Welcome to Ambetter Health & Ambetter from Superior HealthPlan

Your Partner In Better Healthcare

2026 Provider Orientation

AGENDA

OVERVIEW

- Who We Are
- Affordable Care Act
- The Health Insurance Marketplace
- Our Networks

WHAT YOU NEED TO KNOW

- Key Contact Information
- Provider Manual
- Provider Engagement
- Public Website and Secure Portal
- Verification of Eligibility, Benefits and Cost Shares
- Referrals
- Prior Authorization
- Claims, Billing and Payments
- Complaints, Grievances and Appeals
- Responsive and Person-Centered Care
- Specialty Companies and Vendors

QUESTIONS & ANSWERS

2026 Provider Orientation

OVERVIEW

WE ARE AMBETTER HEALTH

We provide market-leading, affordable health insurance on the marketplace.

#1 carrier

on the Health Insurance Marketplace*

5.7M+

members insured

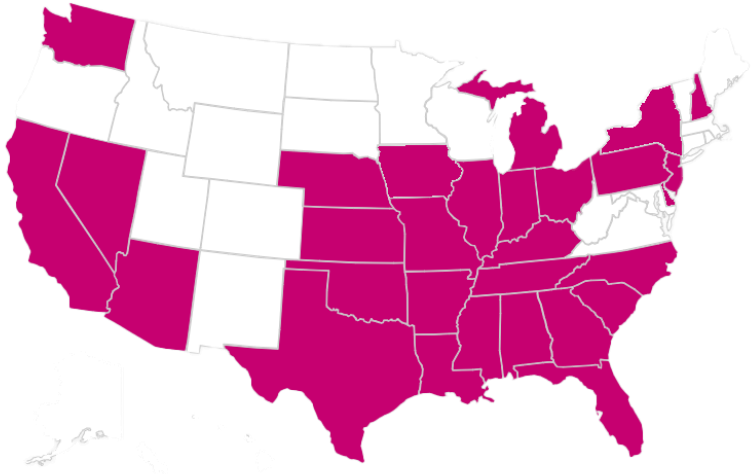
**Statistical claims and the #1 Marketplace Insurance statement are in reference to national on-exchange marketplace membership and based on national Ambetter data in conjunction with findings from 2023 Rate Review data from CMS, 2023 State-Level Public Use File from CMS, state insurance regulatory filings, and public financial filings.*

2014

Year Ambetter launched it's first Marketplace plans

29

states



LOCAL APPROACH TO CARE

Ambetter delivers high quality, locally-based healthcare services to its members, with our providers benefiting from enhanced collaboration and strategic care coordination programs.

We target a focused demographic

We lower income, underinsured and uninsured

PARTNERSHIP

- The **Ambetter Health plan designs** are built to support subsidy-eligible individuals and families purchasing coverage through the Health Insurance Marketplace.
- **Ambetter Health products** offer a range of cost-sharing options, including plans with low or no copays, tailored to meet the financial and healthcare needs of our members.
- The **emphasis on reducing barriers and improving access to care** mitigates the risk of individuals showing up without insurance (uncompensated care). Ambetter Health's cost-sharing lowers member costs and eases provider collections at care.
- Most importantly, Ambetter plans encourage members to establish relationships with their primary care providers to **achieve favorable health outcomes**.

We are proud to be your partner.

AFFORDABLE CARE ACT

AFFORDABLE CARE ACT (ACA): Key Objectives

- Expand access to affordable, quality health coverage for individuals & families
- Make healthcare more affordable through subsidies and cost-sharing reductions

ADDITIONAL PARAMETERS:

- Coverage for dependents up to age 26*
- No lifetime maximum benefits
- Preventative care covered at 100% when provided by in-network providers
- Insurer minimum loss ratio (80%* for individual coverage)

*May be greater based on state requirements

AFFORDABLE CARE ACT

REFORM OF THE COMMERCIAL INSURANCE MARKET

- No more underwriting – guaranteed issue
- There is no federal tax penalty for not having minimum essential coverage; however, some states may impose their own penalties.
- Minimum standards for coverage: essential health benefits and cost sharing limits
- The ACA created premium tax credits (also known as subsidies) and cost-sharing reductions (CSR) to help reduce costs for eligible consumers who buy a plan through the Marketplace
- Subsidies may be available to eligible individuals/families who have a household income between 100 and 400 percent of the Federal Poverty Level (FPL), based on the taxpayer's family size
    - The subsidy cap has been extended through Plan Year 2026 under current federal policy.
- CSRs are available to eligible individuals/families with household incomes between 100% and 250% of the FPL, based on family size.

**States may enact tax penalties for not purchasing insurance*

HEALTH INSURANCE MARKETPLACE

The Health Insurance Marketplace is a service available in every state that helps people shop for and enroll in affordable health insurance. The federal government operates the Marketplace (HealthCare.gov) for most states, but some states run their own Marketplaces, also called Exchanges.

The Health Insurance Marketplace provides health plan shopping and enrollment services through websites, call centers, and in-person help.

Potential members can:

- Register for the Exchange
- Determine eligibility for all health insurance programs (including Medicaid)
- Shop for plans
- Enroll in a plan
- Exchanges may be state-based, federally facilitated, or a federal-state hybrid — **Texas *is a federally-facilitated Marketplace***

The Health Insurance Marketplace allows individuals to receive subsidies. Qualified Health Plans (QHPs) can be purchased through Healthcare.gov, or a direct enrollment platform.

HEALTH INSURANCE MARKETPLACE

FINANCIAL COMES IN THE FORM OF:

- Advanced Premium Tax Credits (APTC)
- Cost-Sharing Reductions (CSR)

All benefit plans include cost shares in the form of copays, coinsurance, and deductibles, which vary by plan type and subsidy eligibility.

- Members may qualify for CSRs based on household income and family size.

Eligible individuals can receive financial assistance in the form of APTCs and CSRs when purchasing Qualified Health Plans (QHPs) through Healthcare.gov or approved direct enrollment platforms.

2026 Provider Orientation

OUR NETWORKS

OUR NETWORKS

- Ambetter Health offers a diverse suite of network options tailored to meet the coverage and budget needs of Marketplace members.
- By offering increased product options, Ambetter also benefits providers by giving them exclusive access to new patient populations.
- Each Ambetter Health network is designed to meet the specific coverage needs of members in their respective states. Plan structures, covered benefits, and referral requirements may vary by state and network type.
- Providers must confirm the member's network and plan before delivering services to ensure coverage and compliance with referral or authorization requirements. This information is located on the member's ID card and can also be confirmed when verifying the member's eligibility.

Networks Build To Offer More

OUR NETWORKS

- **PREMIER*:** The Ambetter from Superior HealthPlan core network – our broadest network of healthcare providers and hospitals offering affordable care to individuals or families that need to purchase healthcare coverage on their own. Referrals are not required.
- **VALUE*:** This exclusive Ambetter from Superior HealthPlan network of healthcare providers has referral requirements for certain types of care, along with prior authorization requirements for non-Value providers.
- **SOLUTIONS*:** Ambetter Health's dedicated 'off-exchange only' product designed to meet the needs of individuals purchasing individual health insurance through a defined contribution / Health Reimbursement Arrangement (HRA), such as **Individual Coverage Health Reimbursement Arrangement (ICHRA) or ** Qualified Small Employer Health Reimbursement Arrangement (QSEHRA).

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 you confirm which network and plan a member is in before extending care. This information is located on the member's ID card and can also be confirmed when verifying the member's eligibility.

**Network availability varies by state.*

***ICHRA and QSHERA are forms of HRAs that allow organizations to reimburse their employees, tax free, for their individual health insurance premiums.*

Our Innovative Networks

AMBETTER FROM SUPERIOR HEALTHPLAN - PREMIER

- The Ambetter core network consists of both Premier Silver and Premier Gold plans.
- Premier offers our broadest network of healthcare providers and hospitals offering affordable care to individuals or families that need to purchase healthcare coverage on their own.
- Referrals are not required.
- Premier silver plans provide the best value and most balance between monthly premiums and out-of-pocket costs.
- Premier Gold offers peace of mind for all healthcare needs. Members can expect higher monthly premiums to limit out-of-pocket expenses later.

AMBETTER FROM SUPERIOR HEALTHPLAN - VALUE

- **VALUE:** This exclusive network of healthcare providers has referral requirements for certain types of care, along with prior authorization requirements for non-Value providers.
- Value has a more restrictive, yet inclusive and adequate network being offered within a limited set of counties:
  - Collin, Dallas, Denton, Fort Bend, Harris, Montgomery, Rockwall, Tarrant, Travis, Williamson.
- The Ambetter Health Value plan design differs in the following:
  - Members will be assigned a PCP at the practitioner level.
  - Any specialty care rendered by a specialist outside of the PCP's group will require a referral prior to services being rendered to our members.
- Referrals are NOT required or applicable to the following specialties or service types:
  - OB/GYN, Behavioral Health/Substance Use Disorder, Urgent Care, Emergent Care, Labs, Radiology, Ambulance and Anesthesia.
  - The above provider or facility types will still be required to be in-network and prior authorization requirements will continue to apply, as applicable.

NEW: AMBETTER HEALTH SOLUTIONS

- **AMBETTER HEALTH SOLUTIONS** is designed to support individuals enrolled through an Individual Coverage Health Reimbursement Arrangement (ICHRA).
- Available in 4 counties: Collin, Dallas, Ellis and Hood
- This plan allows employers to contribute tax-free funds toward employees' individual health insurance premiums.
- Employees can then 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 provider network and member benefits.
- No referrals are required to a see a specialist.
- If you are currently a contracted Ambetter provider, there is no action required for you to begin serving Ambetter Health Solutions members.
- For any questions on this new plan, please contact Ambetter Provider Services at 1-833-543-3145 or contact your Provider Representative. To access their contact information visit, Find My Provider Representative.

OUR NETWORKS

Ambetter offers diabetes-specific plan designs in select markets for Plan Year 2026, including FL, TN, NJ, NC, GA, and TX.

- The Ambetter from Superior HealthPlan Enhanced Diabetes Care Silver plan includes essential health benefits, along with added services that may help members manage ongoing health needs.
- While this plan offers enhanced benefits that may be especially helpful for managing conditions like diabetes, these features are available to all members enrolled in the plan.
- With this plan, members pay as little as $0 for:
  - Preferred insulin
  - Covered medications used to treat diabetes, high blood pressure, high cholesterol, and mental health
  - Select diabetic supplies, including lancets, glucometers, insulin syringes, pen needles, ketone and urine test strips
  - Labs such as routine A1c tests
  - Annual retinal e ye exam
  - Routine foot care
  - Care Management to support your health goals
- Medications and supplies marked with a "D" or a "D+" symbol are available at a $0* Copay. Formulary Drug List can be found in the Ambetter Pharmacy Resources webpage.

**Network availability varies by state.*

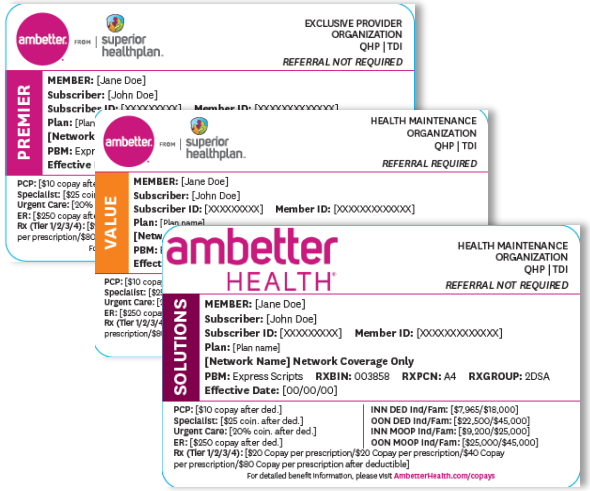
Our Innovative Networks

HOW TO IDENTIFY A MEMBER'S NETWORK

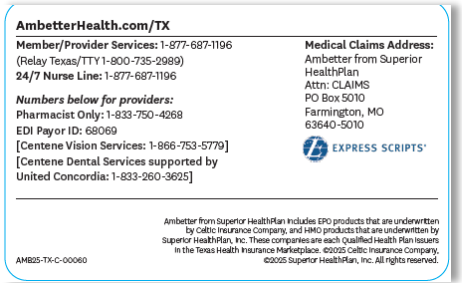
All members receive an Ambetter member identification card. Ambetter member ID cards include key information such as:

- The specific **Ambetter plan** selected by the member.
- The **Provider Network** associated with the member's plan.
- **Referral requirements** , if applicable, based on the member's network type.

Note: *Member ID cards do not guarantee eligibility. Providers must verify eligibility on the date of service using the Secure Provider Portal or Provider Services.*



Back of Member ID Card



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WHAT YOU NEED TO KNOW

KEY CONTACT INFORMATION

Ambetter from Superior HealthPlan and Ambetter Health Solutions

PHONE
1-877-687-1196 (Premier and Value)
1-833-543-3145 (Solutions)

TTY/TDD
1-800-735-2989

WEB
AmbetterHealth.com/en/tx

PORTAL
Provider.SuperiorHealthPlan.com

AMBETTER PROVIDER MANUAL

THE PROVIDER MANUAL IS YOUR COMPREHENSIVE GUIDE TO DOING BUSINESS WITH AMBETTER.

The manual includes a wide-range of important information relevant to providers doing business with Ambetter. Key information includes:

- Network information
- Billing guidelines
- Claims information
- Regulatory information
- Key contact list
- Quality initiatives

The Provider Manual can be found under the *Reference Materials* section on Ambetter's Provider Resources webpage.

PROVIDER SERVICES

The **Ambetter** Provider Engagement team includes trained staff available to respond quickly and efficiently to all provider inquiries, or requests, including:

- Credentialing/Network status
- Claims
- Request for adding/deleting physicians to an existing group

By calling Ambetter Provider Services, providers are able to access real time assistance for all their service needs.

- 1-877-687-1196 (Premier and Value)
- 1-833-543-3145 (Solutions)

PROVIDER ENGAGEMENT

- As an **Ambetter** provider, you will have a dedicated Network Performance Advisor available to assist you
- Our Provider Engagement teams serve as the primary liaisons between Ambetter and the provider network
- Your Provider Representative is here to help you operate your practice and address needs, such as:

✓Inquiries related to administrative policies, procedures, and operational issues

✓Performance pattern monitoring

✓Contract clarification

✓Membership/provider roster questions

✓Secure Portal registration, PaySpan/Zelis enrollment, and-Availity Essentials onboarding support

✓Provider education

✓HEDIS/care gap reviews

✓Electronic Health Record Utilization

✓Demographic information updates

✓Initiate credentialing of a new practitioner

PROVIDER NETWORK OPERATIONS

- Providers should submit updates to demographic data to their Provider Representative within 30 Calendar Days of the change.
- Forms to add new practitioners can be found on our website and should be submitted along with all credentialing documentation to **SHP.NetworkDevelopment@SuperiorHealthPlan.com**.
- Enrollments are effective 30 Calendar Days from the date all clean documents are received by Ambetter.

Please send the following items to SHP.NetworkDevelopment@SuperiorHealthPlan.com:

- **Contract Clarification**
- **Demographic information updates**
- **Initiate credentialing of a new practitioner**
- **Inquiries related to the status of a new practitioner or Join Our Network request**

PROVIDER DIRECTORY UPDATES

Providers can improve member access to care by ensuring that their data is current in our provider directory.

To update your provider data:

- Login to Superior's Secure Provider Portal
- From the main tool bar, select “Account Details”
- Select the provider whose data you want to update
- Choose the appropriate service location
- Make appropriate edits and click “Save”

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PUBLIC WEBSITE AND SECURE PORTAL

AMBETTER PUBLIC WEBSITE

WHAT'S ON THE PUBLIC WEBSITE AmbetterHealth.com/en/tx?

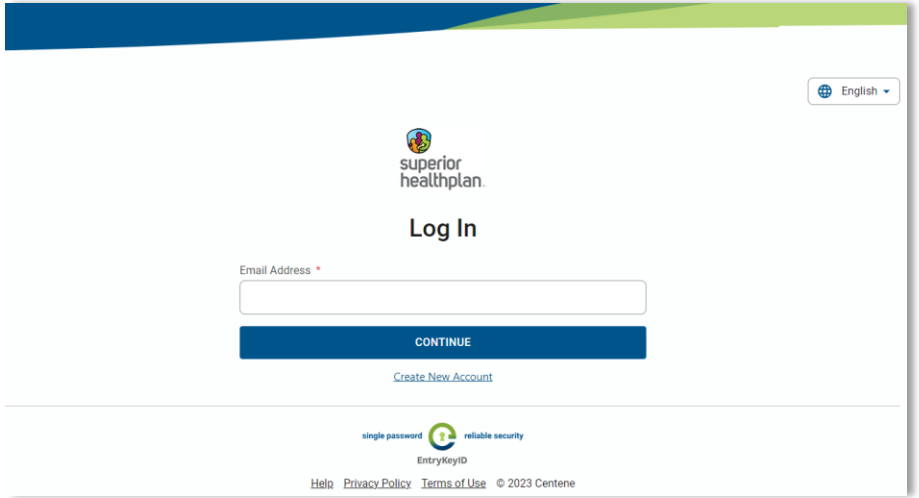
- Provider Manual
- Provider Quick Reference Guides
- Important Forms (Notification of Pregnancy, Prior Authorization Request Forms, ect.)
- Pre-Authorization Lookup Tool
- Preferred Drug List (PDL)

Ambetter Public Website

SECURE PROVIDER PORTAL

REGISTRATION IS FREE AND EASY!

Visit the Secure Provider Portal to register or contact your local Provider Representative. To access their contact information visit, Find My Provider Representative.



Secure Provider Portal

SECURE PROVIDER PORTAL

WHAT'S ON THE SECURE PROVIDER PORTAL?

- Member eligibility verification and patient panel listings
- Care gap reports and quality measure tracking
- Submit and track prior authorizations
- Submit claims and check claim status
- Submit corrected claims and request adjustments
- Payment history
- Monthly PCP performance and cost reports
- Provider performance and utilization analytics
- Referral submission for Value network plans

SECURE PROVIDER PORTAL

INSIGHTFUL REPORTS

- PCP reports available on the Secure Provider Portal are generated monthly and can be exported into a PDF or Excel format

PCP REPORTS INCLUDE:

- Patient List with HEDIS Care Gaps
- Emergency Room Utilization
- Rx Claims Report
- High-Cost Claims

AVAILITY ESSENTIALS

Ambetter has transitioned to Availity Essentials as its secure provider portal for eligibility, claims, authorizations, and payer resources.

- The legacy Ambetter Secure Provider Portal remains available for select functions during the phased transition.
- The provider organization's designated Availity administrator is the person responsible for registering their practice in Essentials, managing user accounts, and should have legal authority to sign agreements for their organization.
- Practice administrators can register for Availity Essentials at:
  - **Availity Essentials website**
  - Providers needing additional assistance with registration can call Availity Client Services at **1-800-AVAILITY (1-800-282-4548),** Monday through Friday, 8 a.m. – 8 p.m. ET.
- For general questions, providers can reach out to their health plan Provider Representative.

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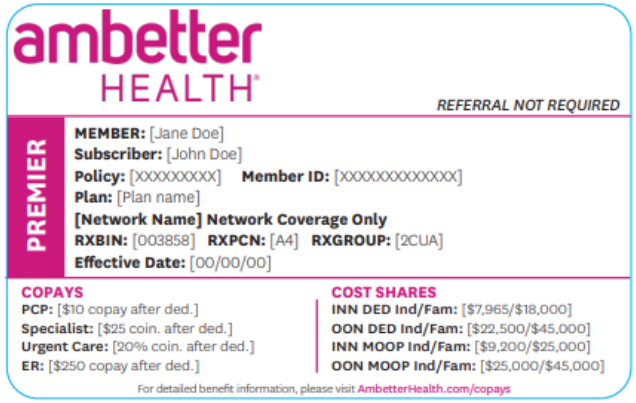
VERIFICATION OF ELIGIBILITY, BENEFITS AND COST SHARES

MEMBER ID CARD

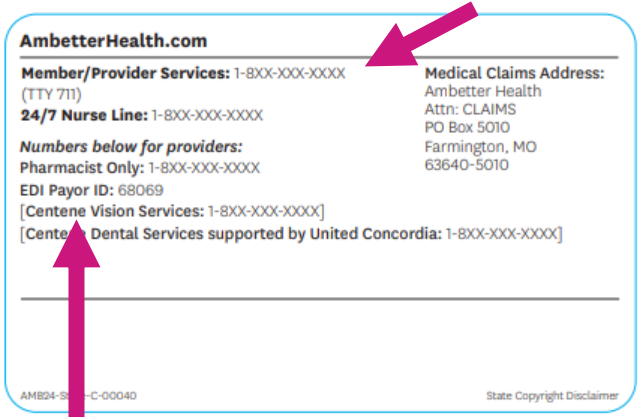


Plans can include:
- PREMIER
- VALUE
- SOLUTIONS

Certain plans may have a referral requirement. Please note:

1. Referral from PCP is required to see a specialist. Auth may be required.
2. Referral from PCP is **not** required to see a specialist. Auth may be required.

Provider Services Contact Information



Pharmacy Benefit Information

Navigating the Member ID Card

ELIGIBILITY, BENEFITS AND COST SHARE

PROVIDER MUST VERIFY MEMBER ELIGIBILITY

- Every time a member schedules an appointment
- When the member arrives for the appointment

PANEL STATUS

- PCPs should confirm that a member is assigned to their patient panel using the Secure Provider Portal.
  - The patient list includes member name, ID number, date of birth, care gaps, disease management enrollment, and product enrollment.
- PCPs may administer services even if the member is not currently assigned to their panel, and request reassignment for future care.

Verification of Eligibility, Benefits and Cost Share

ELIGIBILITY, BENEFITS AND COST SHARE

ELIGIBILITY, BENEFITS AND COST SHARES CAN BE VERIFIED IN THREE WAYS:

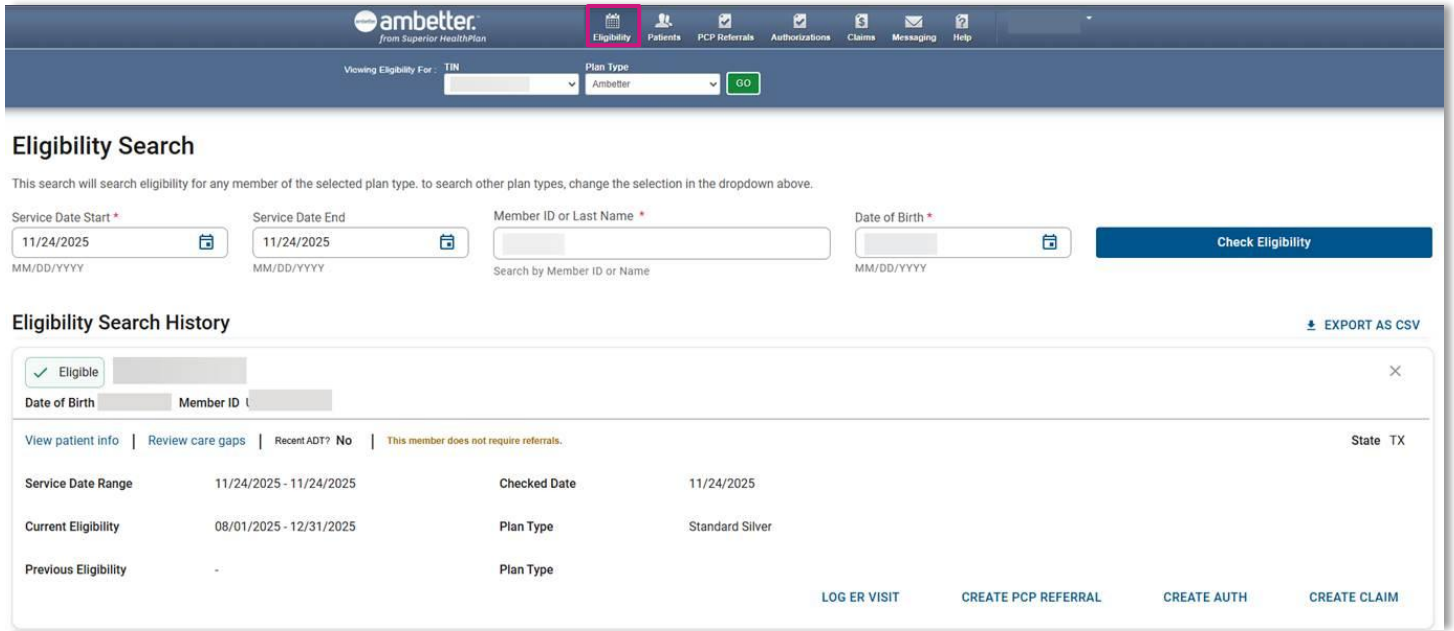
- ✓ **The Secure Provider Portal**
  - If you are already a registered user of the Ambetter's secure provider portal, you do NOT need a separate registration!

- ✓ **24/7 Interactive Voice Response System**
  - Enter the Member ID Number and the month of service to check eligibility

- ✓ **Contact Provider Services: 1-877-687-1196 (Premier and Value) or 1-833-543-3145 (Solutions)**

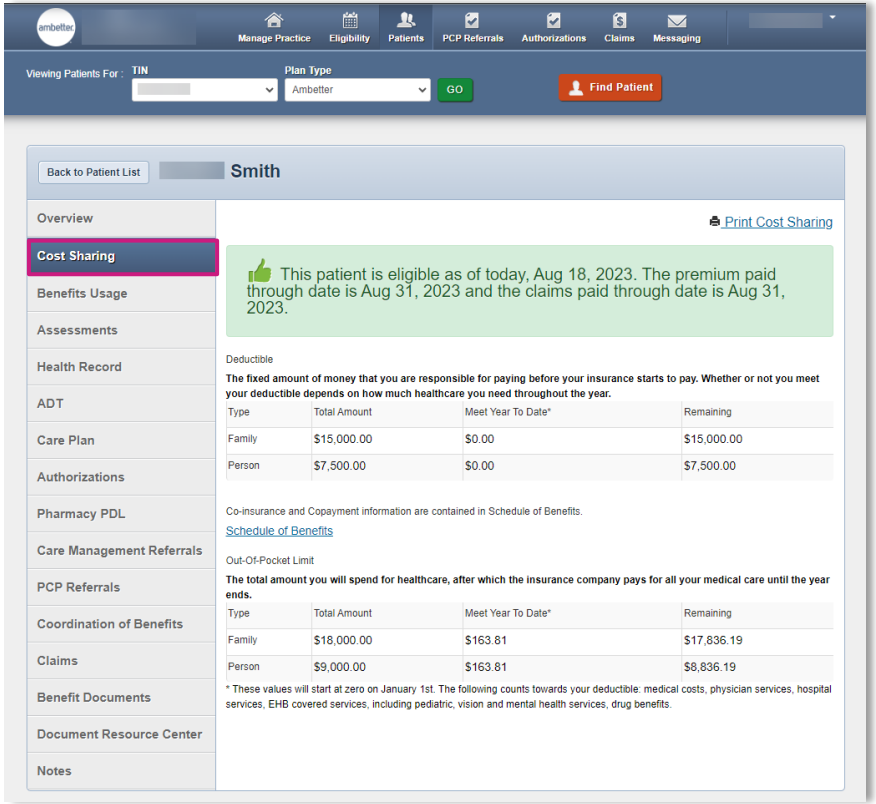
Verification of Eligibility, Benefits and Cost Share

VERIFICATION OF ELIGIBILITY ON THE PORTAL

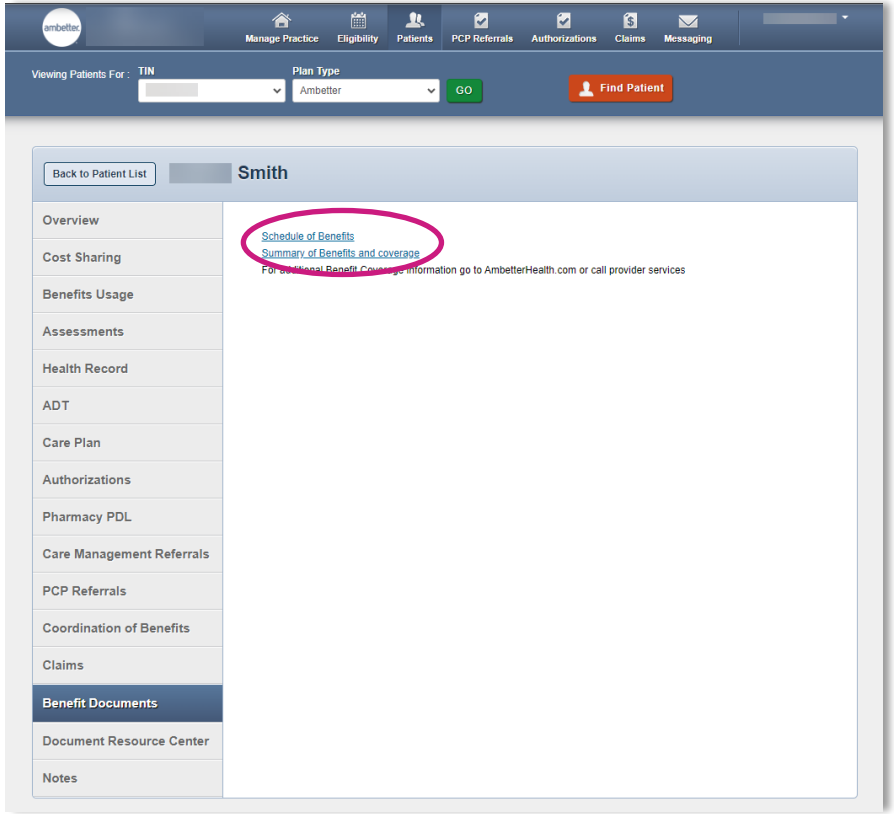


VERIFICATION OF COST SHARES ON THE PORTAL

- To verify how much remains of a member's deductible, visit the **Cost Sharing** tab in their profile.

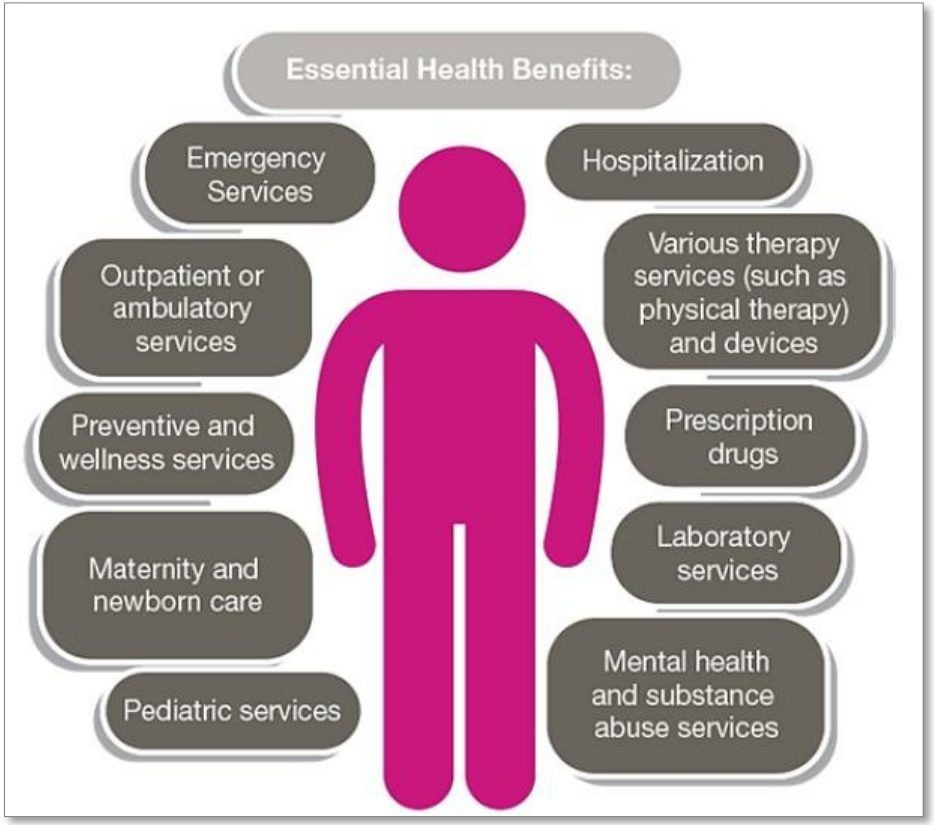


VERIFICATION OF BENEFITS ON THE PORTAL



ESSENTIAL HEALTH BENEFITS

- Essential Health Benefits are offered within each Ambetter Health plan.



OTHER BENEFITS

- My Health Pays Rewards
- Start Smart for Your Baby
- Abenity – Ambetter Perks
- Farmbox
- Virtual 24/7 Care
  - This is one-time, episodic care, available 24/7, and delivered virtually

2026 Provider Orientation

REFERRALS

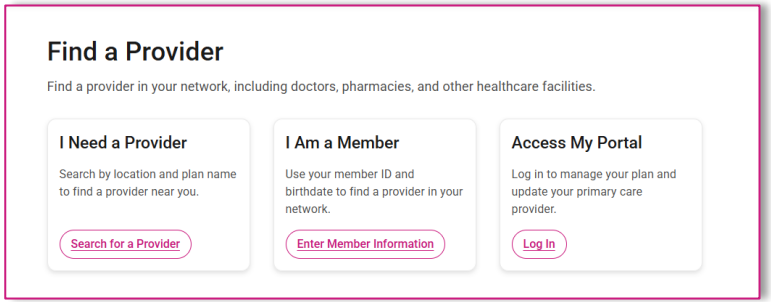
AMBETTER PCP REFERRAL REQUIREMENTS

- Some Ambetter plans have referral requirements. Value plans require referrals for specialist care outside of the assigned PCP or Medical Group.
- For services to be covered under these plans, they must be provided by or referred by a PCP.
- If a referral is not initiated, services performed outside of the member's assigned PCP or Medical Group may be denied. Prior authorization may also be required.
- Prior authorization requirements will also apply, as necessary.
- Referral requirements are reiterated throughout the Ambetter Guide and member plan materials to ensure members understand the rules associated with their plan.
- Referring providers must use the Secure Provider Portal to initiate referrals. Coordination with the Medical Management Department may be necessary.

AMBETTER REFERRAL REQUIREMENTS

Ambetter Plan	Referral Requirement?
PREMIER	No
VALUE	Yes – referrals required for specialist care outside of assigned PCP or Medical Group.
SOLUTIONS	No

MAKING AN AMBETTER VALUE REFERRAL FOR A SPECIALIST



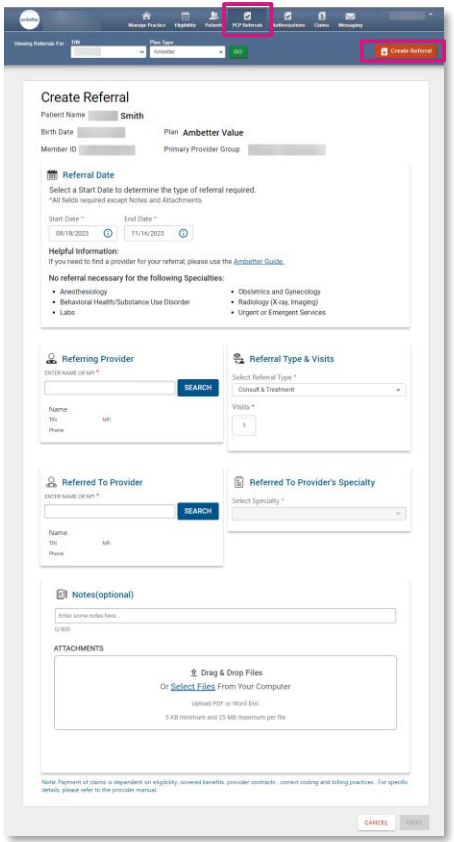
1. Go to the Ambetter Guide webpage
2. Click the option for **I Need a Provider**.
3. On the next screen, set the state field to the member's **City, County, or ZIP Code** and click **Continue**. If a year field is present (e.g., during Open Enrollment), select the plan year. Click the button to advance.
4. On the next screen, select the Ambetter **Value** option. Click the **Continue** button to advance.
    a. If you do not see an Ambetter Value option, go back to the prior screen and make sure you have the location (and year, if present) set correctly.
5. The next screen includes fields the option to search by the **provider name, specialty, facility, condition, or NPI**.
    b. There is also an option to Search By Category and Popular Searches.
6. Submit the search.
7. On the results page, use the filters to narrow the results to the specific specialty you need.
8. Click through on any result to see full details about the provider, including their NPI.

MAKING A REFERRAL:
SECURE PROVIDER PORTAL

Once you identify the specialist's name and NPI, submit the information on this screen.

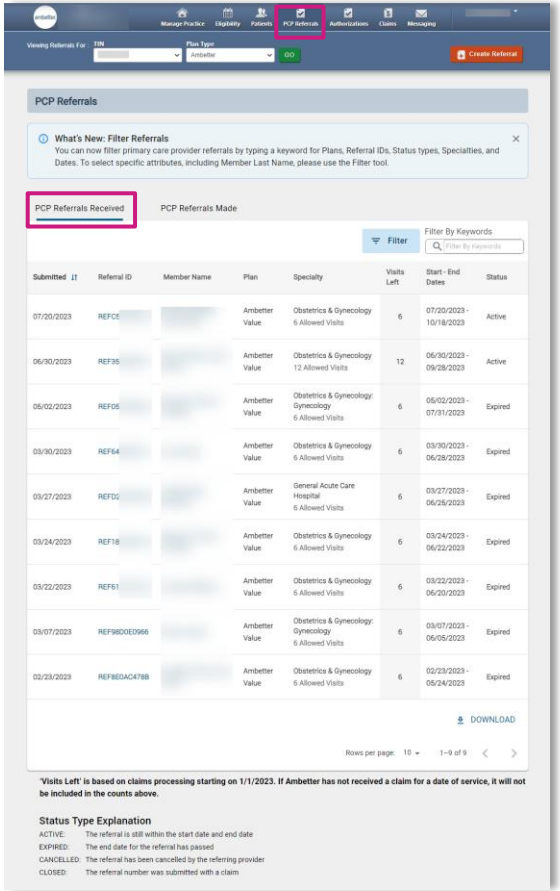
1. Click on **PCP Referrals** tab at the top of the screen.
2. Click the **Create Referral** button.
3. Complete the fields on the PCP Referral form.

Tip: Please utilize the *Helpful Information* section for assistance / guidance.



RECEIVING A REFERRAL

1. Once you receive a referral for care from the member's PCP, the member will schedule an appointment with you.
2. Log in to the Secure Provider Portal.
3. Navigate to **Referrals** tab at the top.
4. Click on **Referrals Received** to see the referral tracking table.
5. When you are ready to submit a claim for the referred service, reference this table for the referral ID/REF#.
6. Submit claims form with the REF#.
7. Claim form **MUST** include a REF# if a referral is required for the service. **If no REF# is submitted, the claim will be denied.**



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PRIOR AUTHORIZATION

HOW TO SECURE A PRIOR AUTHORIZATION

NEED PRIOR AUTHORIZATION?
Submit requests using one of the following methods:

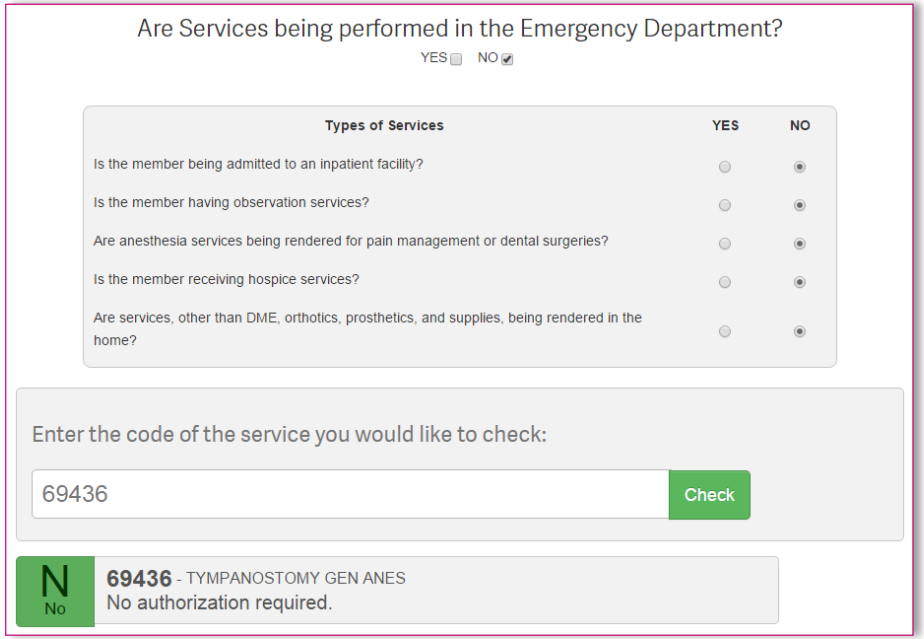
- ✓ The Secure Provider Portal (This is the preferred and fastest method.)

- ✓ Phone
  - Contact the Utilization Management Department using the number listed on the member's ID card.
- ✓ Fax
  - Outpatient: 1-855-537-3447 (Medical) or 1-844-307-4442 (Behavioral)
  - Inpatient: 1-866-838-7615 (Medical) or 1-844-824-9016 (Behavioral)
    - The fax authorization forms are located on Ambetter's Provider Resources webpage. Fax submissions are reviewed during business hours only.

After normal business hours and on holidays, calls are directed to the plan's 24-hour nurse advice line. Notification of authorization will be returned via phone, fax, or web.

IS PRIOR AUTHORIZATION NEEDED?

- Use the **Pre-Auth Needed Tool** to quickly determine if a service or procedure requires prior authorization.
- Available on the provider section of the Ambetter website at: **AmbetterHealth.com/en/tx**



REQUIREMENTS

Services that require prior authorization include: *:

- All inpatient admissions
- Selected outpatient services
- Experimental or investigational treatments
- High-tech imaging (e.g. CT, MRI, PET)
- Infertility services
- Pain Management procedures
- Organ transplant evaluations
- Clinical trial services
- Out-of-network services (excluding emergency care)

**This list is not all-inclusive. Use the Pre-Auth Needed Tool to check if a specific service or procedure requires prior authorization.*

Prior Authorization Requirements

REQUIREMENTS

INPATIENT AUTHORIZATION IS NEEDED FOR THE FOLLOWING*:

- All elective/scheduled admission notifications requested at least 5 Business Days prior to the scheduled date of admit including:
  - All services performed in out-of-network facilities
  - Behavioral Health Services:
    - Partial Hospitalization Program (PHP) and/or Intensive Outpatient Program (IOP)
    - Residential Treatment (Mental Health/Substance Use)
  - Hospice care
  - Rehabilitation facilities
  - Transplants, including evaluation
  - Observation stays more than **48 hours** require Inpatient Authorization
  - Urgent/Emergent Admissions
    - Within **1 Business Day** following the date of admission
    - Newborn deliveries must include birth outcomes

**This list is not all-inclusive. Use the Pre-Auth Needed Tool to check if a specific service or procedure requires prior authorization.*

Prior Authorization Requirements

REQUIREMENTS

ANCILLARY SERVICES THAT NEED PRIOR AUTHORIZATION INCLUDE*:

- Air ambulance transport (fixed-wing)
- Durable medical equipment (DME)
- Home health care services, including:
  - Home infusion
  - Skilled nursing care
  - Physical, occupational, and speech therapy
  - Private duty nursing
  - Adult medical day care
  - Hospice care
  - Medical supplies and equipment furnished in the home

**This list is not all-inclusive. Use the Pre-Auth Needed Tool to check if a specific service or procedure requires prior authorization.*

Prior Authorization Requirements

TIMEFRAMES

Service Type	Timeframe
Scheduled admissions	Prior Authorization required 5 Business Days prior to the scheduled admission date
Elective outpatient services	Prior Authorization required 5 Business Days prior to the elective outpatient admission date
Emergent inpatient admissions	Notification within 1 Business Day
Observation – 48 hours or less	Notification within 1 Business Day for non-participating providers
Observation – greater than 48 hours	Requires inpatient prior authorization within 1 Business Day
Emergency room and post stabilization, urgent care and crisis intervention	No prior authorization required
Maternity admissions	Notification within 1 Business Day
Newborn admissions	Notification within 1 Business Day
Neonatal Intensive Care Unit (NICU) admissions	Notification within 1 Business Day
Outpatient Dialysis	Notification within 3 Calendar Day

Prior Authorization Timeframes

TIMEFRAMES

Type	Timeframe
Prospective/Urgent	3 Calendar Days
Prospective/Non-Urgent	3 Calendar Days; 3 Calendar Days for adverse determination
Concurrent/Urgent	24 Hours
Retrospective	30 Calendar Days

Utilization Determination Timeframes

CORRECT CODING

PRIOR AUTHORIZATION WILL BE GRANTED AT THE CPT CODE LEVEL

- If a claim is submitted that contains CPT codes that were not authorized, the services will be denied.
- If additional procedures are performed during the procedure, the provider **must** contact the health plan to update the authorization in order to avoid a claim denial.
- It is recommended that this be done within 72 hours of the procedure. However, it **must** be done prior to claim submission or the claim will deny.
- Ambetter does **not** retro-authorize services.
  - Claims submitted without updated authorization will be denied.
  - Providers may appeal if extenuating circumstances prevented timely authorization.

Correct Coding For Prior Authorization

PREAUTHORIZATION EXEMPTIONS

- Providers will be exempt for six months from obtaining prior authorizations for specific services in which, during the review period, if they received 90% medical necessity approval, with a minimum of 5 requests per service/procedure code/prescription.
    - Concurrent Inpatient review services are excluded from preauthorization exemption.
    - Prescription, outpatient and elective inpatient procedures are subject to review for prior authorization exemption.
- January and June of each year we are able to review between 5 and 20 medical records for claims received and may rescind prior authorization exclusion if:
    - 90% of medical necessity criteria are not met for the sample size.
    - Providers may request an independent review from an IRO if they disagree with Ambetter Health's decision.
- Out-of-network providers will still require prior authorization unless the provider is exempt for the service/procedure code/prescription.

2026 Provider Orientation

CLAIMS, BILLING AND PAYMENTS

CLAIMS

WHAT IS A CLEAN CLAIM?

- A clean claim is one submitted in a nationally accepted format using current CPT, ICD-10, and HCPCS codes, without defects or missing documentation, and that meets all billing requirements for timely payment

ARE THERE ANY EXCEPTIONS?

- A claim for which fraud is suspected
- A claim for which a third-party resource should be responsible

HOW TO SUBMIT A CLAIM

The timely filing deadline for initial claims is 95 calendar days from the date of service, or date of primary payment, when Ambetter is secondary.

CLAIMS MAY BE SUBMITTED IN THREE WAYS:

1. The Secure Provider Portal

2. **Electronic Clearinghouse**
    1. Payor ID 68069
    2. Clearinghouses currently utilized by Ambetter will continue to be utilized
    3. For a listing of our clearinghouses, visit the *Claims and Claims Payments* section of the Ambetter Provider Resources webpage.

3. **Mail**
    Ambetter
    P.O. Box 5010
    Farmington, MO 64640-5010

CLAIM RECONSIDERATIONS AND DISPUTES

CLAIM RECONSIDERATIONS

- For reconsideration requests, providers can use the **Reconsider Claim** button on the Claim Details screen within the Secure Provider Portal.
- A written request from a provider about a disagreement in the manner in which a claim was processed. No specific form is required.
- Must be submitted within 120 Calendar Days of the Explanation of Payment.
- Mail claim reconsiderations to:
  Ambetter from Superior HealthPlan
  Attn: Level I – Request for Reconsideration
  PO Box 5010
  Farmington, MO 63640-5010

CLAIM DISPUTES

- Must be submitted within 120 Calendar Days of the Explanation of Payment
- A Claim Dispute form can be found on our website at Ambetter Provider Resources webpage.
- Mail completed Claim Dispute form to:

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

CLAIM SUBMISSION SUSPENDED STATUS

WHAT IF A MEMBER IS IN SUSPENDED STATUS?

- After the first month of non-payment, the member enters a suspended status. The Explanation of Payment will indicate LZ Pend: Non-Payment of Premium.
- Under the Affordable Care Act (ACA), members receiving Advanced Premium Tax Credits (APTCs) are granted a three-month grace period to pay outstanding premiums before coverage is terminated.
- During suspended status (months 2 and 3 of the grace period), claims may be pended or denied depending on payment status.
- When the premium is paid by the member, the claims will be released and adjudicated.
- If the member does not pay the premium by the end of the grace period, coverage is terminated retroactively, and providers may bill the member directly for services rendered during suspended status.

CLAIM SUBMISSION SUSPENDED STATUS

EXAMPLE TIMELINE OF A MEMBER IN SUSPENDED STATUS

- **January 1st**
  Member pays premium
- **February 1st**
  Premium due; member does not pay
- **March 1st**
  Member enters suspended status (Month 2 of grace period)
- **April 1st**
  Member remains in suspended status (Month 3 of grace period)
- **May 1st**
  If premium remains unpaid, coverage is terminated retroactively. Provider may bill member directly for services rendered during suspended status.

Claims for members in suspended status may be pended or denied depending on payment status and are not considered "clean claims."

HELPFUL INFORMATION ABOUT CLAIMS

MAKE SURE TO INCLUDE THE RENDERING TAXONOMY CODE!

- Claims **must** include the rendering provider's taxonomy code.
- Claims submitted without a valid taxonomy code will be rejected upfront and will not enter the adjudication system.
- For paper claims, include the taxonomy code in in Box 24J and 33b.
- For electronic claims, include it in loop 2310B/2420A and 2010AA.

REMINDER: DO NOT FORGET THE CLIA NUMBER!

- For CLIA-certified or CLIA-waived services, the CLIA number **must** be entered in **Box 23** of the CMS 1500 paper claim form.
- For electronic claims, report the CLIA number in loop 2300 or 2400 (REF02 with REF01 = X4).
- Claims missing CLIA numbers will be rejected upfront.

BILLING THE MEMBER

COPAYS, CO-INSURANCE AND DEDUCTIBLES

- Copays, coinsurance, and any unpaid portion of the deductible may be collected at the time of service. Providers must verify the member's benefit design and cost share responsibility prior to rendering services.
- Deductible information, including the amount paid toward the deductible, can be accessed via the Secure Provider Portal.
- If the amount collected from the member exceeds the actual liability after claim adjudication, the provider must reimburse the member within 45 Calendar Days.

ELECTRONIC FUNDS TRANSFER- CLAIMS PAYMENTS

PaySpan®/Zelis: A FASTER, EASIER WAY TO GET PAID

- Ambetter offers PaySpan® Health, recently acquired by Zelis, a free solution that enables providers to receive electronic payments (EFT) and electronic remittance advices (ERA) for faster, more efficient claims reimbursement.
- If you currently utilize PaySpan®, you will need to register specifically for Ambetter to receive payments.
- **Set up your PaySpan® account:**
  - Visit the **PaySpan Sign In webpage** and click **Register**.
  - You may need your National Provider Identifier (NPI) and Provider Tax ID Number (TIN) or Employer Identification Number (EIN) to complete registration.

ELECTRONIC FUNDS TRANSFER

2026 Provider Orientation

COMPLAINTS, GRIEVANCES AND APPEALS

COMPLAINTS, GRIEVANCES AND APPEALS

CLAIMS

- If the complaint/grievance is related to claim(s) payment, the provider must follow the process for claim reconsideration and claim dispute prior to filing a complaint/grievance.

COMPLAINT/GRIEVANCE

- A complaint is a verbal or written expression by a provider, which indicates dissatisfaction or dispute with Ambetter Health's policies, procedures, or any aspect of Ambetter Health's functions.
- A letter will be sent to the provider acknowledging receipt of the complaint within 5 Business Days.
- Upon receipt of complete information to evaluate the request, Ambetter will provide a written response within 30 Calendar Days.
    - The letter includes the decision/resolution of the complaint, the facts utilized to resolve it and the provider's right to pursue arbitration or file a complaint with TDI if they are not satisfied with the outcome.

COMPLAINTS, GRIEVANCES AND APPEALS

PROVIDER CLAIM APPEAL PROCESS

- Claim appeal requests must follow the **claim reconsideration and claim dispute process.**
  A claim dispute should be used only when a provider has received an unsatisfactory response to a request for reconsideration.

MEMBER APPEALS PROCESS

- Must be filed within 180 Calendar Days from the Notice of Adverse Determination.
- Ambetter shall acknowledge receipt within 5 Business Days of receiving the appeal.
- Ambetter shall resolve each appeal and provide written notice as expeditiously as the member's health condition requires but not to exceed 30 Calendar Days.
- Expedited appeals may be filed if the time expended in a standard appeal could seriously jeopardize the member's life or health. The timeframe for a decision for an expedited appeal will not exceed 1 Business Day from the date all information necessary to complete the appeal is received.

COMPLAINTS, GRIEVANCES AND APPEALS

MEMBER REPRESENTATIVES

- Members may designate a provider to act as their representative for filing appeals related to medical necessity.
- Ambetter requires that this designation by the member be made in writing and provided to Ambetter.
- No punitive action will be taken against a provider by Ambetter for acting as a member's representative.

NEED MORE INFORMATION?

- Full details of the claim reconsideration, claim dispute, complaints/grievances and appeals processes can be found in our Provider Manual as well as in our Texas-specific QRGs under the *Reference Materials* section of the **Ambetter's Provider Resources webpage**.

2026 Provider Orientation

Responsive and Person-Centered Care

Responsive and Person-Centered Care

- Superior promotes person-centered care that aligns with the National Standards on Culturally and Linguistically Appropriate Service (CLAS). These practices support effective communication, member engagement, and improved health outcomes.
- Why This Matters
  - Understanding and responding to the varied backgrounds, beliefs, and lived experiences of members can strengthen provider-patient relationships and support more effective, coordinated care.
- Core Principles
  - Knowledge
    - Maintain awareness of your own background, communication style, and potential biases that may influence clinical interactions.
    - Understand historical, social, and systemic factors that may impact individuals' access to care and their experiences with the health system.
  - Skills
    - Communicate effectively with members by using qualified interpreters for individuals with limited English proficiency.
    - Identify and utilize community resources to support members.
  - Professional Approach
    - Demonstrate response for the diverse factors that shape member health beliefs, preferences, and decision-making.
    - Acknowledge the role that spirituality, traditions, or personal values may have in a member's care experience.

Responsive and Person-Centered Care

- Provider Expectations
  - Apply person-centered communication strategies during all encounters.
  - Ensure interpreter services are offered and documented, when needed.
    - Superior offers interpretation services to providers at no cost.
  - Engage members in shared decision-making based on their preferences, needs, and values.
- Trainings and Resources
  - To access telephonic interpreters for your members, or to schedule an in-person interpreter, contact Superior's Member Services department.
    - Contact information can be found on Ambetter's Language Assistance webpage.
  - The U.S. Department of Health & Human Services (HHS) Think Cultural Health website offers articles, resources and free, continuing education e-learning programs, to help you provide culturally and linguistically appropriate services.
    - For more information, please visit HHS's Think Cultural Health webpage.
  - EthnoMed contains information about cultural beliefs, medical issues and other related issues pertinent to the health care of recent immigrants.
    - For more information, visit EthnoMed website.
  - Superior's Health Equity webpages offers information on responsive car and available assistance services.
    - For more information, visit Superior's Health Equity Program webpage.

2026 Provider Orientation

SPECIALTY SERVICES & VENDORS

SPECIALTY COMPANIES AND VENDORS

Service	Specialty Company/Vendor	Contact Information
High Tech Imaging Services Musculoskeletal Surgeries Therapy Services Interventional Pain Management Cardiovascular Procedures Genetic Testing Molecular Diagnostics	Evolent	Evolent website Phone: 1-800-424-4916
Vision Services	Envolve Vision	Envolve Vision website Phone: 1-866-753-5779
Dental Services	Envolve Dental	Envolve Dental website Phone: 1-833-260-3625
Pharmacy Services	Express Scripts	Phone: 1-866-399-0928 Fax: 1-866-399-0929

OUR SPECIALTY COMPANIES AND VENDORS

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Questions & Answers