the offering services to Covered Persons and the Payor retains its financial responsibility to Covered Persons.

c. Provider is prohibited from subcontracting its services without the written permission of Health Plan.

d. Company or Payor may approve or disapprove the participation of each health care. provider contracted with Provider for inclusion in or removal from the network (i.e., the status as a Participating Provider with respect to a Coverage Agreement).

e. Provider shall make available for review by the Department of Insurance all provider contracts and subcontracts held by Provider.

f. If Provider assumes risk from Health Plan, pays its health care providers on a risk basis or is responsible for claims payment to its providers, (1) Provider shall provide Health Plan will documentation of utilization and claims payment, and maintain accounting systems and records necessary to support the arrangement; (2) Provider will cooperate with Health Plan in order for it to arrange for financial protection of itself and Covered Persons through such approaches as hold harmless language, retention of signatory control of the funds to be disbursed, or financial reporting requirements; and (3) to the extent provided by law, the Department of Insurance will have access to the books, records and financial information to examine activities performed by Provider on behalf of Health Plan. Provider shall maintain such books and records in the State of North Carolina.

g. Provider shall comply with all applicable statutory and regulatory requirements that apply to the functions delegated by Health Plan and assumed by Provider.

NC-21 Intentionally Omitted.

NC-22 Notices. The name or title and address for notices to each Party under the Agreement, including notices of proposed amendments, are set forth in the "Notices" provision of the Agreement. (N.C. GEN. STAT. § 58-50-275).

NC-23 Amendments. Health Plan may amend the Agreement (including any Product Attachment) by sending written notice of the proposed amendment to the notices contact of the Provider set forth in the Agreement. Unless Provider notifies Health Plan in writing of its objection to such amendment during the sixty (60) day period following receipt of the proposed amendment, Provider will be deemed to have accepted the amendment. If Provider objects to a proposed amendment, then the proposed amendment is not effective, and the Health Plan may terminate the Agreement (and/or the applicable Product Attachment(s)) upon sixty (60) days' written notice to Provider. In addition, Health Plan and Provider may amend the Agreement at any time through mutual written agreement, documented by the signatures of duly authorized representatives of the Parties. (N.C. GEN STAT. § 58-50-280).

NC-24 Recovery of Overpayments. Health Plan shall provide at least thirty (30) days advance written notice to Provider of any offset made to future payments in connection with an overpayment recovery, which notice shall be accompanied by adequate specific information to identify the specific claim and the specific reason for the recovery.

NC-25 Compliance with Applicable Laws. This Product Attachment and the Agreement are intended to comply with all laws applicable to the Individual Market Product Attachment and, to the extent applicable to the Individual Market Product, Health Plan, Payors and Participating Providers, as applicable, shall comply with such laws, including N.C. GEN. STAT. § 58-3-225.

Ohio

STATE REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

OH-1 Services. The Provider Manual describes (a) the specific health care services for which each Participating Provider is responsible, including limitations or conditions on such services (if any); (b) the rights and responsibilities of Health Plan and a Payor, and of the Participating Providers, with respect to administrative policies and programs, including, but not limited to, payments systems, utilization review, quality assurance, assessment, and improvement programs, credentialing, confidentiality requirements, and any applicable federal or state programs; and (c) the specifics of any obligation on a Participating Provider that is a primary care provider to provide, or to arrange for the provision of, Covered Services twenty-four (24) hours per day, seven (7) days per week. The procedures for the resolution of disputes arising out of the Agreement are sent forth in the Agreement or Provider Manual. (OHIO REV. CODE §§ 1751.13(C)(1); 1751.13(C)(4); 1751.13(C)(10); 1751.13(C)(11)).

OH-2 Covered Person Hold Harmless. Each Participating Provider agrees that in no event, including but not limited to nonpayment by Health Plan or the Payor, insolvency of Health Plan or the Payor, or breach of the Agreement, shall the Participating Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a Covered Person or person to whom health care services have been provided, or person acting on behalf of the Covered Person, for Covered Services provided pursuant to the Agreement. This does not prohibit the Participating Provider from collecting co-insurance, deductibles, or copayments as specifically provided in the evidence of coverage, or fees for uncovered health care services delivered on a fee-for-service basis to persons referenced above, nor from any recourse against Health Plan, the Payor, or their respective successors. This Section shall survive the termination of the Agreement with respect to Covered Services provided under the Agreement during the time the Agreement was in effect, regardless of the reason for the termination, including the insolvency of the Payor. (OHIO REV. CODE §§ 1751.13(C)(2); 1751.13(C)(12); 1751.60(C)).

OH-3 Continuity of Care. Each Participating Provider shall continue to provide Covered Services to patients that were Covered Persons under the Agreement in the event of Health Plan's or the Payor's insolvency or discontinuance of operations. Each Participating Provider shall continue to provide Covered Services to patients that were Covered Persons under the Agreement as needed to complete any Medically Necessary procedures commenced but unfinished at the time of Health Plan's or the Payor's insolvency or discontinuance of operations. The completion of a Medically Necessary procedure shall include the rendering of all Covered Services that constitute Medically Necessary follow-up care for that procedure. The foregoing does not require the Participating Provider to continue to provide any Covered Service after the occurrence of any of the following: (a) the end of the thirty-day period following the entry of a liquidation order under Chapter 3903 of the Ohio Revised Code; (b) the end of the Covered Person's period of coverage for a contractual prepayment or premium; (c) the Covered Person obtains equivalent coverage with another health insuring corporation or insurer, or the Covered Person's employer obtains such coverage for the Covered Person; (d) the Covered Person or the Covered Person's employer terminates coverage under the Coverage Agreement or Payor Contract; (e) a liquidator effects a transfer of Health Plan's or the Payor's obligations under the contract under Section 3903.21(A)(8) of the Ohio Revised Code. (OHIO REV. CODE § 1751.13(C)(3)).

OH-4 Records. Each Participating Provider shall keep confidential and make available those health records maintained by the Participating Provider to monitor and evaluate the quality of care, to conduct evaluations and audits, and to determine on a concurrent or retrospective basis the necessity of and appropriateness of health care services provided to Covered Persons. Each Participating Provider shall make these health records available to appropriate State and federal authorities involved in assessing the quality of care or in investigating the grievances or complaints of Covered Persons. Each Participating Provider shall comply with applicable State and federal laws related to the confidentiality of medical or health records. (OHIO REV. CODE § 1751.13(C)(5)).

OH-5 Assignment. The contractual rights and responsibilities under the Agreement may not be assigned or delegated by the Participating Provider without the prior written consent of Health Plan. (OHIO REV. CODE § 1751.13(C)(6)).

OH-6 Insurance. Each Participating Provider shall maintain adequate professional liability and malpractice insurance and shall notify Health Plan not more than ten (10) days after the Participating Provider's receipt of notice of any reduction or cancellation of such coverage. (OHIO REV. CODE § 1751.13(C)(7))

OH-7 Covered Person Rights. Each Participating Provider shall observe, protect, and promote the rights of Covered Persons as patients. Each Participating Provider shall provide health care services without discrimination based on a patient's participation in the health care plan, age, sex, ethnicity, religion, sexual orientation, health status, or disability, and without regard to the source of payments made for health care services rendered to a patient. This requirement shall not apply to circumstances when the Participating Provider appropriately does not render services due to limitations arising from the Participating Provider's lack of training experience, or skill, or due to licensing restrictions. (OHIO REV. CODE §§ 1751.13(C)(8); 1751.13(C)(9)).

OH-8 Definitions. The terms used in the Agreement and defined by Chapter 1751 of the Ohio Revised Code are to be construed when used in the Agreement in a manner consistent with those statutory definitions (OHIO REV. CODE § 1751.13(C)(13)).

OH-9 Payor's Role. Each Participating Provider acknowledges that the Payor is a third-party beneficiary to the Agreement, and that each Payor retains the right to approve or disapprove the participation of the Participating Provider with respect to any provider panel or network available for a particular Coverage Agreement. (OHIO REV. CODE § 1751.13(F)).

OH-10 Oversight. Each Participating Provider acknowledges Health Plan's statutory responsibility to monitor and oversee the offering of Covered Services to Covered Persons. (OHIO REV. CODE § 1751.13(G)).

OH-11 Third Party Access. The Agreement applies to network rental arrangements. One purpose of the Agreement is selling, renting or giving Health Plan rights to the services of the Participating Provider, including other preferred provider organizations, and the third party accessing the Participating Provider's services is any of the following: (i) a Payor or a third-party administrator or other entity responsible for administering claims on behalf of the Payor; (ii) a preferred provider organization or preferred provider network that receives access to the Participating Provider's services pursuant to an arrangement with the preferred provider organization or preferred provider network in a contract with the Participating Provider that is in compliance with Ohio Rev. Code § 3963.02(A)(1)(c), and is required to comply with all of the terms, conditions, and affirmative obligations to which the

originally contracted primary participating provider network is bound under its contract with the Participating Provider, including, but not limited to, obligations concerning patient steerage and the timeliness and manner of reimbursement; (iii) an entity that is engaged in the business of providing electronic claims transport between Health Plan and the Payor or third-party administrator and complies with all of the applicable terms, conditions, and affirmative obligations of Health Plan's contract with the Participating Provider including, but not limited to, obligations concerning patient steerage and the timeliness and manner of reimbursement; (iv) an employer or other entity providing coverage for health care services to its employees or members, and that employer or entity has a contract with Health Plan or its Affiliate for the administration or processing of claims for payment for services provided pursuant to the Agreement with the Participating Provider; or (v) an entity that is an Affiliate or subsidiary of Health Plan or is providing administrative services to, or receiving administrative services from, Health Plan or an Affiliate or subsidiary of Health Plan. (OHIO REV. CODE § 3963.02).

OH-12 Summary Disclosure Form. The summary disclosure form, attached hereto as Schedule A-1, is incorporated herein by this reference. (OHIO REV. CODE § 3963.03).

Oklahoma

STATE REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

OK-1 Claims Timeliness - In the administration, servicing, or processing of any accident and health insurance policy, every insurer shall reimburse all clean claims of an insured, an assignee of the insured, or a health care provider within forty-five (45) calendar days after receipt of the claim by the insurer. If the insurer does not process clean claims timely, interest will be paid at the greater of: (1) the penalty amount for late payment referred to in applicable provisions in Title 36 of the Oklahoma Statutes; or (2) the contracted penalty rate for late payment set forth in the contract between the provider and the insurer.

OK-2 Payment for Serves to Arrested/Detained Individuals – Oklahoma Complete Health shall reimburse otherwise allowable claims which occur in conjunction with the arrest or pretrial detention of the policyholder prior to adjudication of guilt and sentencing to incarceration of the policyholder. The reimbursement rate for out-of-network claims for these services shall be set at the current Medicare rate.

Pennsylvania

STATE REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

PA-1. Hold Harmless. Each Participating Provider hereby agrees that in no event, including, but not limited to non-payment by the Payor, Payor insolvency or breach of the Agreement, shall Participating Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Covered Persons or persons other than Payor acting on their behalf for services listed in this Agreement. This provision does not prohibit collection of supplemental charges or copayments on the Payor's or Participating Provider's behalf made in accordance with the terms of the applicable Coverage Agreement. Each Participating Provider further agrees that (a) the hold harmless provisions herein will survive the termination of the Agreement or this Product Attachment regardless of the cause giving rise to termination and will be construed to be for the benefit of the Covered Person and that (b) this hold harmless provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Participating Provider and Covered Person or persons acting on a Covered Person's behalf. Any modification, addition, or deletion to the provisions of this Section will become effective on a date no earlier than fifteen (15) days after the Secretary of Health of the Commonwealth of Pennsylvania has received written notice of such proposed changes. (31 PA. CODE § 301.122).

PA-2. Inpatient Continuation of Benefits. If a Payor becomes insolvent, each Participating Provider shall continue to provide services to Covered Persons for the duration of the period after the Payor's insolvency for which premium payment has been made and until the any Covered Persons that are inpatients at the time of the Payor's insolvency are discharged from the inpatient facilities. (31 PA. CODE § 301.123(b)(2)).

PA-3. Termination by Participating Provider. Each Participating Provider shall provide at least sixty (60) days' notice to Payor if Participating Provider terminates the Agreement or termination of their or its participation under the Agreement or this Product Attachment. (31 PA. CODE § 301.124).

PA-4. Managed Care Plans; Continuation of Benefits. This Section 4 applies only with respect to Coverage Agreements that constitute "managed care plans", as defined at 40 PA. STAT. § 991.2102 and 31 PA. CODE § 154.2, which generally involve the use of a gatekeeper and incentives for Covered Persons to use Participating Providers. If Company or a Payor terminates the Agreement or a Participating Provider's participation under the Agreement or this Product Attachment, each

Participating Provider shall continue to provide services to Covered Persons in an ongoing course of treatment (as that term is defined in 31 PA. CODE § 154.2) with the Participating Provider, at the Covered Person's option, for a transitional period of up to sixty (60) days from the date the Covered Person's is notified of the termination by Company or Payor. With respect to those Covered Persons in the second or third trimester of pregnancy at the time of notice of termination, such transitional period will extend through postpartum care related to the delivery. If Company or a Payor terminates the Agreement or a Participating Provider's participation under the Agreement or this Product Attachment for cause, including breach of contract, fraud, criminal activity or posing a danger to a Covered Person or the health, safety, or welfare of the public, as determined by the Company or Payor, the Company or Payor is not responsible for health care services provided to Covered Persons following the date of termination. (40 PA. STAT. § 991.2117).

PA-5. Participating Provider's Participation. The Health Plan shall not sanction, terminate, or fail to renew the health care provider's participation for any of the following reasons:

PA-5.1 Discussing the process that the managed care plan or any entity contracting with the managed care plan uses or proposes to use to deny payment for a health care service.

PA-5.2 Advocating for medically necessary and appropriate care with or on behalf of the enrollee, including information regarding the nature of treatment; risks of treatment; alternative treatments; or the availability of alternative therapies, consultations, or tests.

PA-5.3 Discussing the decision of any managed care plan to deny payment for a health care service.

PA-5.4 Filing a grievance on behalf of and with the written consent of an enrollee or helping an enrollee file a grievance.

South Carolina

STATE REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

SC-1 Percentage Copayments and Deductibles. Each Participating Provider agrees that percentage copayments and deductibles paid by Covered Persons are applied to the negotiated rates

set forth in the Agreement or lesser charge of such Participating Provider. Nothing in this Section precludes a Payor from offering a Coverage Agreement that contains fixed dollar copayments and deductibles. (S.C. CODE ANN. § 38-71-241).

SC-2 Continuation of Care.

SC-2.1 As used in this Section SC-2: (a) "continuation of care" means the provision of in-network level benefits for services rendered by certain out-of-network providers for a definite period of time in order to ensure continuity of care for Covered Persons for a serious medical condition; and (b) "serious medical condition" means a health condition or illness, that requires medical attention, and where failure to provide the current course of treatment through the current provider would place the person's health in serious jeopardy, and includes cancer, acute myocardial infarction, and pregnancy. Such attestation by the treating physician must be made upon the request of the patient and in a written form approved by the South Carolina Department of Insurance or prescribed through regulation, order, or bulletin. (S.C. CODE ANN. § 38-71-243(A)).

SC-2.2 Each Participating Provider agrees that continuation of care will be provided for ninety (90) days or until the termination of the benefit period, whichever is greater. Each Participating Provider agrees that continuation of care will not be provided if suspension or revocation of the Participating Provider's license occurs. (S.C. Code Ann. §§ 38-71-243(A) and (B)).

SC-2.3 If the If the Agreement is terminated or nonrenewed, the Participating Provider shall comply with the following requirements: (a) except as required by this Section, the benefits payable for Covered Services rendered during the continuation of care are subject to the terms and conditions of the Coverage Agreement; (b) the Participating Provider shall not require a Covered Person to pay a deductible or copayment that is greater than the in-network rate for Covered Services rendered during the continuation of care; (c) the Participating Provider shall accept as payment in full for services rendered within in the continuation of care the negotiated rate under the Agreement; (d) except for an applicable deductible or a copayment, the Participating Provider shall not bill or otherwise hold a Covered Person financially responsible for services rendered in the continuation of care and furnished by such Participating Provider, unless the Participating Provider has not received payment in accordance with State law; (e) upon receipt of the patient's request accompanied by the physician's attestation on the prescribed form, the Participating Provider and the Covered Person will be notified by the Payor or its delegate of the Participating Provider's date of termination from the network and of the continuation of care provisions as provided for in this Section; and (f) the Participating Provider acknowledges that the Payor determines whether a Covered Person qualifies for continuation of care and may request additional information in reaching such determination. (S.C. CODE ANN. § 38-71-243(C)).

SC-3 Limitations. Each party to the Agreement is responsible for the legal consequences and costs of their or its own acts or omissions, or both, and is not responsible for the acts or omissions, or both, of the other party. (S.C. CODE ANN. § 38-71-1740).

SC-4 Hold Harmless. Each Participating Provider agrees not to bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have recourse against, Covered

Persons or persons acting on their behalf, for health care services which are rendered to such Covered Persons by the Participating Provider, and which are covered benefits under the Covered Person's Coverage Agreement. The Participating Provider agrees this provision extends to all Covered Services furnished to the Covered Person during the time they are enrolled in, or otherwise entitled to benefits promised by the Payor. The Participating Provider agrees this provision further applies in all circumstances including, but not limited to, non-payment by the Payor and insolvency of the Payor. This provision does not prohibit collection of copayments from Covered Persons by the Participating Provider in accordance with the terms of the Coverage Agreement issued by the Payor. The Participating Provider further agrees that this provision shall be construed to be for the benefit of Covered Persons of the Payor and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered between the Participating Provider and such Covered Persons, or persons acting on their behalf. (S.C. CODE ANN. § 38-38-130B).

Tennessee

STATE REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

For Providers and Contracted Providers in the State of Tennessee, Health Plan or Celtic Insurance Company, an Affiliate, may issue the Coverage Agreement that applies to a Covered Person. In such case the following provisions may apply to the Covered Person or the Participating Provider as applicable.

TN-1 Hold Harmless. Participating Provider agrees that the Agreement contains a hold harmless clause that relieves a Covered Person from any liability for services rendered by Participating Providers except for reasonably copayment and non-Covered Services. (TENN. CODE § 56-32-105(c)).

TN-2 Network Access by Third Parties. Participating Provider agrees to authorize the Health Plan to enter into an agreement with third parties allowing each third party to exercise the Health Plan's and/or Payor's rights and responsibilities under the Agreement as if the third party were the Health Plan. (TENN. CODE § 56-60-105).

Texas

STATE REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to this Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

A. Health Plan Requirements. For a Product that is a Health Plan Product, Participating Providers and Health Plan are required to comply with the provisions of Schedule A-1 and A-2 (State-Mandated Provisions) as applicable to their Agreement, with the following exception described below:

1. Section 5 (Compliance with Prompt Payment Regulations) shall be revised to delete the reference to "Medicaid Covered Persons" and to replace it with "Covered Persons" and revised to replace the phrase "within thirty (30) days of its receipt" with "within forty-five (45) days of its receipt."

B. Insurance Company Requirements. For a Product for which the Payor is not Health Plan, Participating Providers and the Payor are required to comply with the following provisions:

The following provisions are only applicable to HMO product lines:

TX-1 Batched Claims. No Payor or delegate or clearinghouse of a Payor or delegate may refuse to process or pay an electronically submitted clean claim, as that term is defined in Tex. Ins. Code Ann. § 843.336, as may be amended, because the claim is submitted together with or in a batch submission with a claim that is not a clean claim. (TEX. INS. CODE ANN. §§ 843.323; 1301.0641).

TX-2 Upon the giving or receipt of any notice to termination or non-renewal of a Participating Provider's participation under a Coverage Agreement, the Participating Provider will immediately provide the Health Plan or Payor with a list of the Covered Persons currently being treated by the Participating Provider. If the Health Plan or Payor terminates the participation of a Participating Provider under a Coverage Agreement, the Health Plan, Payor, or its delegate will provide notice to each Covered Person currently being treated by the affected Participating Provider of the impending termination of the Participating Provider's participation as a Participating Provider under the Covered Person's Coverage Agreement. If Provider or a Participating Provider terminates the participation of the Participating Provider under a Coverage Agreement, the Participating Provider will provide notice to each Covered Person currently being treated by the affected Participating Provider of the impending termination of the Participating Provider's participation as a Participating Provider under the Covered Person's Coverage Agreement. (TEX. INS. CODE ANN. §§ 1301.152; 1301.160).

TX-3 Podiatrists. If a Participating Provider is a podiatrist licensed by the Texas State Board of Podiatric Medical Examiners, the provisions set forth in this Section apply. The Participating Provider may request, and the Payor shall provide not later than the thirtieth (30th) day after the date of the request, a copy of the coding guidelines and payment schedules applicable to the compensation that the Participating Provider receives or will receive under this Attachment. The Payor may not

unilaterally make material retroactive revisions to the coding guidelines and payment schedules. The Participating Provider may, while practicing within the scope of the law regulating podiatry, provide x-rays and non-prefabricated orthotics covered by the Coverage Agreement. (TEX. INS. CODE ANN. §§ 843.311, 1301.062).

TX-4 Claim Submission, Prompt Payment.

TX-4.1 As required by applicable State law, Provider and each Participating Provider shall submit a claim no later than the ninety-fifth (95th) day after the date of service. A claim not submitted within such time frame may be denied for payment, unless the failure to submit the claim in compliance with this section is a result of a catastrophic event that substantially interferes with the normal business operations of the Provider or the Participating Provider. Neither Provider nor a Participating Provider (or any delegate) shall submit a duplicate claim for payment before the forty-sixth (46th) day after the date the original claim was submitted. (TEX. INS. CODE ANN. §§ 843.337, 1301.102).

TX-4.2 Except as otherwise provided in applicable State law, Payor shall determine whether a clean claim submitted by Provider or a Participating Provider for Covered Services is payable not later than the forty-fifth (45th) day after the date on which a clean claim in a nonelectronic format is received, or not later than the thirtieth (30th) day after the date on which a clean claim in an electronic format is received. Except as otherwise provided in applicable State law, Payor shall pay clean claims submitted by Provider or a Participating Provider for Covered Services on or before the later of (i) the forty-fifth (45th) day after the date on which the claim for payment is received with the documentation reasonably necessary to process the claim, or (ii) the last day in the time specified in the Agreement or the Provider Manual for payment of claims. (TEX. INS. CODE ANN. §§ 843.336-843.354; 1301.064, and 1301.101-109).

TX-5 Waiver of Electronic Claims. When expressly required by applicable State law, a waiver of any requirement under the Agreement or this Product Attachment for the electronic submission of a claim made with respect to a Coverage Agreement may be obtained in accordance with the process set forth in the Provider Manual. (TEX. INS. CODE ANN. § 1213.003).

TX-6 Gag Clause. Neither Health Plan nor Payor shall limit, prohibit, or attempt to prohibit Provider or a Participating Provider from discussing with or communicating in good faith with Covered Persons that are patients or a person designated by a Covered Person that is a patient with respect to: (a) information or opinions regarding the Covered Person's health care, including the patient's medical condition or treatment options; (b) information or opinions regarding the terms, requirements, or services of the Coverage Agreement as they relate to the medical needs of the Covered Person; or (c) the termination of the Agreement or the fact that the Participating Provider will otherwise no longer be providing medical care, dental care, or health care services under the Coverage Agreement. Neither Health Plan nor Payor shall in any manner penalize, terminate, or refuse to compensate for Covered Services a Provider or Participating Provider for communicating in a

manner protected by this section with a current, prospective, or former patient that is a Covered Person, or a person designated by a patient that is a Covered Person. (TEX. INS. CODE ANN. §§ 843.363, 1301.067).

TX-7 Complaint Resolution. The Agreement or Provider Manual, as applicable, sets forth or identifies the mechanism to be used utilized in resolving complaints initiated by a Covered Person, Provider, or Participating Provider. (TEX. INS. CODE ANN. § 1301.055).

TX-8 Discounted Fees. Provider and each Participating Provider agree that to the extent that Provider or a Participating Provider is compensated on a discounted fee basis, the Covered Person may be billed only on the discounted fee and not the full charge for services. (TEX. INS. CODE ANN. § 1301.061).

TX-9 Overpayments. Neither Health Plan nor Payor may recover an overpayment to Provider or a Participating Provider if, not later than the one hundred eightieth (180th) day after the date the Participating Provider receives the payment, the Payor, Health Plan or one of their delegates provides written notice of the overpayment to Provider or the Participating Provider that includes the basis and specific reasons for the request for recovery of funds, and either Provider or the Participating Provider makes arrangements for repayment of the requested funds on or before the forty-fifth (45th) day after the date the notice is received. (TEX. INS. CODE ANN. §§ 843.350, 1301.132).

TX-10 Access by Payors. Pursuant to this Agreement and notwithstanding anything herein to the contrary, Health Plan has Provider's permission and express authority to provide access to the health care products and services to be provided pursuant hereto, and the contractual discounts provided for herein, to all persons who are Payors, including without limitation, Health Plan, and all group customers of Health Plan (including self-funded employers and other organizations). Health Plan may sell, lease, or otherwise transfer information regarding the payment or reimbursement terms of this Agreement (and its Addenda and Attachments) to such persons and Payors. Health Plan will provide prior notification to Provider of the persons and Payors to whom access is granted by providing the name of the Payor by electronic mail, through its provider newsletter or on its provider website; provided, however, Provider acknowledges that prior adequate notice has been provided with respect to Health Plan, and all self-funded groups existing as of the date hereof. Provider expressly acknowledges that Health Plan may provide the persons and Payors described above with access to Health Plan's rights and responsibilities under this Agreement. On request of Provider or a Contracted Provider, Health Plan will provide information necessary to determine whether a particular person has been authorized to access the Provider's or a Contracted Provider's health care services and the contractual discounts provided for herein. To the extent required by applicable law, this Agreement specifies the applicable fee schedule for each Product and/or line of business contemplated by this Agreement. Each person or Payor granted access to the health care products and services and the contractual discounts hereunder must comply with all applicable terms, limitations, and conditions of this Agreement. Health Plan will provide such person or Payor with reasonable access, including electronic access, during normal business hours for the review of this

Agreement, which access will be allowed only for the purposes of complying with the terms of this Agreement or applicable state law. Pursuant to its signature on the Product Attachments attached hereto, Provider provides its express authority with respect to each line of business and the fee schedule applicable to each such line of business.

The following provisions are only applicable to EPO product line:

TX-11 Contracting with Others. This Agreement does not restrict a participating provider from contracting with other insurers, preferred provider plans, preferred provider networks or organizations, exclusive provider benefit plans, exclusive provider networks or organizations, health care collaborative, or HMOs. (28 TEX. ADMIN. CODE § 3.3703(a)(1)).

TX-12 Limitation on Participation. Any term or condition of this Agreement limiting participation based on quality considerations shall be construed to be consistent with established standards of care for the applicable profession. (28 TEX. ADMIN. CODE § 3.3703(a)(2)).

TX-13 Provider Privileges. In the case of participating providers who provide a significant portion of care in a hospital or institutional provider setting, this Agreement may require the possession of practice privileges at participating hospitals or institutions, provided, however, if no participating hospital or facility offers privileges to a certain class of physicians or providers, the lack of hospital or facility provider privileges may not be a basis for denial of participation as a participating provider to such physicians or providers of that class. (28 TEX. ADMIN. CODE § 3.3703(a)(3)).

TX-14 Staff Membership or Privileges. A physician or provider is not required to enter into a participating provider agreement as a condition of staff membership or privileges at a particular hospital or facility. This prohibition does not apply to requirements concerning practice conditions other than conditions of membership or privileges. (28 TEX. ADMIN. CODE § 3.3703(a)(4)).

TX-15 Billing for Unnecessary Care. A participating provider will not bill the member for unnecessary care, if the care has been determined to be unnecessary, provided, however, the participating provider will not be required to pay for hospital, institutional, laboratory, x-ray, or like charges resulting from the provision of services lawfully ordered by a physician or provider, even though such service may be determined to be unnecessary. (28 TEX. ADMIN. CODE § 3.3703(a)(5)).

TX-16 Referrals to Other Providers. This Agreement does not impose restrictions on the classes of physicians and providers who may refer a member to another physician or provider. This Agreement does not require a referring physician or provider to bear the expenses of a referral for specialty care in or out of the participating provider network. (28 TEX. ADMIN. CODE § 3.3703(a)(6)).

TX-17 Financial Incentives. Financial incentives will not be provided to a physician or a provider that act directly or indirectly as an inducement to limit medically necessary services. The requirements of TX-16 (above) and this Paragraph TX-17 do not prohibit the savings from cost-

effective utilization of health services from being shared with participating providers in the aggregate. (28 TEX. ADMIN. CODE § 3.3703(a)(7)).

TX-18 Resolution of Complaints. This Agreement provides for a mechanism for the resolution of complaints initiated by a member, a physician, physician group, or provider, which mechanism provides for reasonable due process including, in an advisory role only, a review panel selected in accordance with Section 3.3706(b)(2) of the PPO/EPO Regulations. (28 TEX. ADMIN. CODE § 3.3703(a)(8)).

TX-19 Hold Harmless. A provider, physician, or physician group will not be required to execute a hold harmless clause that shifts the tort liability resulting from acts or omissions of Health Plan to the participating provider. (28 TEX. ADMIN. CODE § 3.3703(a)(9)).

TX-20 Member Billing. Any participating provider who is compensated on a discounted fee basis agrees to bill the member only on the discounted fee and not the full charge. (28 TEX. ADMIN. CODE § 3.3703(a)(10)).

TX-21 Prompt Payment. Health Plan will comply with all applicable statutes and rules pertaining to prompt payment of clean claims with respect to payment to the provider for covered services rendered to members. (28 TEX. ADM. CODE § 3.3703(a)(11)).

TX-22 Continuity of Care. Health Plan and the participating provider will comply with Tex. Ins. Code §§1301.152 - 1301.154, relating to continuity of care. (28 TEX. ADM. CODE §3.3703(a)(12)).

TX-23 Member Communication. Health Plan will not, as a condition of this Agreement or in any other manner, prohibit, attempt to prohibit, or discourage a physician or provider from discussing with or communicating to a current, prospective, or former member, or a person designated by a member, information or an opinion: (a) regarding the member's health care, including the member's medical condition or treatment options; or (2) in good faith regarding the provisions, terms, requirements, or services of the health insurance coverage as they relate to the member's medical needs. Health Plan may not in any way penalize, terminate the participation of, or refuse to compensate for covered services, a physician or health care provider for discussing or communicating with a current, prospective, or former member, or a person designated by a member. (28 TEX. ADM. CODE § 3.3703(a)(13)).

TX-24 Economic Profiles. To the extent Health Plan conducts, uses, or relies upon economic profiling to terminate physicians or providers from a plan, it will make available to a physician or provider on request the economic profile of that physician or provider, including the written criteria by which the physician's or provider's performance is to be measured. An economic profile must be adjusted to recognize the characteristics of a physician's or provider's practice that may account for variations from expected costs. (28 TEX. ADMIN. CODE § 3.3703(a)(14)).

TX-25 Quality Assessments. To the extent Health Plan engages in quality assessments, it will do so in accordance with the requirements of applicable law through a panel of at least three physicians selected by Health Plan from among a list of participating physicians. The participating physicians in the applicable service area shall provide the list of physicians to Health Plan. (28 TEX. ADMIN. CODE § 3.3703(a)(15)).

TX-26 Immunization and Vaccination Protocol. A participating physician is not required to issue an immunization or vaccination protocol for an immunization or vaccination to be administered to a member by a pharmacist. (28 TEX. ADMIN. CODE § 3.3703(a)(16)).

TX-27 Immunizations and Vaccinations by Pharmacist. A pharmacist will not be prohibited from administering immunizations or vaccinations if such immunizations or vaccinations are administered in accordance with the Tex. Occ. Code Chapters 551-566 and 568-569, and applicable rules promulgated thereunder. (28 TEX. ADMIN. CODE § 3.3703(a)(17)).

TX-28 Member Notice Upon Termination. If the participating provider voluntarily terminates this Agreement, the participating provider must provide reasonable notice to the member, and Health Plan will provide assistance to the participating provider in assuring that such notice is provided. (28 TEX. ADMIN. CODE § 3.3703(a)(18))

TX-29 Termination Review. Written notice will be provided to the participating provider on termination of this Agreement by Health Plan, and such notice will include the participating provider's right to request a review. (TEX. ADMIN. CODE § 3.3703(a)(19)).

TX-30 Information on Compensation. The participating provider is entitled, upon request, to all information necessary to determine that the participating provider is being compensated in accordance with the terms of this Agreement. The participating provider may make the request for information by any reasonable and verifiable means. The information must include a level of detail sufficient to enable a reasonable person with sufficient training, experience, and competence in claims processing to determine the payment to be made for covered services that are rendered to members. Health Plan may provide the required information by any reasonable method through which the participating provider can access the information, including e-mail, website, computer disks, paper, or access to an electronic database. Health Plan will provide the fee schedules and other required information by the 30th day after receipt of the request.

a. This information will include a specific summary and explanation of all payment and reimbursement methodologies that will be used to pay claims submitted by the participating provider, including the information required in Section 3.3703(a)(20) of the PPO/EPO Regulations.

b. In the case of a reference to source information as the basis for fee computation that is outside the control of Health Plan, such as state Medicaid or federal Medicare fee schedules,

the information will clearly identify the source and explain the procedure by which the participating provider may readily access the source electronically, telephonically, or as otherwise agreed to by the parties.

c. Nothing herein may be construed to require Health Plan to provide specific information that would violate any applicable copyright law or licensing agreement. However, Health Plan will supply, in lieu of any information withheld based on copyright law or licensing agreement, a summary of the information that will allow a reasonable person with sufficient training, experience, and competence in claims processing to determine the payment to be made for covered services that are rendered to members.

d. No amendment, revision, or substitution of claims payment procedures or any of the information required to be provided will be effective as to the participating provider, unless Health Plan provides at least 90 calendar days written notice to the participating provider identifying with specificity the amendment, revision, or substitution. Health Plan will not make retroactive changes to claims payment procedures or to any of the information required to be provided as described above.

e. A participating provider that receives the information described above (i) may not use or disclose the information for any purpose other than for practice management, billing activities, other business operations, or communications with a governmental agency involved in the regulation of health care or insurance; (ii) may not use the information to knowingly submit a claim for payment that does not accurately represent the level, type or amount of services that were actually provided to a member or to misrepresent any aspect of the services; and (iii) may not rely upon the information as a representation that a member is covered for that service under the terms of the member's policy or certificate.

f. A participating provider that receives the information described above may terminate this Agreement on or before the 30th day after the date the participating provider receives the information without penalty or discrimination with respect to the participation in other health care products or plans of Health Plan. If a participating provider chooses to terminate the Agreement, Health Plan is required to assist the participating provider in providing the notice required by Paragraph 18 above. (28 TEX. ADMIN. CODE § 3.3703(a)(20)).

TX-31 Other Health Benefit Coverage. A participating provider must retain in its records updated information concerning a member's other health benefit plan coverage. (28 TEX. ADMIN. CODE § 3.3703(a)(21)).

TX-32 Claim Submission. Upon request by a participating provider, Health Plan agrees that it and its clearinghouse will not refuse to process or pay an electronically submitted clean claim because the claim is submitted together with or in a batch submission with a claim that is deficient. As used in this paragraph, the term batch submission is a group of electronic claims submitted for

processing at the same time within a HIPAA standard ASC X12N 837 Transaction Set and identified by a batch control number. (28 TEX. ADMIN. CODE § 3.3703(a)(22))

TX-33 Referral Information. A referring physician or provider, or a designee, must disclose to the member (a) that the physician, provider, or facility to whom the member is being referred might not be a participating provider; and (b) if applicable, that the referring physician or provider has an ownership interest in the facility to which the member is being referred. The notice specified in (a) will allow for exceptions for emergency care and as necessary to avoid interruption or delay of medically necessary care and will not limit access to nonparticipating providers. (28 TEX. ADMIN. CODE § 3.3703(a)(23) and (24)).

TX-34 Overpayments. The participating provider who receives an overpayment from a member must refund the amount of the overpayment to the member not later than the 30th day after the date the participating provider determines that an overpayment has been made. (28 TEX. ADMIN. CODE § 3.3703(a)(25)).

TX-35 Facility Based Physician Groups. A participating hospital or facility must provide notice to Health Plan of the termination of a contract with a facility-based physician group (that is a participating provider) as soon as reasonably practicable, but not later than the fifth business day following termination of the contract. (28 TEX. ADMIN. CODE § 3.3703(a)(26)).

TX-36 Referrals to Out-Of-Network Providers. Except for instances of emergency care, a participating provider referring a member to a hospital or facility for surgery must (a) notify the member of the possibility that out-of-network providers may provide treatment and that the member may contact Health Plan for more information; (b) notify Health Plan that surgery has been recommended; and (c) notify Health Plan of the hospital or facility that has been recommended for the surgery. (28 TEX. ADMIN. CODE § 3.3703(a)(27)).

TX-37 Referrals to Out-Of-Network Facilities. Except for instances of emergency care, when scheduling surgery, a hospital or facility must (a) notify the member of the possibility that out-of-network providers may provide treatment and that the member may contact Health Plan for more information; and (b) notify Health Plan that surgery has been scheduled. (28 TEX. ADMIN. CODE § 3.3703(a)(28)).

Washington

STATE REGULATORY REQUIREMENTS

RCW 48.49.020 Balance billing—when prohibited—Carrier's duty to hold an enrollee harmless from balance billing under certain circumstances (effective January 1, 2020.).

(1) An out-of-network provider or facility may not balance bill an enrollee for the following health care services:

(a) Emergency services provided to an enrollee, or

(b) Nonemergency health care services provided to an enrollee at an in-network hospital licensed under chapter 70.41 RCW or an in-network ambulatory surgical facility licensed under chapter 70.230 RCW if the services:

(i) Involve surgical or ancillary services, and

(ii) Are provided by an out-of-network provider.

(2) Payment for services described in subsection (1) of this section is subject to the provisions of RCW 48.49.030 and 48.49.040.

RCW 48.49.070 Hospital or ambulatory surgical facility—Requirement to provide certain information on web site or upon consumer request—Requirement to provide carriers with non-employed provider lists (effective January 1, 2020).

(1)(a) A hospital or ambulatory surgical facility must post the following information on its web site, if one is available:

(i) The listing of the carrier health plan provider networks with which the hospital or ambulatory surgical facility is an in-network provider, based upon the information provided by the carrier pursuant to RCW 48.43.730(7), and

(ii) The notice of consumer rights developed under RCW 48.49.060.

(b) If the hospital or ambulatory surgical facility does not maintain a web site, this information must be provided to consumers upon an oral or written request.

(2) Posting or otherwise providing the information required in this section does not relieve a hospital or ambulatory surgical facility of its obligation to comply with the provisions of this chapter.

(3) Not less than thirty days prior to executing a contract with a carrier, a hospital or ambulatory surgical facility must provide the carrier with a list of the non-employed providers or provider groups contracted to provide surgical or ancillary services at the hospital or ambulatory surgical facility. The hospital or ambulatory surgical facility must notify the carrier within thirty days of a removal from or addition to the non-employed provider list. A hospital or ambulatory surgical facility also must provide an updated list of these providers within fourteen calendar days of a request for an updated list by a carrier.

RCW 48.49.080 Health care provider—Requirement to provide certain information on web site or upon consumer request—Requirement to submit network status information to carriers (effective January 1, 2020).

(1)(a) A health care provider must provide the following information on its web site, if one is available:

(i) The listing of the carrier health plan provider networks with which the provider contracts, based upon the information provided by the carrier pursuant to RCW 48.43.730(7), and

(ii) The notice of consumer rights developed under RCW 48.49.060.

(b) If the health care provider does not maintain a web site, this information must be provided to consumers upon an oral or written request.

(2) Posting or otherwise providing the information required in this section does not relieve a provider of its obligation to comply with the provisions of this chapter.

(3) An in-network provider must submit accurate information to a carrier regarding the provider's network status in a timely manner, consistent with the terms of the contract between the provider and the carrier.


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