ambetter. of Oklahoma

Provider and Billing Manual

2026

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AMBETTER HEALTH PROVIDER MANUAL REVISIONS

Effective Date	Section Header	Change
1/1/2026	Products & Network Descriptions	Updated products
1/1/2026	Availity Essentials	Updated language
1/1/2026	Member Rights	Updated language to no. 23
1/1/2026	Ambetter Health Benefits: Overview	Updated language
1/1/2026	Additional Benefit Information	Updated language
1/1/2026	Preferred Method to Verify Benefits, Eligibility and Cost Shares	Updated language
1/1/2026	Utilization Determination Timeframes	Updated table
1/1/2026	Procedure for Requesting Prior Authorizations for Medical and Behavioral Health Services	Updated language
1/1/2026	Emergency Medical, Behavioral Health, or Substance Use Disorder Condition	Updated language
1/1/2026	Utilization Review Criteria	Updated language
1/1/2026	Verification Procedures	Updated language
1/1/2026	Request for Reconsideration	Updated language
1/1/2026	Provider Claim Appeal Process	Updated language
1/1/2026	988 Suicide & Crisis Line	Updated language
1/1/2026	Electronic Medical Record (EMR) Access	Updated language
1/1/2026	National Network	Updated language
1/1/2026	Ambetter Health Solutions & ICHRA Overview	New Section
1/1/2026	Prior Authorization	Updated language
1/29/2026	Use of Artificial Intelligence (AI)-Based Algorithms in Health Care Service Reviews	New Section
2/4/2026	Hospital Requirements	Updated section
2/5/2026	New Jersey State Regulatory Requirements	Updated NJ-8 and added additional Regulatory Requirement (NJ-20 Orthotic or Prosthetic Appliance Coverage)
2/23/2026	Hospice SIA Payment	New Section
2/23/2026	Appendix VIII: Reimbursement Policies	Updated language
3/2/2026	Premium Grace Period for Members Receiving Advanced Premium Tax Credits (APTCs)	Updated language
3/2/2026	Preferred Method to Verify Benefits, Eligibility, and Cost Shares	Updated language

3/6/2026	State Mandated Regulatory Requirements	Updated section (also, removed or changed product reference in each state's regulatory language)
3/6/2026	Qualifying APM Participants	New Section
3/6/2026	Telemedicine	Updated language
3/6/2026	National Network	Updated language
3/9/2026	Cultural Competency	Updated section
3/26/2026	Nurse Practitioner (NP) and Clinical Nurse Specialist (CNS) Payment Rules	Deleted Section
3/26/2026	Non-physician Payment Reduction Rule	New Section
3/30/2026	Physician Assistant (PA) Payment Rules	Updated section
3/31/2026	Ancillary Provider Manuals	Deleted section
5/6/2026	Utilization Review Criteria	Moved section
5/7/2026	How To Use This Provider Manual	Updated section
5/26/2026	Key Contacts & Important Phone Numbers	Updated Dental Link
5/26/2026	Dental and Vision Provider Manuals	Updated Dental Link
6/25/2026	Type of Bill (TOB) Codes	Updated Grid (Type of Bill (TOB) Codes)
6/25/2026	** Billing Expectations for Type of Bill (TOB) 86X	New section

WELCOME TO AMBETTER HEALTH

Welcome to Ambetter of Oklahoma ("Ambetter"). Thank you for participating in our network of high-quality physicians, hospitals, and other healthcare professionals.

Ambetter's Health Insurance Marketplace plans target a consumer population of lower income, previously uninsured individuals, and families who, prior to having this health insurance, may have been Medicaid-eligible or unable to access care due to financial challenges.

Partnering with Ambetter provides an opportunity for you to access a previously untapped consumer population by providing coverage to those who qualify for generous premium and cost sharing subsidies. Ambetter has been very successful in attracting and retaining our target population and continues to focus on engaging and acquiring these subsidy-eligible consumers through its unique plan designs, incentive programs, and effective communication.

Ambetter is a Qualified Health Plan (QHP) as defined in the Affordable Care Act (ACA). Ambetter is offered to consumers through the Health Insurance Marketplace, also known as the Exchange. The Health Insurance Marketplace makes buying health insurance easier.

The Affordable Care Act is the law that has changed healthcare. The goals of the ACA are:

- To help more Americans get health insurance and stay healthy; and
- To offer consumers a choice of coverage leading to increased healthcare engagement and empowerment.

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/ok. 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 1-833-492-0679 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, 2026.

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 Centenevision.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 of Oklahoma	140000 Quail Springs Parkway, Suite 650 Oklahoma City, OK 73134 Phone: 1-833-492-0679 Fax: 1-833-959-3364 www.AmbetterHealth.com/en/ok

Department	Phone	Fax/Web Address
Provider Services	1-833-492-0679	N/A
Member Services		N/A
Medical Management Inpatient and Outpatient Prior Authorization		1-833-739-0814

HEALTH PLAN INFORMATION		
Concurrent Review/Clinical Information		1-833-739-0815
Admissions/Census Reports/		1-833-739-1745
Facesheets		1-833-739-1747
Medical Records		1-833-739-0817
Care Management		1-833-959-3364
Behavioral Health Prior Authorization - Inpatient		1-833-739-1874
Behavioral Health Prior Authorization - Outpatient		1-833-739-1875
24/7 Nurse Advice Line		N/A
Centene Pharmacy Solution		1-866-399-0929
Centene Vision		CenteneVision.com
Centene Dental		www.CenteneDental.com
Interpreter Services		N/A
Transplant Services	1-833-492-0679	1-833-739-1867
Advanced Imaging (MRI, CT, PET) (NIA)	1-866-214-2569	www.RadMD.com
Cardiac Imaging (NIA)	1-866-214-2569	www.RadMD.com
Therapy Services	1-866-214-2569	www.RadMD.com
To report suspected fraud, waste and abuse	1-866-685-8664	N/A
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 2026, Ambetter is expanding our plans to help our members find more coverage options that best fit their needs and their budget.

Our networks include:[1]

- **PREMIER:** The Ambetter core network. Our broadest network offering of health care providers and hospitals.
- **SOLUTIONS:** Ambetter's 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. [2]
- **SELECT:**
    - **Plus SELECT:** Ambetter's product that partners exclusively with the Piedmont provider network. This product is only offered within certain areas of Georgia
    - **Wellstar SELECT:** Ambetter's product that partners exclusively with the Wellstar provider network. This product is only offered within certain areas of Georgia
    - **St. Joseph Candler's SELECT:** Ambetter's product that partners exclusively with the St. Joseph Candler's provider network. This product is only offered within certain areas of Georgia
    - **Gwinnett Clinic SELECT:** Ambetter's product that partners exclusively with the Gwinnett Clinic 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.
- 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 you confirm the member's network and plan before providing care to ensure it aligns with your contract. This information is located on the member's ID card and can also be confirmed when verifying the member's eligibility.

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

	Premier	Premier	Solutions	Select	Value	Public Option
OK	●		●			
PA	●	●				
SC	●		●			
TN	●		●			
TX[3]	●		●		●	
WA	● ●					●

- Green = New for '26
- 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.

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.

Market Availability:

- **2025:** GA, IN, MO, MS, OH, SC
- **2026:** AZ, FL, KS, NE, OK, TN, TX
- **2027 and beyond:** Additional markets planned

ICHRA Contribution Design Example:

- **Class 1:** Corporate/Home Office – Group Plan
- **Class 2:** Full-Time Field – ICHRA ($1,000/month for premium + out-of-pocket expenses)

[3] TX – Will leverage TX AVA chassis for TXSMP

- **Class 3:** Part-Time Field – ICHRA ($500/month for premium only)

Enrollment & Billing Process:

1. **Employer Contribution Defined:** Based on employee classification
2. **Employee Enrollment:** Employees work with brokers to select coverage
3. **Billing:** Full premium paid to broker; any remaining balance is payroll-deducted

SECURE PROVIDER PORTAL

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/ok.

Functionality

All users of the Secure Provider Portal must complete a registration process. Once registered, providers may:

- Check eligibility and view member roster
- View the specific benefits for a member
- Check member benefit limitations and usage
- Check authorization requirements
- Verify members remaining yearly deductible and amounts applied to plan maximums
- View status of all claims that have been received, regardless of how submitted
- For primary care providers, view, and print patient lists. The patient list will indicate the member's name, id number, date of birth, care gaps, disease management enrollment, and product in which they are enrolled
- Submit authorizations and view the status of authorizations that have been submitted for members
- View, submit, copy, and correct claims
- Submit batch claims via an 837 file
- View and download explanations of payment (EOP)
- View a member's health record, including visits (physician, outpatient hospital, therapy, etc.), medications, and immunizations
- View gaps in care specific to a member, including preventive care or services needed for chronic conditions
- Send and receive secure messages with Ambetter staff
- Access both patient and provider analytic tools

Manage Account Access allows you to perform functions as an account manager such as adding portal accounts needed in your office.

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. If you are new to Availity Essentials, getting your Essentials account is the first step toward working with Ambetter Health on Availity. Your provider organization's designated Availity administrator is the person responsible for registering your organization in Essentials and managing user accounts. This person should have legal authority to sign agreements for your organization. If you are the administrator, you can register at www.availity.com/multi-payer-portal. If you need additional assistance with your registration, please call Availity Client Services at 1-800-AVAILITY (282-4548).Assistance is available Monday through Friday, 8 a.m. – 8 p.m. ET. For general questions, please reach out to your Ambetter Health Provider Relations Representative.

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 Ambetter, as well as applicable government regulations and standards of accrediting agencies.

If a practitioner/provider already participates with Ambetter 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 Ambetter 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 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 clinical laboratory improvement amendments (CLIA) certificate, if applicable

Ambetter will primary source verify 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 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 Credentialing Committee will usually render a decision on acceptance following its next regularly scheduled meeting in accordance with state and federal regulations.

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

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 https://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 https://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 Credentialing 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.

Recredentialing

Ambetter conducts practitioner/provider recredentialing at least every 36 months from the date of the initial credentialing decision or most recent recredentialing decision. The purpose of this process is to identify any changes in the practitioner's/provider's licensure, sanctions, certification, competence, or health status which may affect the practitioner's/provider's ability to perform services under the contract. This process includes all practitioners, facilities, and ancillary providers previously credentialed and currently participating in the network.

In between credentialing cycles, Ambetter 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 newly sanctioned or excluded from participation in Medicare or Medicaid. Ambetter also reviews member complaints/grievances against providers on an ongoing basis.

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

Practitioner Right to Review and Correct Information

All practitioners participating within the network have the right to review information obtained by Ambetter 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 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. Ambetter 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 your Provider Relations Representative. 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 Ambetter Credentialing 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 PR_Ambetter_OK@oklahomacompletehealth.com.

Practitioner Right to Appeal or Reconsideration of Adverse Credentialing Decisions

Applicants who are existing providers and who are declined 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 reconsideration of adverse credentialing decisions should be sent to the attention of the Credentialing Manager listed on the denial letter.

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 healthcare 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 the Provider Services Department at 1-833-492-

0679. 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.

The member may change their PCP at any time with the change becoming effective no later than the beginning of the month following the member's request for change. Members are advised to contact the Member Services Department at 1-833-492-0679 for further information.

PCP Coordination of Care to Specialists

When medically necessary 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.

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 member's 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: https://www.ambetterhealth.com/en/ok/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 & 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:

1. To participate with providers in making decisions about their healthcare. This includes working on any treatment plans and making care decisions. The member should know 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. The member must be informed of their care options.
2. 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.
3. To receive the benefits for which the member has coverage.
4. To be treated with respect and dignity.
5. To privacy of their personal health information, consistent with state and federal laws, and Ambetter policies.

6. To receive information or make recommendations, including changes, about Ambetter's organization and services, the Ambetter network of providers, and member rights and responsibilities.
7. 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.
8. To make recommendations regarding the Ambetter member's rights, responsibilities, and policies.
9. To voice complaints or appeals about: Ambetter, any benefit or coverage decisions Ambetter makes, Ambetter coverage, or the care provided.
10. 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.
11. To see their medical records.
12. 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:
13. Any changes in clinical review criteria,
14. A statement of the effect of such changes on the personal liability of the member for the cost of any such changes.
15. To have access to a current list of network providers. Additionally, a member may access information on network providers' education, training, and practice.
16. To select a health plan or switch health plans, within the guidelines, without any threats or harassment.
17. 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.
18. To access medically necessary urgent and emergency services 24 hours a day and seven days a week.

19. To receive information in a different format in compliance with the Americans with Disabilities Act if the member has a disability.
20. 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.
21. 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 home or work.
22. 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.
23. To have access to an interpreter when the member does not speak or understand the language of the area.
24. 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.
25. To execute an advance directive for healthcare decisions. An advance directive will assist the primary care provider and other providers to understand the member's wishes about the member's healthcare. The advance directive will not take away the member's right to make their own decisions. Examples of advance directives include:
    a. Living Will
    b. Healthcare 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

1. 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.
2. To treat all healthcare professionals and staff with courtesy and respect.
3. 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. The member needs to ask questions of their provider, so they understand the care they are receiving
4. To review and understand the information they receive about Ambetter. The member needs to know the proper use of covered services.

5. 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.
6. 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.
7. To understand their health problems and participate, along with their healthcare providers in developing mutually agreed upon treatment goals to the degree possible.
8. To supply, to the extent possible, information that Ambetter and/or their providers need to provide care.
9. To follow the treatment plans and instructions for care that they have agreed on with their healthcare providers.
10. 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.
11. To follow all health benefit plan guidelines, provisions, policies, and procedures.
12. To use any emergency room only when they think they have a medical emergency. For all other care, the member should seek care at an Urgent Care Center or call their primary care provider.
13. 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.
14. To pay their monthly premium, all deductible amounts, copayment amounts, or cost-sharing percentages at the time of service.

PROVIDER RIGHTS & RESPONSIBILITIES

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

Provider Rights

1. To be treated by their patients who are Ambetter members and other healthcare workers with dignity and respect.
2. To receive accurate and complete information and medical histories for members' care.
3. 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.
4. To expect other network providers to act as partners in members' treatment plans.

5. To expect members to follow their healthcare instructions and directions, such as taking the right amount of medication at the right times.
6. To make a complaint or file an appeal against Ambetter and/or a member.
7. To file a grievance on behalf of a member, with the member's consent.
8. To have access to information about Ambetter quality improvement programs, including program goals, processes, and outcomes that relate to member care and services.
9. To contact Provider Services with any questions, comments, or problems.
10. To collaborate with other healthcare professionals who are involved in the care of members.
11. 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.
12. To collect member copays, coinsurance, and deductibles at the time of the service.

Provider Responsibilities

Providers must comply with each of the items listed below.

1. 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:
    a. Recommend new or experimental treatments,
    b. Provide information regarding the nature of treatment options,
2. Provide information about the availability of alternative treatment options, therapies, consultations, or tests, including those that may be self-administered,
3. Be informed of risks and consequences associated with each treatment option or choosing to forego treatment as well as the benefits of such treatment options.
4. To treat members with fairness, dignity, and respect.
5. 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.
6. 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.
7. 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.

8. To provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA.
9. To allow members to request restriction on the use and disclosure of their personal health information.
10. To provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records.
11. 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.
12. 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.
13. 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.
14. To respect members' advance directives and include these documents in their medical record.
15. To allow members to appoint a parent/guardian, family member, or other representative if they can't fully participate in their treatment decisions.
16. To allow members to obtain a second opinion, and answer members' questions about how to access healthcare services appropriately.
17. To follow all state and federal laws and regulations related to patient care and rights.
18. To participate in Ambetter data collection initiatives, such as HEDIS® and other contractual or regulatory programs and allow use of provider performance data.
19. To review clinical practice guidelines distributed by Ambetter.
20. To comply with the Ambetter Medical Management program as outlined herein.
21. To disclose overpayments or improper payments to Ambetter.
22. To provide members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status.
23. To obtain and report to Ambetter information regarding other insurance coverage the member has or may have.
24. To give Ambetter timely, written notice if provider is leaving/closing a practice.
25. To contact Ambetter to verify member eligibility and benefits, if appropriate.

26. 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.
27. To provide members with information regarding office location, hours of operation, accessibility, and translation services.
28. To object to providing relevant or medically necessary services based on the provider's moral or religious beliefs or other similar grounds.
29. To provide hours of operation to Ambetter members which are no less than those offered to other commercial members.

APPOINTMENT AVAILABILITY & WAIT TIMES

Ambetter follows the accessibility and appointment wait time requirements set forth by applicable regulatory and accrediting agencies. Ambetter monitors participating provider compliance with these standards at least annually and will use the results of appointment standards monitoring to ensure adequate appointment availability and access to care and to reduce inappropriate emergency room utilization. The table below depicts the appointment availability for members:

HEALTH PLAN INFORMATION	
Ambetter of Oklahoma	Ambetter of Oklahoma 140000 Quail Springs Parkway, Suite 650 Oklahoma City, OK 73134 Phone: 1-833-492-0679 Fax: 1-833-959-3364 www.AmbetterHealth.com/en/ok

Department	Phone	Fax/Web Address
Provider Services	1-833-492-0679	N/A
Member Services		N/A
Medical Management Inpatient and Outpatient Prior Authorization		1-833-739-0814
Concurrent Review/Clinical Information		1-833-739-0815
Admissions/Census Reports/		1-833-739-1745
Facesheets		1-833-739-1747
Medical Records		1-833-739-0817
Care Management		1-833-959-3364
Behavioral Health Prior Authorization - Inpatient		1-833-739-1874
Behavioral Health Prior Authorization - Outpatient		1-833-739-1875
24/7 Nurse Advice Line		N/A
Pharmacy Solution		1-866-399-0929

HEALTH PLAN INFORMATION		
Centene Vision		CenteneVision.com
Centene Dental		CenteneDental.com
Interpreter Services		N/A
Transplant Services	1-833-492-0679	1-833-739-1867
Advanced Imaging (MRI, CT, PET) (NIA)	1-866-249-1581	www.RadMD.com
Cardiac Imaging (NIA)	1-866-249-1581	www.RadMD.com
Therapy Services	1-866-249-1581	www.RadMD.com
To report suspected fraud, waste and abuse	1-866-685-8664	N/A
EDI Claims assistance	1-800-225-2573 ext. 2	e-mail: EDIBA@centene.com

Wait Time Standards for All Provider Types

It is recommended that office wait times do not exceed 30 minutes 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, 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 that 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 with this requirement.

COVERING PROVIDERS

PCPs and specialist providers must arrange for coverage with another provider during scheduled or unscheduled time off. In the event of unscheduled time off, the provider must notify the Provider Services department of coverage arrangements as soon as possible. For scheduled time off, the provider must notify the Provider Services department prior to the scheduled time off. The provider who engaged the covering provider must ensure that the covering physician has agreed to be compensated in accordance with the Ambetter fee schedule in such provider's agreement.

Provider Phone Call Protocol

PCPs and specialist providers must:

- Answer the member's telephone inquiries on a timely basis
- Schedule appointments in accordance with appointment standards and guidelines set forth in this manual
- Schedule a series of appointments and follow-up appointments as appropriate for the member and in accordance with accepted practices for timely occurrence of follow-up appointments for all patients
- Identify and, when possible, reschedule cancelled and no-show appointments
- Identify special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, non-compliant individuals, or persons with cognitive impairments)
- Adhere to the following response times for telephone call-back wait times:
    - After hours for non-emergent, symptomatic issues: within 30 minutes
    - Same day for all other calls during normal office hours
- Schedule continuous availability and accessibility of professional, allied, and supportive personnel to provide covered services within normal office hours
- Have protocols in place to provide coverage in the event of a provider's absence
- Document after-hours calls in a written format in either in the member's medical record or an after-hours call log and then transfer to the member's medical record

NOTE: If after-hours urgent or emergent care is needed, the PCP, specialist provider, or their designee should contact the urgent care center or emergency department to notify the facility of the patient's impending arrival. Ambetter does not require prior authorization for emergent care.

Ambetter will monitor appointment and after-hours availability on an on-going basis through its Quality Improvement Program (QIP).

24-Hour Access to Providers

PCPs and specialist providers are required to maintain sufficient access to needed healthcare services on an ongoing basis and must ensure that such services are accessible to members as needed 24 hours a day, 365 days a year as follows:

- A provider's office phone must be answered during normal business hours; and
- A member must be able to access their provider after normal business hours and on weekends; this may be accomplished through the following:
    - A covering physician;
    - An answering service;
    - A triage service or voicemail message that provides a second phone number that is answered; or
    - If the provider's practice includes a high population of Spanish speaking members, it is recommended that the message be recorded in both English and Spanish.
- Examples of unacceptable after-hours coverage include, but are not limited to:
    - Calls received after-hours are answered by a recording telling callers to leave a message;
    - Calls received after-hours are answered by a recording directing patients to go to an emergency room for any services needed; or
    - Not returning calls or responding to messages left by patients' after-hours within 30 minutes.

The selected method of 24-hour coverage chosen by the provider must connect the caller to someone who can render a clinical decision or reach the PCP or specialist provider for a clinical decision. Whenever possible, PCP, specialist providers, or a covering professional must return the call within 30 minutes of the initial contact. After-hours coverage must be accessible using the medical office's daytime telephone number.

Ambetter will monitor provider's compliance with this provision through scheduled and unscheduled visits and audits conducted by Ambetter staff.

Provider Data Updates and Validation

Ambetter believes that providing easy access to care for our members is extremely important. When information (for instance address, office hours, specialties, phone number, hospital affiliations, etc.) about your practice, your locations, or your practitioners' changes, it is your responsibility to provide timely updates to Ambetter. Ambetter will ensure that our systems are updated quickly to provide the most current information to our members.

Additionally, Ambetter, and our contracted vendors, perform regular audits of our provider directories. This may be done through outreach to confirm your practice information. Access to care is critical to ensuring the health and well-being of our members, and to provide reliable access to care, it is important to respond to the outreach. Without a response, we are unable to accurately make your information available to patients and you may be at risk of being removed from the Ambetter of Oklahoma Provider Directory.

We need your support and participation in these efforts. CMS may also be auditing provider directories throughout the year, and you may be contacted by them as well. Please be sure to notify your office staff so that they may route these 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" are 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 (which can be chosen at the time of enrollment)
- 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 services described in the Schedule of Benefits (SOB), Summary of Benefits and Coverage (SBC) and Evidence of Coverage (EOC) documents for each Ambetter plan type. If there are questions as to a covered service or required prior authorization, please contact Ambetter Provider Services at 1-833-492-0679. Prior authorization criteria and a quick check tool are available on our website, as well.

Detailed information about benefits and services are found in the current year EOC available at www.AmbetterHealth.com/en/ok on the "Our Health Plans" page.

Each plan offered on the Health Insurance Marketplace is categorized within one of these "Metal Tiers." The tiers are based on the amount of member liability. For instance, at a gold level, a member

will pay higher premiums but will have lower out-of-pocket costs, like copays. Below is a basic depiction of how the cost levels are determined within each plan.

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 is subject to member reimbursement if determined no member liability is required.

PPO

To receive the highest level of benefits at the lowest cost share amounts, members enrolled with Ambetter PPO plans are incentivized to utilize in-network participating providers. If a member receives care from an out-of-network provider, they will receive benefit(s) and may be balanced billed for additional charges above what has been reimbursed by the health plan in accordance with state law. Members and providers can identify participating providers by visiting our website at www.AmbetterHealth.com/en/ok and clicking on Find-A-Provider.

HMO and EPO

Members who enroll in HMO and EPO 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/ok and clicking on Find-A-Provider. When an out-of-network provider is utilized, except in the case of emergency services, 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.
- Most copayments will be collected before services are rendered and are not subject to the deductible.
- Coinsurance is applied 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, mental health services, and pharmacy benefits.

- Claims information, including the members' 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.
- Copays 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
- Only claims for pharmacy benefits will count towards the non-integrated prescription deductible.
- Claims information including the member's 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 healthcare (excluding premium payments). Maximum out-of-pocket costs can be determined on the Member's Evidence of Coverage available through www.AmbetterHealth.com/en/ok 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.
- 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.

Verifying 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. Ambetter of Oklahoma offers a Pre-Auth Check tool to determine if a pre-authorization is needed before services are rendered. This tool can be located at the www.AmbetterHealth.com/en/ok 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/ok.

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 of Oklahoma 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 of Oklahoma 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 of Oklahoma 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 of Oklahoma Member Handbook.

If you have additional questions or want to learn more about changes to the 2026 Health Insurance Marketplace, checking eligibility or submitting claims via the secure portal, we are here to help. Contact your Ambetter of Oklahoma Provider Engagement Representative by calling 1-833-492-0679 or send us a message at www.ambetterhealth.com/en/ok/.

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, 2026
- Member Receives APTC: Yes
- Member Eligibility Status: Active
- Premium Paid Through Date: Jan. 31, 2026
- Claims Paid Through Date: Feb. 28, 2026
- 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, 2026
- Member Receives APTC: No
- Member Eligibility Status: *Active*
- Premium Paid Through Date: Jan. 31, 2026
- Claims Paid Through Date: Jan. 31, 2026
- 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, 2025

- Member Receives APTC: No
- Member Eligibility Status: *Active – Pending Investigation* or *Delinquent*
- Premium Paid Through Date: Jan. 31, 2026
- Claims Paid Through Date: Jan. 31, 2026
- 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, 2026
- Member Receives APTC: Yes
- Member Eligibility Status: *Active – Pending Investigation* or *Delinquent*
- Premium Paid Through Date: Jan. 31, 2026
- Claims Paid Through Date: Feb. 28, 2026
- 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, 2026
- Member Receives APTC: Yes
- Member Eligibility Status: *Active–Pending Investigation* or *Suspended*
- Premium Paid Through Date: Dec. 31, 2025
- Claims Paid Through Date: Jan. 31, 2026
- 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, 2026
- Member Receives APTC: No
- Member Eligibility Status: *Inactive*
- Premium Paid Through Date: Jan. 31, 2026
- Claims Paid Through Date: Feb. 28, 2026
- 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 1-833-492-0679 (TTY 711)	The automated system will prompt you to enter the member ID number and the month of service to check eligibility.
Provider Services at 1-833-492-0679	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 services, the member's coverage status and other information about obtaining services. Please refer to our website and the "Medical Management & Prior Authorization" section 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).

NOTE: 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/ok.

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
  - 1 (One) preventive every 10 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
  - 1 (One) preventive every 24 months with billed with a High-risk procedure code and a high-risk diagnosis code
  - Does not require modifier to be billed
- Diagnostic Colonoscopy Service
  - When billed with modifiers PT or 33 will be treated as preventive
  - When a modifier is not billed 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 that a physician or other healthcare provider 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 at www.AmbetterHealth.com/en/ok 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 that provides education and care management techniques. The program offers support for pregnant women and their babies through the first year of life by providing educational materials as well as incentives for going to prenatal, postpartum, and well child visits.

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. 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 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.

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. *We* 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 related services to the transplant *surgery*. Transplant services must meet medical criteria as set by Medical Management Policy.

Claims submission shall be followed related to transplant services is available to both the recipient and donor of a covered transplant 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 you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits under this contract will be provided for both you and the donor. In this case, payments made for the donor will be charged against enrollees' benefits.
- If you are the donor for the transplant and no coverage is available to you from any other source, the benefits under this contract will be provided for you. However, no benefits will be provided for the recipient.
- If lapse in coverage due to non-payment of premium, no services related to transplants will be paid as a covered benefit.

For additional questions or information on Prior Authorizations 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.

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, www.cms.gov/Medicare/Coding, indicated below:

- 05 Indian Health Service Free-Standing Facility. (A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization. (Effective January 1, 2003).
- 06 Indian Health Service Provider-Based Facility. (A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients. (Effective January 1, 2003).
- 07 Tribal 638 Free-Standing Facility. (A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization. (Effective January 1, 2003).
- 08 Tribal 638 Provider-Based Facility. (A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients. (Effective January 1, 2003).

Ambetter requires that all other Non- Indian Health Services (I.H.S) or Tribal providers billing on UB and CMS 1500 forms be billed in a place of services as recognized by CMS, www.cms.gov/Medicare/Coding.

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 member-centered, goal-oriented, culturally relevant, and logically managed processes to help ensure that a member receives needed services in a supportive, effective, 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 is not following the plan of care or requires additional services.

Upon member acceptance of Care Management, 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 the pregnancy, postpartum, and newborn periods integrating care to address both physical and behavioral health needs including perinatal and postnatal depression. Our care management team partners with you and the member to provide comprehensive care and coordinate resources that address general wellness and social barriers as well as condition specific needs such as alcohol use, asthma, and gestational diabetes. Every member has access to clinically informed health education materials promoting prenatal care, postpartum care, newborn care, and healthy lifestyle habits. In addition, our trimester-based assessment model, inclusive of the fourth trimester, provides ongoing review of mental, physical, and social health needs keeping you informed as their trusted partner in care and improving access to ongoing support, resources, and coordination of care for both parent and infant. Your partnership is essential. The time you spend filling out the Notification of Pregnancy (NOP) for your patient provides an irreplaceable opportunity to identify existing and potential risks as early in pregnancy as possible. The NOP is available in your provider portal and is a key catalyst for initiating enrollment for a pregnant patient in our Start Smart program.

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 plan of care 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 Care Management, call Ambetter of Oklahoma at 1-833-492-0679 or have them visit us online at www.AmbetterHealth.com/en/ok.

Health Management

Health management is the concept of reducing healthcare 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 healthcare 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/ok to complete their Wellbeing survey or they can call our Member Services at 1-833-492-0679.

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;
- Receiving their flu vaccine in the fall;
- Plus, much more!

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 copays***[4];
- Deductibles;
- Coinsurance;
- Monthly premium payments;

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

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 healthcare 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 coverage.

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:

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

- Is consistent with the symptoms or diagnosis;
- Is provided according to generally accepted medical practice standards;
- 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 quickly 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	Within 3 calendar days from receipt of the request.
Prospective/Non-Urgent	Within 7 calendar days from receipt of the request.
Concurrent/Urgent	Within 1 calendar day from receipt of the request. Extension: A onetime extension may be granted of up to 3 calendar days if additional information is needed. If all information is not received by the end of the 3rd calendar day, a determination will be made based on available information.
Retrospective	30 calendar days

Concurrent Review

The Ambetter Medical 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

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 and machine learning systems to improve operations, enhance member experience and strengthen clinical support. We ensure these tools are designed and used responsibly, prioritizing human well-being, fairness, accountability and transparency.

AI-based algorithms may be used to assist in approving certain health care service requests. These tools are not used to make denial decisions and are not the only factor considered in any review.

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

If you have questions about this disclosure, please contact Member Services at 1-833-890-0329 (TTY 711).

PRIOR AUTHORIZATION

Services Requiring Prior Authorization

To verify if a service requires prior authorization, please visit the Ambetter website at www.AmbetterHealth.com/en/ok 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.

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 inpatient admissions require prior authorization.

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

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

Timeframes for Prior Authorization Requests and Notifications

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

Service Type	Timeframe
Scheduled admissions	Prior Authorization required 5 days prior to the scheduled admission date
Elective outpatient services	Prior Authorization required 5 days prior to the elective outpatient service date
Emergent inpatient admissions	Notification within 24 hours
Observation – 48 hours or less	Notification within 24 hours for non-participating providers
Observation – greater than 48 hours	Requires inpatient prior authorization within 24 hours
Maternity admissions	Notification within 24 hours
Newborn admissions	Notification within 24 hours
Neonatal Intensive Care Unit (NICU) admissions	Notification within 24 hours
Outpatient Dialysis	Notification within 24 hours

Service Type	Timeframe
Organ Transplant - Initial Evaluation	Prior Authorization required at least 30 days prior to the initial evaluation for organ transplant services.
Clinical trials services	Prior Authorization required at least 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/ok. 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 1-833-492-0679. Our 24/7 Nurse Advice line can assist with urgent prior authorizations after normal business hours.

Fax

Fax prior authorization requests utilizing the Prior Authorization fax forms posted on the Ambetter website at www.AmbetterHealth.com/en/ok. Please note faxes will not be monitored after hours and will be responded to on the next business day. Please contact our 24/7 Nurse Advice Line at 1-833-492-0679 for after hour urgent admissions, inpatient notifications, or requests.

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;
- Provider location if the request is for an ambulatory or office procedure;

- The procedure code(s); Note: If the procedure codes submitted at the time of authorization differ from the services performed, it is **required** within 72 hours or prior to the time the claim is submitted that you phone Utilization Management at 1-833-492-0679 to update the authorization; otherwise, this may result in claim denials;
- Relevant clinical information (e.g., Past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed);
- Admission date or proposed surgery date if the request is for a surgical procedure;
- 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, RadMD.com, which should be used to obtain on-line authorizations. For urgent authorization requests please call 866-249-1581 and follow the prompt for radiology authorizations. For more information call our Provider Services department.

Advanced Diagnostic Imaging

As part of a continued commitment to further improve advanced imaging and radiology services, Ambetter of Oklahoma is using Evolent to provide prior authorization services and utilization management for advanced imaging and radiology services. Evolent focuses on radiation awareness designed to assist providers in managing imaging services in the safest and most effective way possible.

Prior authorization is required for the following outpatient radiology procedures:

- CT/CTA/CCTA,
- MRI/MRA
- PET Scan

Key Provisions:

- Emergency room, observation, and inpatient imaging procedures do not require authorization.
- It is the responsibility of the ordering physician to obtain authorization.
- Providers rendering the above services should verify that the necessary authorization has been obtained. Failure to do so may result in claim non-payment.

To reach Evolent and obtain authorization, please call 866-249-1581. Evolent also provides an interactive website which may be used to obtain on-line authorizations. Please visit www.RadMD.com for more information or call our Provider Services department.

Cardiac Solutions

Ambetter of Oklahoma in collaboration with Evolent, will launch a cardiac imaging program to promote healthcare quality for patients with possible cardiac disease.

Under this program, prior authorization will be required for certain cardiac studies to determine if the cardiac test or procedure is the most appropriate next step in a patient's diagnosis or treatment—and to recommend an alternate approach when indicated. By supporting the most efficient diagnosis and management of cardiac disease, Evolent addresses unnecessary procedures and promotes the least invasive, most medically appropriate approach.

Evolent has developed proprietary utilization management guidelines for these cardiac modalities. These consensus-based guidelines draw on current literature, American College of Cardiology (ACC) appropriateness criteria, recommendations from the American Heart Association, and input from our Cardiac Advisory Board and other experts. Our guidelines are transparent and available throughout our programs. Evolent also includes references to the Choosing Wisely campaign by the American Board of Internal Medicine (ABIM) Foundation, which provides specialty society considerations for the selection of appropriate tests.

How does this program improve patient health?

Managing cardiac studies will promote the use of optimal diagnostic methods in the assessment and treatment of cardiac diseases. Based on criteria adapted from the ACC and AMA, this program will minimize patients' radiation exposure by using the most efficient and least invasive testing options available.

Program Components

- Evidence-based clinical guidelines and proprietary algorithms to support clinically appropriate diagnostic options for each patient
- Consultations with cardiologists related to elective cardiac diagnostic imaging, when needed
- Quality assessment of imaging providers to ensure the highest technical and professional standards

How the Program Works

In addition to the other procedures that currently require prior authorization for members, prior authorization will be required for the following cardiac procedures:

- Myocardial Perfusion Imaging (MPI)

- MUGA Scan
- Echocardiography
- Stress Echocardiography

The following services do not require authorization through Evolent:

- Inpatient advanced radiology services
- Observation setting advanced radiology services
- Emergency Room radiology services

To reach Evolent and obtain authorization, please call 866-249-1581 and follow the prompt for radiology and cardiac authorizations. Evolent also provides an interactive website which may be used to obtain on-line authorizations. Please visit www.RadMD.com for more information.

Physical Medicine Program

To help ensure that physical medicine services (physical, occupational and speech therapy) provided to our members are consistent with nationally recognized clinical guidelines, Ambetter of Oklahoma partnered with Evolent to implement a prior authorization program for physical medicine services. Evolent provides utilization management services for outpatient physical, occupational and speech therapy services on behalf of Ambetter of Oklahoma members

How the Program Works

Outpatient physical, occupational and speech therapy requests are reviewed by Evolent's peer consultants to determine whether the services meet policy criteria for medically necessary and appropriate care. The medical necessity determinations are based on a review of objective, contemporaneous, and clearly documented clinical records that may be requested to help support the appropriateness of care. Clinical review helps determine whether such services are both medically necessary and eligible for coverage. Although prior authorization for the therapy evaluation alone is not required, additional services provided at the time of the evaluation and for any ongoing care is required through Evolent. There is no need to send patient records in advance. Evolent will contact the provider via phone and fax if additional clinical information is needed to complete the request. If the clinical documentation fails to establish that care is medically necessary, is not received, or is not received in an appropriate amount of time, it may result in non-certification of the authorization request.

Under terms of the agreement between Ambetter of Oklahoma and Evolent, Ambetter of Oklahoma oversees the Evolent Therapy Management program and continues to be responsible for claims adjudication. If Evolent therapy peer reviewers determine that the care provided fails to meet our criteria for covered therapy services, you and the patient will receive notice of the coverage decision.

For additional information on this new program, please attend an upcoming provider training webinar. Details of these webinars can be found on the Evolent website www.RadMD.com, the questions, www.AmbetterHealth.com/en/ok or by calling Evolent's Provider Services at 1-866-249-1581.

Habilitation and Rehabilitation Services

As part of a continued commitment to further improve habilitation and rehabilitation services, Ambetter is using Evolent to provide prior authorization services and utilization management for therapy services. Evolent focuses on assisting providers in managing habilitation and rehabilitation in the most effective way possible and consistent with nationally recognized clinical guidelines.

Prior authorization is required for the following home outpatient therapy procedures:

- Physical Therapy, Occupational Therapy, Speech Therapy

Key Provisions:

- It is the responsibility of the ***ordering*** physician to obtain authorization; and
- Providers rendering the above services should verify that the necessary authorization has been obtained; failure to do so may result in denial of all or a portion of the claim.

How the Program Works

Outpatient physical, occupational, and speech therapy requests are reviewed by Evolent's peer consultants to determine whether the services meet policy criteria for medically necessary and appropriate care. The medical necessity determinations are based on a review of objective, contemporaneous, and clearly documented clinical records that may be requested to help support the appropriateness of care. Clinical review helps determine whether such services are both medically necessary and eligible for coverage. Although prior authorization for the therapy evaluation alone is not required, additional services provided at the time of the evaluation and for any ongoing care is required through Evolent. There is no need to send patient records in advance. Evolent will contact the provider via phone and fax if additional clinical information is needed to complete the request. If clinical documentation fails to establish that care is medically necessary, is not received, or is not received in an appropriate amount of time, it may result in non-certification of the authorization request.

Ambetter oversees the Evolent Therapy Management program and continues to be responsible for claims adjudication. If Evolent therapy peer reviewers determine that the care provided fails to meet our criteria for covered therapy services, you and the member will receive notice of the coverage decision.

Should you have questions, please contact Ambetter Provider Services at 1-833-492-0679.

Interventional Pain Management

Evolent manages non-emergent outpatient prior authorizations for Interventional Pain Management (IPM) procedures. It is the responsibility of the ordering physician to obtain authorization for all IPM procedures outlined below. Outpatient IPM procedures requiring prior authorization include:

- Spinal Epidural Injections
- Paravertebral Facet Joint Injections or Blocks
- Paravertebral Facet Joint Denervation (Radiofrequency Neurolysis)
- Sacroiliac Joint Injections
- Spinal Cord Stimulators
- Sympathetic Nerve Blocks

Note: A separate prior authorization number is required for each procedure ordered. Prior authorization is not required through Evolent for services performed in the emergency department, on an inpatient basis or in conjunction with a surgery. To obtain authorization through Evolent, visit RadMD.com or call 1-866-249-1581.

Musculoskeletal Care Management (MSK)

In keeping with our commitment of promoting continuous quality improvement for services provided to Ambetter of Oklahoma members, Ambetter of Oklahoma has partnered with Evolent to implement a Musculoskeletal Care Management (MSK) program. This program includes prior authorization for non-emergent MSK procedures for Ambetter of Oklahoma 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 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 questions, please contact Evolent at 1- 866-249-1581.

Second Opinion

Members or a healthcare professional with the member's consent may request and receive a second opinion from a qualified professional within the Ambetter network. If there is not an appropriate provider to render the second opinion within the network, the member may obtain the second opinion from an out of network provider only upon receiving a prior authorization from the Ambetter Utilization Management Department.

Preventive Healthcare

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 healthcare 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 healthcare 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 services for purposes of 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 National Imaging Associates (NIA). Criteria developed by representatives in the disciplines of radiology,

	internal medicine, nursing, and cardiology. The criteria are available at www.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, review 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 1-833-492-0679. 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 1-833-492-0679 and asking for the Medical Director. An Ambetter Care Manager may also coordinate communication between the Medical Director and the requesting provider

Participants or healthcare professionals, with the Participant's consent, may request an appeal related to a medical necessity decision made during the authorization or concurrent review process orally or in writing to:

(For Physical Health related authorization appeals)
Ambetter of Oklahoma
Attn: Appeals and Grievances Department
PO Box 10341
Van Nuys, CA 91410-0341
Fax: 1-833-886-7956

(For Behavioral Health related authorization appeals)
Ambetter of Oklahoma
Attn: BH Appeals Department
PO Box 10378
Van Nuys, CA 91410-0378
Fax: 1-866-714-7991

The Participant consent form may be found at www.AmbetterHealth.com/en/ok. under "For Members" in the Forms and Materials section.

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.

PHARMACY

The pharmacy benefits for Ambetter members vary based on the plan benefits. Information regarding the member's pharmacy coverage can be best found via our Secure Provider Portal. Additional resources available on the website include the Ambetter Formulary, the Centene Pharmacy Services 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 and preferences, 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 Medical Directors and Pharmacists, 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/ok. Providers may also call Provider Services for hard copies of the formulary.

Centene Pharmacy Services is simplifying the prescriber process with a streamlined prior authorization process that can be accessed online through CoverMyMeds®. CoverMyMeds® automates drug prior 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 under the "CoverMyMeds®" link.

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. Reimbursement Policy can be viewed on our website and in the Appendix of this Manual.

Verification Procedures

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 to their highest number of digits available.
- 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
- Members are 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, authorization is received to provide services to the eligible member. (Except services by an “out of network” provider for an emergency medical condition including post-stabilization services, do not require authorization.)
- 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 healthcare 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 v. Denials

Upfront Rejection

An upfront rejection is defined as an unclean claim that contains invalid or 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

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
180 days	90 days	180 days	180 days	180 days from the primary payers EOP date to the date received.	90 days from the primary payers EOP date to the date received.

- **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, along with supporting documentation (copy of the remittance advice along with affected claims identified), to the following address:

Ambetter of Oklahoma
Attn: Claims Department
P.O. Box 5010
Farmington, MO 63640-5010

Who Can File Claims?

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, extension 6075525
Or by e-mail at 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 www.AmbetterHealth.com/en/ok.

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 a 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 Ext. 6075525, 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

1. Institutional Claims – 837Iv5010 Edits
2. 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 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 Ext. 6075525 or (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 Ext. 6075525 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

For providers who have internet access and choose not to submit claims via EDI or paper, Ambetter has made it easy and convenient to submit claims directly using the Secure Provider Portal at www.AmbetterHealth.com/en/ok.
You must request access to our secure site by registering for a username and password. If you have technical support questions, please contact Provider Services.

Once you have access to the secure portal, you may file first time claims individually or submit first time batch claims. You will also have the capability to find, view, and correct any previously processed claims. Detailed instructions for submitting via Secure Provider Portal are also stored on our website; you must login to the secure site for access to this manual.

Exclusions

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

- Claim records requiring 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. Provider is required to submit the invoice with the claim.
- Claims for services requiring clinical review, e.g., complicated, or unusual procedure. 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 Claims Submission

The mailing address for first time claims (Medical and Behavioral Health) corrected claims and requests for reconsideration:

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

The mailing address for claim disputes/appeals (Medical and Behavioral Health):

Ambetter of Oklahoma
Attn: Level II – Claim Dispute
PO Box 5000
Farmington, MO 63640-5000

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 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 www.AmbetterHealth.com/en/ok.
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. Ensure an authorization is given for services that require prior authorization by Ambetter.
11. Providers billing CLIA services on a CMS 1500 paper form must enter the CLIA number in Box 23 of the CMS 1500 form.
12. 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.
13. 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.

Corrected Claims, Requests for Reconsideration or Claim Disputes

All requests for corrected claims, reconsiderations, or claim disputes must be received within 180 days from the date of the original explanation of payment or denial. Prior processing will be upheld for corrected claims or provider claims requests for reconsideration or disputes/appeals received outside of the 180-day timeframe, unless a qualifying circumstance is offered, and appropriate documentation is provided to support the qualifying circumstance. Qualifying circumstances include:

1. 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, administrative delays, or errors by Ambetter or the Federal and/or State regulatory body.
2. The member was eligible; however, the provider was unaware that the member was eligible for services at the time services 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; and
- The provider has not filed a claim for this member prior to the filing of the claim under review.

Relevant Claim Definitions

- **Corrected claim** – A provider is *changing* the original claim.
- **Request for reconsideration** – A provider disagrees with the original claim outcome (payment amount, denial reason, etc.).
- **Claim dispute/appeal** – A provider disagrees with the outcome of the request for reconsideration.

Corrected Claims

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

1. Submit a corrected claim via the Secure Provider Portal. Follow the instructions on the portal for submitting a correction.
2. Submit 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**
3. Submit a corrected paper claim to:

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

- Upon submission of a corrected paper claim, the original claim number must be **typed** in field 22 (CMS 1500) and 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 claims must be submitted on standard red and white forms. Handwritten corrected claims will be upfront rejected.

Request for Reconsideration

A request for reconsideration is a communication from the provider about a 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 is related to a code audit, code edit, or

authorization denial, medical records must accompany the request for reconsideration. If the medical records are not received, the original denial will be upheld.

Reconsiderations may be submitted in the following ways:

1. Providers may submit a request for reconsideration via the Secure Provider Portal (preferred method).
2. Providers may elect to call to Provider Services. This method is for requests for reconsideration that do not require 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 did not reflect that rate.
3. Providers may submit a request for reconsideration using the Claim Dispute form found on our website
4. Providers may send a written letter that includes a detailed description of the reason for the request. To ensure timely processing, the letter must include sufficient identifying information, which includes, at a minimum, the member's name, member ID number, date of service, total charges, provider name, original EOP, and/or the original claim number found in box 22 on a CMS 1500 form or field 64 on a CMS 1450 (UB-04 form). The corresponding frequency code should also be included with the original claim number (7 = replacement or corrected; 8 = voided or cancelled) in field 22 of the CMS 1500 and in field 4 of the CMS 1450 (UB-04) form.

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

Written requests for reconsideration and any applicable attachments must be mailed 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 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 claim dispute/appeal form found on our website. The claim dispute form must be completed in its entirety. Mail completed claim dispute/appeal forms to:

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

A claim dispute/appeal will be resolved within 30 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 download 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.

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:

- Code billed 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/ok. 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 any laboratory service). The line-item services must be submitted with a 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.

Below are three scenarios involving the Taxonomy Code Billing Requirements:

Scenario One: Rendering NPI is different than the Billing NPI

CMS 1500 Form

Required Data	Paper CMS 1500	Electronic Submission	
		Loop ID	Segment/Data Element
Rendering NPI	Unshaded portion of box 24J	2310B	NM109
		2420A	NM109
Taxonomy Qualifier ZZ	Shaded portion of box 24 I	2310B	PRV02 REF01
		2420A	PRV02 REF01
Rendering Provider Taxonomy Number	Shaded portion of box 24J	2310B	PRV03 REF02
		2420A	PRV03 REF02
Group NPI	Box 33a	2010AA	NM109
Billing Provider Group Taxonomy utilizing the ZZ Qualifier (for the 2000A PROV02 = qualifier "PXC") e.g., box 33b ZZ208D00000X EDI PRV*PE*PXC*208D00000X	Box 33b	2000A	PRV03
Billing Provider Group FTIN(EI)/SSN(SY)		2010AA	REF01 REF02

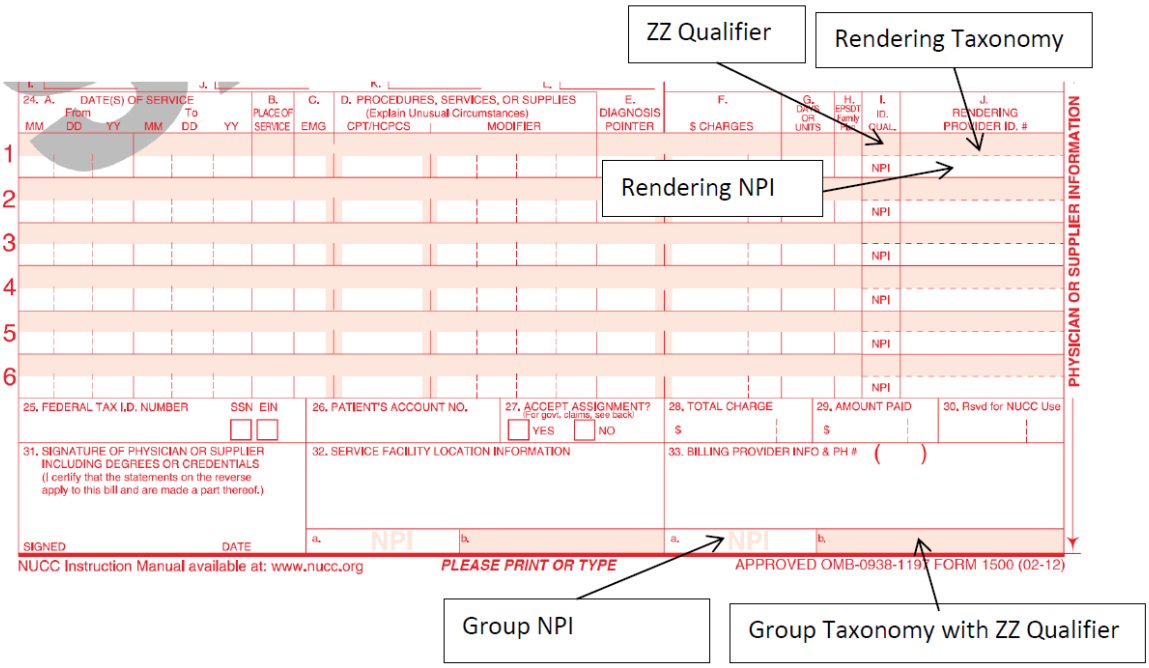
Scenario Two: Rendering NPI and Billing NPI are the same

CMS 1500 Form

It is NOT necessary to submit the Rendering NPI and Rendering Taxonomy in this Scenario; however, if box 24 I and 24 J are populated, then all data MUST be populated.

Required Data	Paper CMS 1500	Electronic Submission	
Applicable NPI	Box 33a	2010AA	NM109
Applicable Taxonomy utilizing the ZZ Qualifier (for the 2000A PROV02 = qualifier "PXC") Billing Provider Group FTIN(EI)/SSN(SY) e.g., REF*EI*999999999	Box 33b	2000A	PRV03
		2010AA	REF01 REF02

Below is an example of the fields relevant to Scenario One and Scenario Two above.

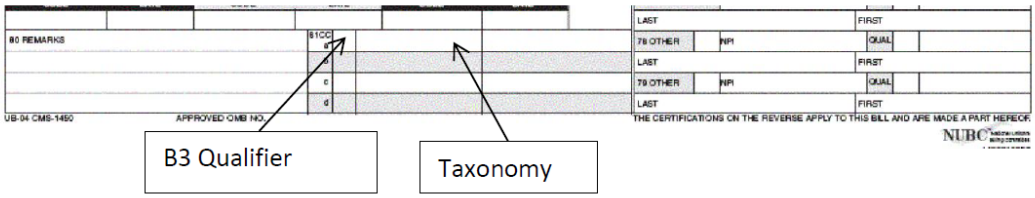


Scenario Three: Taxonomy Requirement for UB 04 Forms

Required Data	Paper UB 04	Electronic Submission
Taxonomy Code with B3 Qualifier	Box 81 CC	Billing Level 2000A Loop and PRVR segment

Below is an example of the UB 04 form:

Below is an example of the UB 04 form



Claim Reconsiderations Related To Code Editing

Claims reconsiderations resulting from claim-editing are handled per the provider 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 or 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. Additionally, 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 correct coding guidelines.

CPT and HCPCS Coding

The Healthcare Common Procedure Coding System (HCPCS) is a set of healthcare procedure codes based on the American Medical Association's (AMA) Current Procedural Terminology (CPT). The HCPCS system was designed to standardize coding to ensure accurate claims payment and consists of two levels of standardized coding.

1. ***Level I HCPCS Codes (CPT):*** This code set is maintained by the AMA. CPT codes are a 5- digit, uniform coding system used by providers to describe medical procedures and services rendered to a patient. These codes are updated (added, revised, and deleted) on an annual basis.
2. ***Level II HCPCS Codes***: The Level II set of HCPCS codes is used to describe supplies, products and services that are not included in the CPT code descriptions (durable medical equipment, orthotics, and prosthetics, etc.). The Level II set is an alphanumeric coding system which is maintained by CMS. These codes are updated on an annual basis.
3. ***Miscellaneous/Unlisted Codes:*** These codes are a subset of the Level II HCPCS coding system and are used by a provider or supplier when there is no existing CPT code to accurately represent the services provided. Claims submitted with miscellaneous or unlisted codes are subject to a manual review. To facilitate the manual review, providers are required to submit medical records with the initial claim submission. If records are not received, the provider will receive a denial indicating that medical records are required. The medical documentation should clearly define the procedure performed including, but not limited to, office notes, operative report, and pathology report and related pricing information. Once received, a

registered nurse reviews the medical records to determine if there was a more specific code(s) to accurately describe the service or procedure rendered. Clinical validation also includes identifying and reviewing other procedures and services billed on the claim that may be related to the miscellaneous code. For example, if the miscellaneous code is determined to be the primary procedure, then other procedures and services that are integral to the successful completion of the primary procedure should be included in the reimbursement value of the primary code.

4. ***Temporary National Codes***: These codes are a subset of the Level II HCPCS coding system and are used to code services when no permanent, national code exists. These codes are considered temporary and may only be used until a permanent code is established. These codes consist of G, Q, K, S, H and T code ranges.
5. ***Modifiers:*** Modifiers are used to indicate additional information about the HCPCS, or CPT code billed. On occasion, certain procedures require more explanation because of special circumstances. For example, modifier -24 is appended to evaluation and management services to indicate that a patient was seen for a new or special circumstance unrelated to a previously billed surgery for which there is a global period.

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 publications.

- Clinical consultants who research, document, and provide edit recommendations based on the most common clinical scenario
- 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.

Unbundling Edits

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) 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 (MUEs) for Practitioners, DME Providers and Facilities

An 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 an 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 do 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 or 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 a previous admission. For example, a 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 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.

Modifiers –59 and -X{EPSU}

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.

Viewing Claims Coding Edits

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.

This tool offers many benefits:

- Prospectively access the appropriate coding and supporting 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. Once adopted by the health plan, these policies are posted on the health plan's Secure Provider Portal.

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 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.

- xE: Procedure Code is disallowed with this Diagnosis Code(s) Per Plan Policy.

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 reconsiderations, 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:

1. Statement of why the service is medically necessary.
2. Medical evidence which supports the proposed treatment.
3. How the proposed treatment will prevent illness or disability.

4. How the proposed treatment will alleviate physical, mental, or developmental effects of the patient's illness.
5. How the proposed treatment will assist the patient to maintain functional capacity.
6. A review of previous treatments and results, including, based on your clinical judgment, why a new approach is necessary.
7. 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, or 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 healthcare expenses of the member.

If third party liability coverage is determined after services are rendered, Ambetter will coordinate with the provider to pay any claims that may have been denied for payment due to third party liability.

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:

1. 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.)
2. Should a provider make the decision to render services, the provider may collect from the member. Providers must submit a claim to Ambetter.
3. 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.
4. 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.
5. 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 both 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:

1. The specific service(s) to be provided
2. A statement that the service is not covered by Ambetter
3. A statement that the member chooses to receive and pay for the specific service
4. 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 less 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.

Interim Billing

It is the policy of Ambetter Marketplace not to accept interim billing for estimated monies owed to participating and non-participating facilities. Claims processing will begin upon receipt of the bill for total services rendered.

- Ambetter Marketplace requires that participating and non-participating Providers submit final claim upon Members discharge from facility.
- Interim billing will not be accepted for Per Diem, DRG and Billed Charges reimbursement. The claim will be denied until the claim with the first date of admission through the date of final discharge is received.

GRIEVANCES AND APPEALS

Complaint/Grievance

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

If the Complaint/Grievance 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/Grievance.

Provider Complaint/Grievance Process

The provider can contact Provider Services if they have any questions or concerns. We will attempt to answer and address any issues during initial contact, as most Complaints/Grievances can be resolved with a phone call. If we are unable to resolve their issue, the provider may elect to file a verbal Complaint/Grievance with Provider Services or send us details of their Complaint/Grievance in writing.

The mailing address for non-claim related Provider Complaints/Grievances and Appeals is:

Ambetter
PO Box 10341
Van Nuys, CA 91410

A provider has 30 calendar days from the date of the incident, such as the original Explanation of Payment date, to file a Complaint/Grievance. After research and a full review of the Complaint/Grievance has been completed, Ambetter shall provide a written notice to the provider within 30 calendar days from the date we receive the provider's Complaint/Grievance.

MEMBER GRIEVANCE 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. Additionally, information regarding the Complaint/Grievance process can be found on our website at AmbetterofOklahoma.com or by calling Ambetter at 1-833-492-0679 (TTY 711).

If a member is displeased with any aspect of services rendered:

1. The member should contact our Member Services department at 1-833-492-0679 (TTY 711). The Member Services representative will assist the member.
2. If the member continues to be dissatisfied, they may file a formal complaint/grievance. Again, our Member Services department is available to assist with this process. Information regarding this process can be found at www.AmbetterHealth.com/en/ok.
3. Depending on the nature of the complaint/grievance, the member will be offered the right to appeal our decision. At the conclusion of this formalized process, the member will receive written confirmation of the determination. Ambetter will complete the appeal process in the timeframes as specified in rules and regulation.
4. The member has the right to appeal to an external independent review organization.
5. A member may designate in writing to Ambetter that a provider is acting on behalf of the member regarding the complaint/grievance and appeal process.

If and when a threshold number of members complain about a specific provider, Ambetter may undertake a review of the provider including, but not limited to, a site review. Site reviews are performed at provider offices and facilities when the member complaint threshold is met. A site review evaluates:

- physical accessibility;
- physical appearance;
- adequacy of waiting and examining room space; and
- adequacy of medical/treatment record keeping.

The mailing address for Member Complaints/Grievances is:

Ambetter of Oklahoma
Attn: Appeals and Grievances Department
PO Box 10341
Van Nuys, CA 91410-0341

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, the appeal must be transferred to the timeframe for standard resolution of appeals.

Provider Claim Appeal Process

Claim Appeal requests must follow the claim reconsideration and claim dispute process. Please refer to 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 of Oklahoma
Attn: Level I - Request for Reconsideration
PO Box 5010
Farmington, MO 63640-5010

Ambetter of Oklahoma
Attn: Level II – Claim Dispute
PO Box 5000
Farmington, MO 63640-5000

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 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. Ambetter may extend the timeframe for resolution of the appeal up to 14 calendar days if the member requests the extension or Ambetter demonstrates that there is need for additional information and how the delay is in the member's best interest. For any extension not requested by the member, Ambetter shall provide written notice to the member for the delay.

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.

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 AmbetterofOklahoma.com or by calling Ambetter at 1-833-492-0679 (TTY 711).

The mailing address for Member Appeals is:

(For Physical Health related authorization appeals)
Ambetter of Oklahoma
Attn: Appeals and Grievances Department
PO Box 10341
Van Nuys, CA 91410-0341
Fax: 1-833-886-7956

(For Behavioral Health related authorization appeals)
Ambetter of Oklahoma
Attn: BH Appeals Department
PO Box 10378
Van Nuys, CA 91410-0378
Fax: 1-866-714-7991

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 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, 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's 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
- 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 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).

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 of Oklahoma auditors request medical records for a defined review period. Providers have 30 days 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 of Oklahoma will recover all amounts paid for the services in question.

Ambetter of Oklahoma 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 of Oklahoma 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 of Oklahoma will seek recovery of all overpayments. Depending on the number of services provided during the review period, Ambetter of Oklahoma 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 Partnership Manager.

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)., such as:

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/about/organization/bureaus/ohe/health-literacy. Providers can find free online courses on topics such as addressing health literacy, cultural competency, and limited English proficiency.

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 healthcare services in non-English prevalent languages

Information is deemed to be critical for obtaining health insurance coverage or access to healthcare 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 at: 1-833-492-0679 or 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.

Americans With Disabilities Act (ADA)

Title III of the ADA mandates that public accommodations, such as a Provider's office, be accessible to those with disabilities. The provisions of the ADA protect qualified individuals with a disability from:

Exclusion from participation in the benefits of services, programs, or activities of a public entity.

Denial of the benefits of services, programs, or activities of a public entity.

Discrimination by any such entity. Ambetter providers must provide physical access, accommodations, and accessible equipment for members with physical or mental disabilities as required by 42 CFR Section 438.206(c)(3).

Providers are required to comply with all federal and state disability access laws and regulations (including, but not limited to, the Medicaid/CHIP Managed Care final rule provisions noted above, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and Section 1557 of the Affordable Care Act). Ambetter must inspect the office of any Provider who provides services on-site at the Provider's location and who seeks to participate in the Provider Network to determine whether the office is architecturally and programmatically accessible to persons with disabilities. "Physical access," also referred to as "architectural access," refers the ability to access buildings, structures, and the environment by a person with a disability. "Programmatic access" refers to the ability to access goods, services, activities and equipment by a person with a disability.

If any disability access barriers are identified, the provider agrees, in writing, to remove the barrier to make the office, facility, or services accessible to persons with disabilities within one hundred eighty (180) days after Ambetter has identified the barrier.

Providers are also required to:

- Provide Interpretation Services in all languages, including American and Mexican Sign Language, at all key points of contact through a variety of formats, including but not limited to:

an in-person interpreter upon a member's request; telephone, relay, or video remote interpreting 24 hours a day seven days a week; or through other formats, such as real-time captioning or augmentative & alternative communication devices, that ensure effective communication.

- Provide Member-Informing Materials (print documents, signage, and multimedia materials such as websites) translated into the currently identified threshold or concentration standard languages and provided through a variety of other means. This may include but not limited to:
    - oral interpretation for other languages upon request;
    - accessible formats (e.g., documents in Braille, large print, audio format, or websites with captioned videos and/or ASL versions) upon request;
    - and easy-to-understand materials provided in a manner that considers various levels of health literacy.
- Provide Reasonable Accommodations that facilitate access for Members. This includes, but is not limited to:
    - accessible medical care facilities,
    - diagnostic equipment, and examination tables & scales; and
    - modification of policies, practices, and procedures (e.g., modify policies to permit the use of service animals or to minimize distractions and stimuli for Members with mental health or developmental disabilities).

Inform Members of the availability of these cultural, linguistic, and disability access services at no cost to Members on brochures, newsletters, outreach and marketing materials, other materials that are routinely disseminated to Members, and at Member orientation sessions and sites where Members receive covered services.

Ambetter and participating providers shall also facilitate access to these services and document a request and/or refusal of services in CRM or the provider's member data system.

Call your Provider Relations Representative at 1-833-492-0679 (TDD/TTY: 711) for more information.

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 at 1-833-492-0679 for more information.

The term "disability" means, with respect to an individual -

Disability 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:

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

Policies for Scheduling and Waiting Appointments

1. Policies that allow scheduling additional time for the duration of appointments for Members with disabilities who may require it
2. 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.

3. Policies to enable Members who may not be able to tolerate waiting in a reception area to be seen immediately upon arrival
4. Members with cognitive, intellectual, or some psychiatric disability may be unable to wait in a crowded reception area without becoming agitated or anxious
5. Policies to allow flexibility in appointment times for Members who use paratransit
6. Members may arrive late at appointments because of delays or other problems with paratransit scheduling or reliability
7. Policies to enable compliance with federal law that guarantees access to provider offices for people with disabilities who use service animals
8. 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:

1. Training of healthcare providers in operation of accessible equipment
2. 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:

1. Current and prospective members, including people with disabilities, should be referred to another provider only for established medical reasons or specialized expertise is necessary.
2. Referrals result in a delay of treatment and subject members to additional time, expenses, and reduces the member's choice of providers.
3. Knowledge and/or attention to the accessibility of laboratories, testing facilities, specialists, or other healthcare delivery venues to which members are referred.
4. Members may be unable to comply with medical referrals if 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 have the effect of subjecting qualified individuals with disabilities to discrimination based on disability;
  - That have 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 perpetuate 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 have the effect of excluding individuals with disabilities from, denying them the benefits of, or otherwise subjecting them to discrimination; or

  - That have 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 an accommodation, aid, service, opportunity, or benefit provided under the ADA or this part which such 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 healthcare 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 provider 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.

988 SUICIDE & CRISIS LIFELINE

As of July 16, 2022, individuals experiencing mental health or substance use-related distress—including thoughts of suicide or other emotional crises—can now contact the 988 Suicide & Crisis Lifeline by calling or texting 988, or via online chat at 988lifeline.org. The service is free, confidential, and available 24/7.

The 988 Lifeline is an initiative 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:** Lifeline provides immediate support to individuals experiencing mental health, suicide, or substance use-related crises.
- **Access:** Callers can reach the Lifeline by dialing 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.
- **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.
- **Substance Use Support:** 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 allow 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 healthcare 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 provide quality healthcare 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 healthcare
- 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 healthcare 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 healthcare
- 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 for 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 healthcare 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 healthcare 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/ok.

Patient Safety and Quality of Care

Patient safety is a key focus of the Ambetter QAPI Program. Monitoring and promoting patient safety is integrated throughout activities across the health plan, primarily through 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 patient 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 (including 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 decide of 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 is tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

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 healthcare 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 healthcare 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 claims and encounter data and submission using appropriate CPT, ICD-10,and HCPCS codes can reduce the necessity of medical record reviews. Visit www.ncqa.org/hedis/measures for more information on reducing HEDIS® 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 healthcare 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 the most 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 chart documentation reflects all 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 1-833-492-0679.

Provider Satisfaction Survey

Ambetter conducts an annual provider satisfaction survey, which includes questions to evaluate the provider experience 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 is meeting 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 of Oklahoma 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 of Oklahoma 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 of Oklahoma in the form of Electronic Medical Record (EMR) data reduces costs for both the provider and Ambetter of Oklahoma.

At Ambetter of Oklahoma's request, Provider will make commercially reasonable efforts to make EMR data relating to Ambetter of Oklahoma's members available and accessible to Ambetter of Oklahoma within a reasonable time frame requested by Ambetter of Oklahoma 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 of Oklahoma's request or authorization, Provider may provide EMR data to Ambetter of

Oklahoma 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 of Oklahoma 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.

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 healthcare 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.

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:

- 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 member's 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.
- Signed and dated required consent forms are included.
- 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 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 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 Ambetter of Oklahoma

Subject only to applicable state and federal confidentiality or privacy laws, the provider shall permit Ambetter of Oklahoma 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 shall be scheduled at mutually agreed upon times, upon at least 30 business days prior written notice by Ambetter of Oklahoma or its designated representative, but not more than 60 days following such written notice.

Electronic Medical Record (EMR) Access

Providers will grant Ambetter of Oklahoma 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 Ambetter of Oklahoma for this access..

Medical Records Transfer for New Members

All PCPs 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 1-833-492-0679 or write (refer to address below) with any questions about our privacy practices.

Ambetter of Oklahoma
140000 Quail Springs Parkway, Suite 650
Oklahoma City, OK 73134

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 attachments(s). Providers may provide services to members who are enrolled with Ambetter in a state which is not where the Providers is located. In these cases, the covered services of the members domiciled state would govern. Providers should confirm that services they provide to the members 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 from Peach State Health Plan
(Illinois)	Ambetter of Illinois
(Indiana)	Ambetter Health
(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 from Magnolia Health
(Missouri)	Ambetter from Home State 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
(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), the font is too small.
- Member Date of Birth is missing.
- Member Name or Identification Number is missing.
- 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 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 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 modifier 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.
- Revenue Code is invalid.
- Dates of Service span do not match the listed days/units.
- Tax Identification Number (TIN) is invalid.

See the bottom of your paper EOP for the updated and complete description of all explanation codes associated with your claims. Electronic Explanations of Payment will use standard HIPAA 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 PROV. MUST CALL PROV 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
KC	DENY: NO REFERRAL ON FILE THAT MATCHES SERVICE(S) BILLED
M3	DENY: NO ASSOCIATED FACILITY CLAIM RECEIVED
sP	SERVICING PROVIDER IS OUTSIDE OF MEMBER'S ASSIGNED MEDICAL GROUP

EX Code	Description
pE	Inappropriate Level of E M Service Billed
w1	Co-surgeon/team surgeon disallowed per CMS surgical billing guidelines
w2	Assistant & primary surgeon procedure codes must match per CMS
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 EXCLUSIVE 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 gender 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 III: Common EOP Denial Codes and Descriptions

See the bottom of your paper EOP for the updated and complete description of all explanation codes associated with your claims. Electronic Explanations of Payment will use standard HIPAA denial codes.

EX Code	Description
18	Deny: Duplicate claim service
28	Deny: Coverage not in effect when service provided

EX Code	Description
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
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

EX Code	Description
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 (ex. 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.

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

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

...	Error Description
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
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

...	Error Description
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
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.

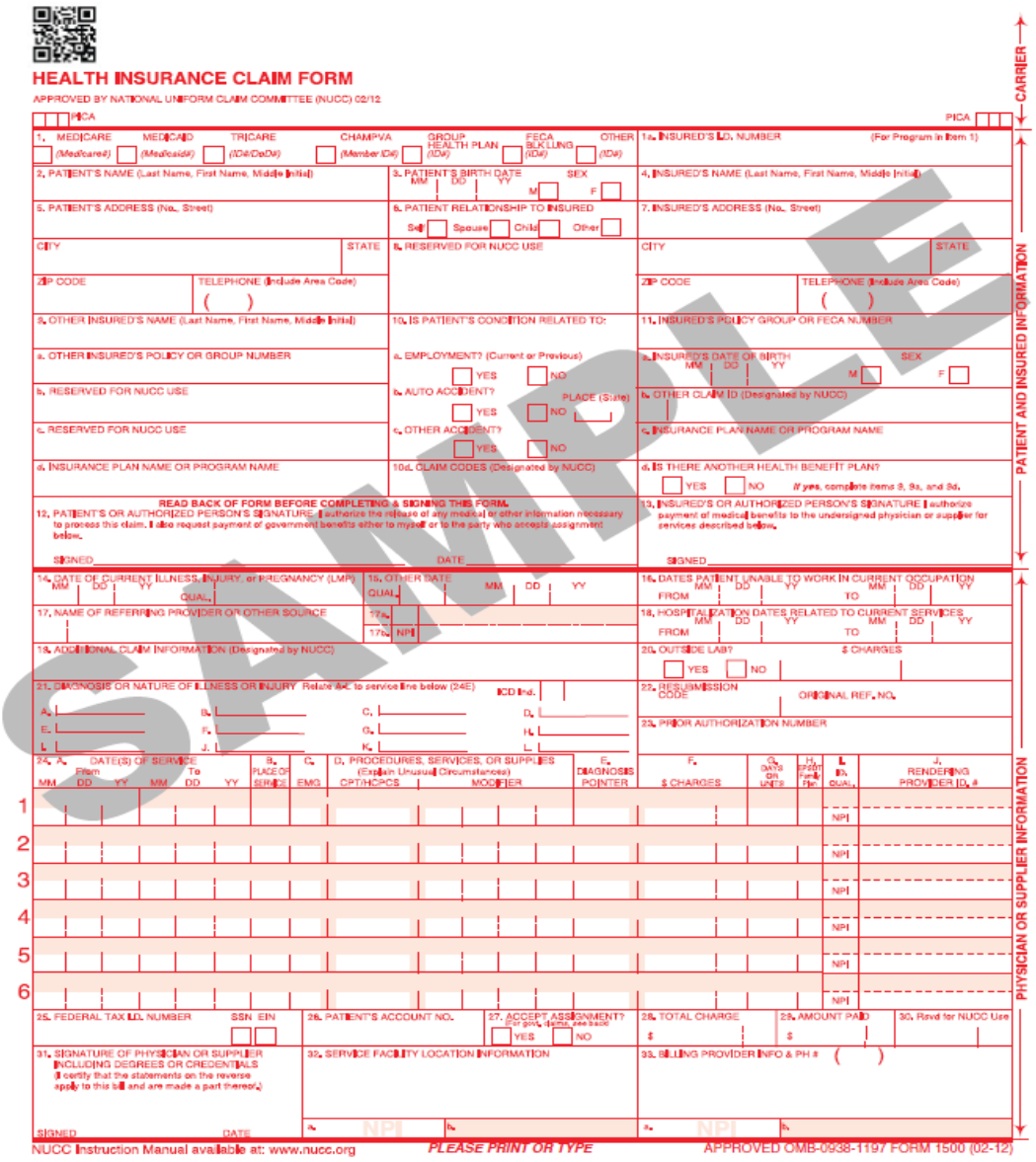
...	Error Description
HP	ICD10 is mandated for this date of service.
ZZ	Claim not processed

Appendix VI: Claim Form Instructions

Claim Forms

Claim forms are the standardized medical billing forms for professional and facility medical billing of health insurance claims in the United States. There are two types of claim forms: CMS 1500 (HCFA) and CMS 1450 (UB 04).

CMS 1500 (HCFA) Sample Form



Overview:

The CMS-1500 is a standard claim form used by healthcare professionals and suppliers including:

All professional services (including specialists)

- Individual practitioners

- Non-hospital outpatient clinics
- Transportation providers
- Ancillary services (laboratory tests, radiology, genetic
- Testing, diagnostic imaging)
- Durable Medical Equipment
- Professional charges
- Technical components of hospital-based physicians
- Certified Nurse Anesthetists (CRNAs).

CMS 1500 Fields

The CMS1500 contains two sections: member information and provider of services or supplier information.

Field #	Field Description	Instruction or Comments	Required or Conditional
1	Insurance Program ID	Type of Health Coverage applicable to the claim.	Not Required
1a*	Insured I.D. Number	10-digit Medicaid id number on the member's health plan I.D. card	Required
2*	Patient's Name	Patients last name, first name, and middle initial	Required
3*	Patient's Birth date/Sex	Patients 8-digit birth date (MM/DD/YYYY) and patient's gender	Required
4	Insured's Name	Patient's name as it appears on their health plan I.D.	Required
5	Patient's Address	Patients complete address	Required
6	Patient's Relation to Insured	Indicates patient's relationship	Conditional
7	Insured's Address	Insured's complete address	Not Required
8	Patient Status		Not Required
9	Other Insured's Name	Refers to someone other than the patient (required if patient is covered by another insurance)	Conditional

Field #	Field Description	Instruction or Comments	Required or Conditional
9a	Other Insured's Policy or Group Number	Refers to someone other than the patient (required if patient is covered by another insurance)	Conditional
9b	Other insured's birth date/sex	Required if field 9 is completed	Conditional
9c	Employer's or School Name	Employer's or School name	Conditional
9d*	Insurance Plan Name	Other insured's insurance plan or program name	Conditional

Field #	Field Description	Instruction or Comments	Required or Conditional
10d	Reserved for Local Use		Not Required
11	Insured's Policy Group or FECA number		Required
11a	Insured's Date of Birth/Sex		Conditional
11b	Employer's Name or School Name		Conditional
11c*	Insurance Plan Name or Program Name		Required
11d*	Is there Another Health Benefit Plan		Required
12	Patient's or Authorized Person's Signature		Required
13	Patient's or Authorized Person's Signature		Not Required
14	Date of current illness, first symptom, or pregnancy		Conditional
15	First date of same or similar illness		Not Required
16	Date patient unable to work in current occupation		Not Required
17	Name of referring provider		Not Required
17a	ID Number of referring physician		Conditional
17b	NPI of referring physician		Conditional

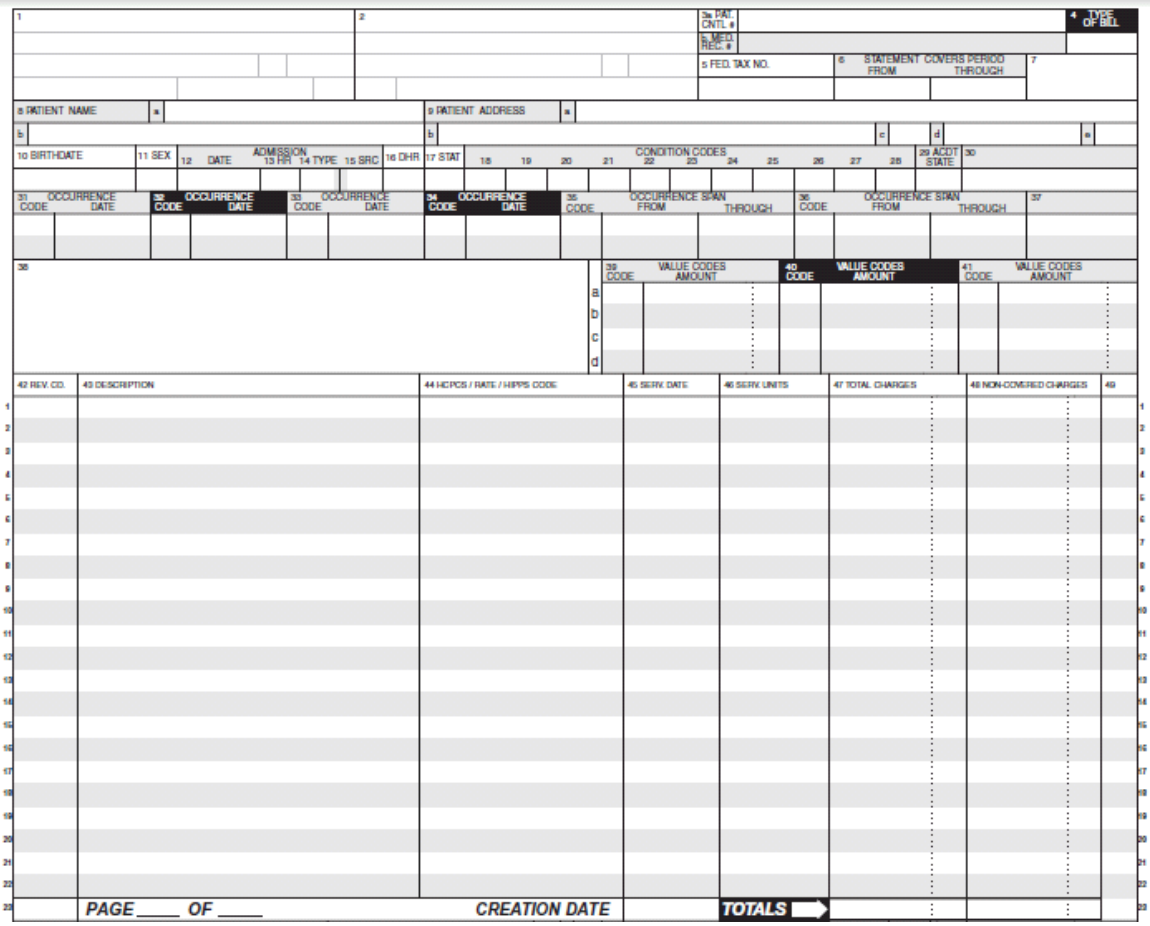
Field #	Field Description	Instruction or Comments	Required or Conditional
18	Hospitalization dates related to current services		Not Required
19	Reserved for local use		Not Required
20	Outside lab/charges		Not Required
21	Diagnosis or nature of illness	ICD-10 codes related to pointers in 24E	Required
22	Medicaid resubmission code / original Ref No.		Conditional
23	Prior Authorization Number		Not Required

Field #	Field Description	Instruction or Comments	Required or Conditional
24A-J	Box 24 contains 6 claim service lines. Each line is split horizontally and has 10 individual fields labeled A – J.		
24A	Date of Service (From and To dates)		Required
24B	Place of Service or Location		Required
24C	EMG (Emergency)		Required
24D	CPT/HCPCS and Modifiers		Required
24E	Diagnosis Code (pointer)		Required
24F	Charges	Charge amount for service line	Required
24G	Days or Units		Required
24H	Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)		Conditional
24I	ID qualifier		Conditional
24J Shaded	Non-NPI Provider		Required
24J	NPI Provider ID		Required

Field #	Field Description	Instruction or Comments	Required or Conditional
Un-shaded			
25	Federal Tax I.D. Number	9-digit TIN	Required
26	Patient's Account Number	Provider's billing account number	Not Required
27	Accept Assignment		Required
28	Total Charges	Total billed charges	Required
29	Amount Paid		Conditional
30	Balance Due		Conditional
31	Signature of Physician or supplier		Required
32	Service Facility Location Information		Conditional

Field #	Field Description	Instruction or Comments	Required or Conditional
32a	NPI Services – Services Rendered		Conditional
32b	Other Provider ID		Conditional
33	Billing provider Information and phone number		Required
33a	Group Billing NPI		Required
33b	Group Billing Other Id		Required

CMS 1450 (UB 04) Sample Form



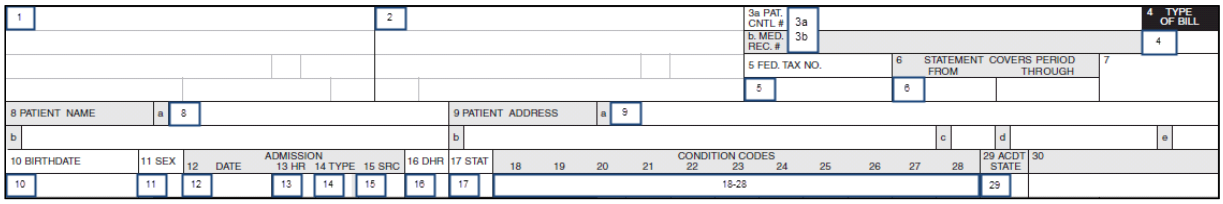
Overview:

The CMS 1450 (UB-04) is the only acceptable claim form for submitting inpatient or outpatient hospital claim charges for reimbursement. The following Providers are required to bill to the CMS 1450 (UB-04):

- Inpatient/Outpatient hospital charges
- Nursing home services
- Home health
- Inpatient Hospice
- Ambulatory surgery center
- Dialysis services

The CMS 1450 contains multiple sections: Provider/Member information, Occurrence and Value codes, Service lines, Other Insurance Carrier Indicators, Diagnosis codes.

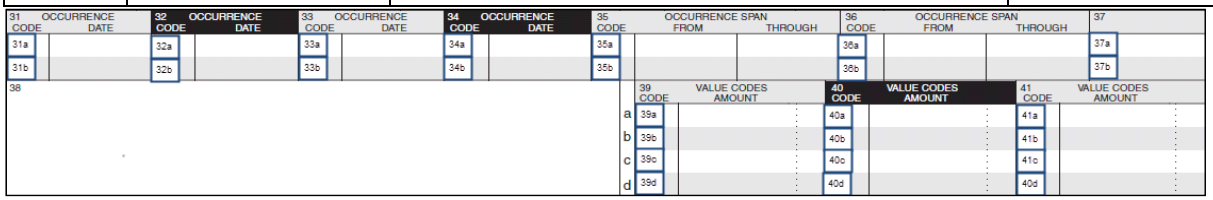
CMS 1450 (UB-04) Fields



Field #	Field Description	Instruction or Comments	Required or Conditional
1	Provider's Name	Provider's name, address, and telephone number	Required
2	Facility (Pay to) Address	Facility name, address, and telephone number	Billed But Not Required
3a	Patient Account or Control Number	Patient account number from doctor/hospital	Billed But Not Required
3b	Medical Record Number	Medical record or health record number	Required
4	Type of Bill	3-digit type of bill code indicating the type of facility, type of care, and billing sequence	Required
5	Federal Tax Number	9-digit federal tax id number (TIN) assigned by the federal government for tax reporting purposes.	Required

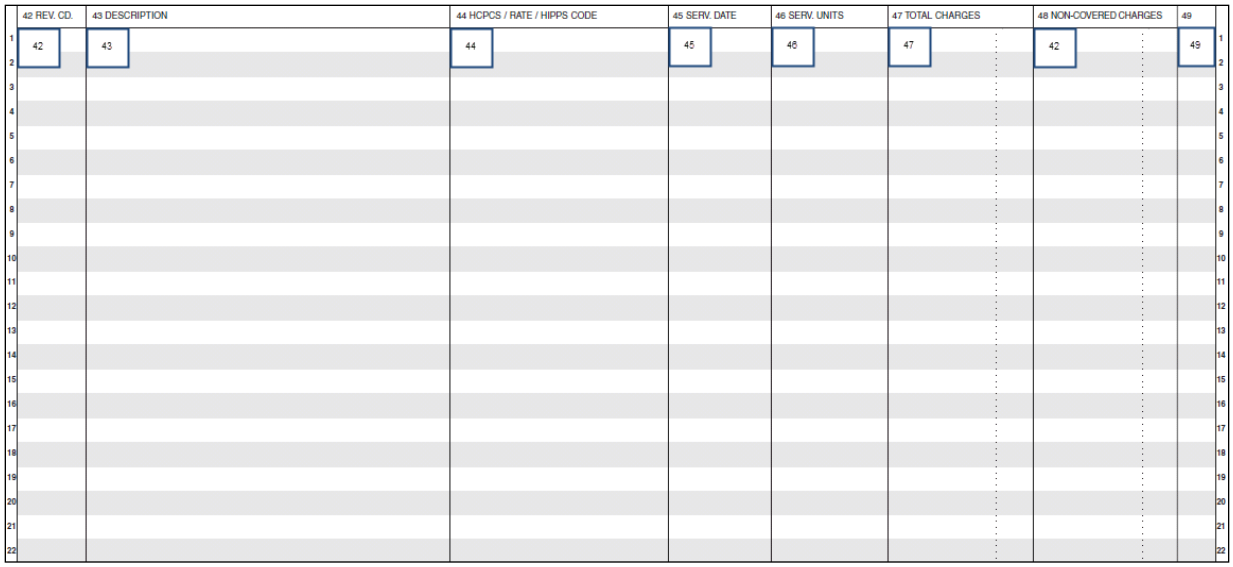
Field #	Field Description	Instruction or Comments	Required or Conditional
6	Statement Covers Period From/Through	Begin and end or admission and discharge dates for the services billed. Inpatient and outpatient observation stays must be billed using the admission date and discharge date. Outpatient therapy, chemotherapy, laboratory, pathology, radiology, and dialysis may be billed using a data span; however, all other outpatient services must be billed using the actual date of service (MMDDYY).	Required
8a-b	Patient Name	Patient's last name, first name, and middle initial.	Required

Field #	Field Description	Instruction or Comments	Required or Conditional
9a-e	Patient Address	Patient's complete address.	Required
10	Birthdate	Patient's date of birth (MMDDYYYY).	Required
11	Sex	Patient's gender	Required
12	Admission Date	Date of admission for inpatient claims and date of service for outpatient claims	Required
13	Admission Hour	2-digit military time (00-23) for inpatient admission or time of treatment for outpatient services.	Required
14	Admission Type	1-digit code indicating the priority of the admission. Required for inpatient claims with a type of bill 11X, 118X, 21X, and 41X.	Conditional
15	Admission Source	1-digit code indicating the source of admission or outpatient service.	Conditional
16	Discharge Hour	2-digit military time (00-23) for time of inpatient or outpatient discharge.	Conditional
17	Patient Status	2-digit disposition or status of the patient as of the "through" date for the billing period listed in field 6. Required for inpatient claims.	Conditional
18-28	Condition Codes	2-digit condition code relating to the bill that may affect payer processing.	Conditional
29	Accident State		Not Required



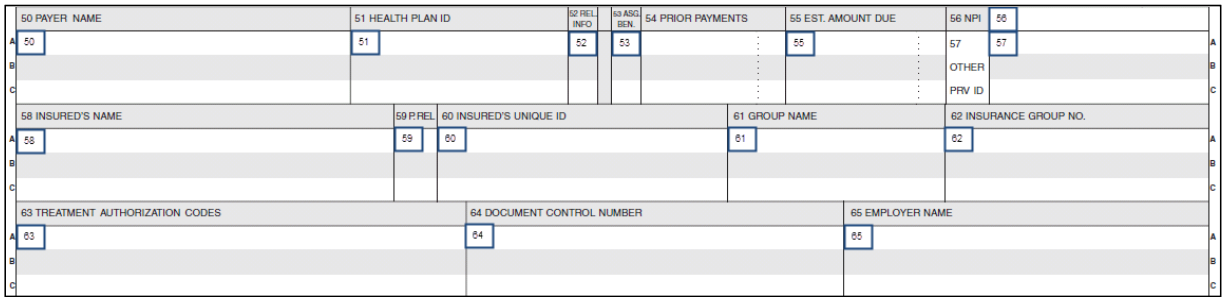
Field #	Field Description	Instruction or Comments	Required or Conditional
31-34 (a-b)	Occurrence Code and Date	Occurrence codes identify relating events that may affect payer processing. It is	Conditional

Field #	Field Description	Instruction or Comments	Required or Conditional
		a 2-character code in alphanumeric sequence. The occurrence dates are a date for the associated occurrence code in a MMDDYYYY format.	
35-36 (a-b)	Occurrence Span Code and Date	Occurrence span codes identify relating events that may affect payer processing. It is a 2-character code in alphanumeric sequence. The occurrence dates are a date for the associated occurrence code in a MMDDYYYY format.	Conditional
38	Responsible Party	name and address of responsible party	Conditional
39-41 (a-d)	Value Codes and Amounts	Value codes are used identify events relating events relating to the bill that may affect payer processing. Up to 12 codes can be entered. All a fields must be entered before using b fields and so on. Entry is a 2-character code.	Conditional



Field #	Field Description	Instruction or Comments	Required or Conditional
The UB-04 consists of 22 service lines for claim detail information. Fields 42, 43, 45, 47, and 48 include conditional instructions for completions of lines 1-22 and line 23.			
42	Revenue Code	4-digit revenue code itemizing accommodations, services, and items furnished to the patient.	Required
43	Description	Description corresponding to the revenue code entered in field 42.	Required
44	HCPCS/RATES	Required for outpatient claims when an appropriate CPT/HCPCS code exists for the service line revenue code billed. Only one CPT/HCPCS and up to two modifiers are accepted	Conditional
45	Service Date	Required on all outpatient claims. Date of service for each line billed (MMDDYYYY).	Conditional
46	Service Units	Number of units, days, or visits for the same service. A value of at least 1 must be entered.	Required
47	Total Charges	Total charges for each service line.	Required

Field #	Field Description	Instruction or Comments	Required or Conditional
Line 23			
48	Non-covered Charges	Non-covered charges included in field 47 for the revenue code listed in field 42 of the service line.	Conditional

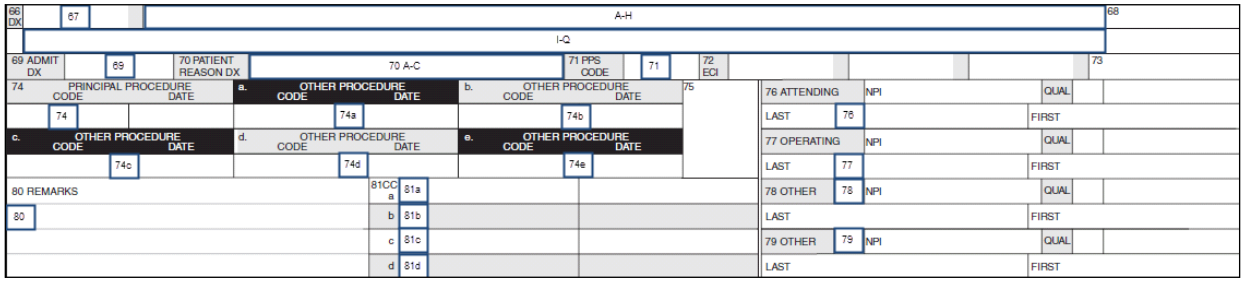


Field #	Field Description	Instruction or Comments	Required or Conditional
50 (A-C)	Payer	4-digit revenue code itemizing accommodations, services, and items furnished to the patient.	Required
51 (A-C)	Health Plan ID Number		Not Required
52 (A-C)	Release Info	Release information certification indicator in which providers are expected to have necessary information on file. Marked with Y or N.	Required
53	Asg. Ben	Indicates a signed form is on file authorizing payment of the payer directly to the provider for services. Marked with a Y or N.	Required

Field #	Field Description	Instruction or Comments	Required or Conditional
54	Prior Payments	Amount received from the primary on the appropriate line when Medicaid/Superior Health Plan is listed as secondary or tertiary.	Conditional
55	Est. Amount Due		Not Required
56	NPI or Provider ID	Provider's 10-digit NPI identification number.	Required

Field #	Field Description	Instruction or Comments	Required or Conditional
57	TPI Number	TPI number (non NPI number) of the billing provider.	Not Required
58 (A-C)	Insured's Name	required for each line completed in field 50, this field contains the names of the person who carries the insurance for the patient	Conditional
59	Patient Relationship	Relationship to the insured	Not Required
60	Insured's Unique ID	patient's insurance/Medicaid identification number exactly as it appears on the patient's ID card	Required
61	Group Name		Not Required
62	Insurance Group Number		Not Required
63	Treatment Authorization Codes		Not Required
64	Document Control Number	12-digit document control number of the paid health claim when submitting a	Conditional

Field #	Field Description	Instruction or Comments	Required or Conditional
		replacement or void on a corresponding A, B, C line reflecting Superior Health plan from field 50.	
65	Employer Name		Not Required



Field #	Field Description	Instruction or Comments	Required or Conditional
66	Primary Diagnosis	Principle or primary diagnosis (ICD-10) or condition	Required
67 (A - Q)	Additional Diagnosis	Additional diagnosis (ICD-10) or conditions that coexist at the time of admission or that develop subsequent to the admission and have an effect on the treatment or care received	Required
69	Admitting Diagnosis	Admitting diagnosis or condition provided at the time of admission as stated by the physician	Required
70 (a – c)	Patients Reason Diagnosis	Required code that reflects he patient's reason for visit at time of outpatient registration	Required
71	PPS of DRG Code		Not Required

Field #	Field Description	Instruction or Comments	Required or Conditional
74 (a – e)	ICD-10 Procedure Code	Identifies significant procedures performed other than the principal or primary procedure.	Required on Inpatient claims when a procedure performed during the date span of the bill
76	Attending Physician	10 digit NPI and name of attending physician in charge of patient care	Not Required
77	Operating Physician	NPI, type of qualifier, and name of operating physician	Required when surgical procedure is performed
78 -79	Other Physician	Provider type qualifier, NPI and name of other physician in charge of the patient's care	Not Required
80	Remarks		Not Required
81	Taxonomy	Taxonomy of billing provider, using the ZZ Qualifier	Not Required

EDI Health Claims

EDI stands for Electronic Data Interchange. EDI refers to the transfer of electronic data. Sending healthcare claims via EDI has many advantages. Since EDI claims are sent electronically from one computer to another, there is no costly paperwork involved. By the time we receive a paper claim through the mail, we would have already received an electronic claim and processed for payment/denial. Reducing printing and mailing costs along with improved accuracy and speed of claim payments makes sending electronic claims extremely cost-effective. The claims are viewed the same way as a paper claim through the AWD system.

Completing a CMS 1450 (UB-04) Claim Form

A UB-04 is the only acceptable claim form for submitting inpatient or outpatient hospital claim charges for reimbursement by Ambetter. In addition, a UB-04 is required for Comprehensive Outpatient Rehabilitation Facilities (CORF), Home Health Agencies, nursing home admissions, inpatient hospice services, and dialysis services. Incomplete or inaccurate information will result in the claim/encounter being rejected for correction.

Attachment Samples

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 patient medical history and care. It is a written transcript of information obtained from a patient, guardian, or medical professional concerning a patient's health history, diagnostic test, diagnosis, treatment, and prognosis.

EOB

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

EOP

An explanation of payment (EOP) is a remittance statement sent to the rendering provider explaining the payment or denial by DOS, amount charged, amount allowed, and 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.

Claim Type Hints

Professional billing is responsible for the billing of claims generated for work performed by physicians, suppliers, and other non-institutional providers for both outpatient and inpatient services.

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

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 standing for the professional format.

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

Forms Used: Institutional charges are billed on a UB-04. The UB-04 is the red ink on white paper standard claim form used by institutional providers for claim billing. The electronic version of the UB-04 is called the 837-I, the I standing for 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. Recipients are required to keep Medicaid informed of any health insurance information.

Providers are also responsible for notifying Medicaid of third-party insurance they find out about as well as informing Medicaid of any third-party payments they receive on behalf of the recipient.

Medicaid is state regulated, therefore, each state has its own billing requirements. Billers must contact the Medicaid program in their own state to find out specific billing information.

The Difference Between A UB 04 and A HCFA 1500

Full Answer

The UB-92 form was replaced by the UB-04 Form per the ruling of the National Uniform Billing Committee in 2005. The UB form is maintained by the NUBC, which is a voluntary committee that procures and develops data for claims and related transactions.

The primary difference between the UB and the HCFA-1500 forms is that the UB form is required for facility billing purposes. The form is filed by an assortment of institutions, including acute care facilities, stand-alone clinics, surgery centers, sub-acute facilities, home healthcare agencies, hospice organizations, and psychiatric, drug and alcohol treatment centers. The UB is a claim for Medicare Part A reimbursement of both inpatient and outpatient services to Medicare MAC's and FI's.

The UB form is not used to file charges of physicians or individual medical providers. These charges are billed on the HCFA-1500 claim form.

The HCFA-1500 is the standard paper claim form used by medical suppliers and professionals to bill Medicare providers and Durable Medical Equipment Medicare Administrative Contractors. The HCFA-1500 must be submitted within one year from the date of service, and beneficiaries cannot be charged for filing or completing this claim.

Types of bill codes and what they mean

- Type of Bill 111 represents a Hospital Inpatient Claim indicating that the claim period covers admit through the patient's discharge.

- Type of Bill 117 represents a Hospital Inpatient Replacement or Corrected claim to a previously submitted hospital inpatient claim that has paid in order for the payer to reprocess the claim.

- Type of Bill 138 represents a Hospital Outpatient Void or Cancel of a Prior claim to a previously submitted hospital outpatient claim that has paid in order for the payer to recoup the payment made.

- Type of Bill 831 represents a Hospital Outpatient Surgery performed in an Ambulatory Surgical Center. For an outpatient surgery performed in a Hospital, the type of bill would be 131 instead of 831.

First Digit of the Bill Type Code - Facility Type

The first digit refers to the type of facility.
1 - Hospital
2 - Skilled Nursing
3 - Home Health
4 - Religious Nonmedical Healthcare Facility (Hospital)
5 - Religious Nonmedical Healthcare Facility (Extended Care)
7 - Clinic
8 - Specialty Facility, Hospital ASC Surgery

Second Digit of the Bill Type Code

What the second digit signifies depends on the first digit is. It has a different set of meanings for clinics and special facilities.

The second digit refers to the bill classification except for clinics and special facilities.

If the first digit is 1-5, then the second digit is:
1 - Inpatient (Medicare Part A)
2 - Inpatient (Medicare Part B)
3 - Outpatient

4 - Other (Medicare Part B)
5 - Level I Intermediate Care
6 - Level II Intermediate Care
7 - Subacute Inpatient (for use with Revenue Code 019X)
8 - Swing Bed

For Clinics only:

If the first digit is 7, then the second digit is:
1 - Rural Health Clinic
2 - Hospital Based or Independent Renal Dialysis Facility
3 - Federally Qualified Health Center (FQHC), Free Standing Provider-Based
4 - Other Rehabilitation Facility (ORF)
5 - Comprehensive Outpatient Rehabilitation Facility (CORF)
6 - Community Mental Health Center (CMHC)

For Special Facilities Only:

If the first digit is 8, then the second digit is:
1 - Nonhospital Based Hospice
2 - Hospital Based Hospice
3 - Ambulatory Surgical Center Services to Hospital Patients
4 - Other Rehabilitation Facility (ORF)
5 - Comprehensive Outpatient Rehabilitation Facility (CORF)
6 - Community Mental Health Center (CMHC)

Third Digit of the Bill Type Code - Frequency

The third digit refers to the frequency:

0 - Nonpayment or Zero Claims
1 - Admit Through Discharge Claim
2 - Interim (First Claim)
3 - Interim (Continuing Claims)
4 - Interim (Last Claim)
5 - Late Charge Only
7 - Replacement of Prior Claim or Corrected Claim
8 - Void or Cancel of a Prior Claim
9 - Final Claim for a Home Health PPS Episode

Types of Facilities Using the UB-04

- Community Mental Health Center
- Comprehensive Outpatient Rehabilitation Facility
- Critical Access Hospital

- End-Stage Renal Disease Facility
- Federally Qualified Health Center
- Histocompatibility Laboratory
- Home Health Agency
- Hospice
- Hospital
- Indian Health Services Facility
- Organ Procurement Organization
- Outpatient Physical Therapy Services
- Occupational Therapy Services
- Speech Pathology Services
- Religious Non-Medical Healthcare Institution
- Rural Health Clinic
- Skilled Nursing Facility

Type of Bill (TOB) Codes

Bill Code	Bill Code Description	Part A or B
011X	Hospital Inpatient	Part A
012X	Hospital Inpatient	Part B
013X	Hospital Outpatient	N/A
014X	Hospital Other	Part B
018X	Hospital Swing Bed	N/A
021X	SNF Inpatient	N/A
022X	SNF Inpatient	Part B
023X	SNF Outpatient	N/A
028X	SNF Swing Bed	N/A
032X	Home Health	N/A
033X	Home Health	N/A
034X	Home Health	Part B Only
041X	Religious Nonmedical Health Care Institutions	N/A
071X	Clinical Rural Health	N/A
072X	Clinic ESRD	N/A
073X	Federally Qualified Health Centers	N/A
074X	Clinic OPT	N/A
074X	Clinic CORF	N/A
076X	Community Mental Health Centers	N/A
081X	Nonhospital based hospice	N/A

Bill Code	Bill Code Description	Part A or B
082X	Hospital based hospice	N/A
083X	Hospital Outpatient (ASC)	N/A
085X	Critical Access Hospital	N/A
086X**	Non-Hospital-Based Residential Treatment Centers (Behavioral Health)	N/A

For more information, visit www.cms.gov/Regulations-and-Guidance.

** Billing Expectations for Type of Bill (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:

1. All participating providers submitting outpatient facility claims using TOB 86X.
2. 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
  - 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.

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

Adult Day Healthcare

- Must be billed on a CMS 1500 Claim Form.
- Must be billed in location 99.

Ambulance

- Must be billed in accordance with CMS billing guidelines.
- Appropriate modifiers must be billed with the Transportation Codes.
- 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. Please 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.)
- 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 total number of minutes in field 24G of the CMS 1500 Claim Form and must be submitted with the appropriate modifier.
- Failure to bill total number of minutes may result in incorrect reimbursement or claim denial.
- Anesthesia claims may not be billed that 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 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 Hospital

- Critical Access Hospitals (CAHs) are required to bill with the appropriate bill type.
- Allowed bill types 85x, 11x, 14x, 18x
- 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

- Must be billed on a CMS -1450.
- Bill type must be 32X or 34X.
- Must be billed with location 12.
- Both Rev and CPT codes are required.
- Must bill Q proc code.
- Each visit must be billed individually on 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 payor responsible.
- Services provided to the member on or after their Ambetter effective date should be correctly coded and submitted to Ambetter.

Modifiers

Appropriate uses of 25, 26, 96, 97, CO, CQ, 73, 74, TC, 50, GN, GO, GP, TD, and TE:

- 25 Modifier - should be used when a significant and separately identifiable E&M service is performed by the same physician on the same day of 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.
- Well-Child and sick visit performed on the same day by the same physician. *NOTE: 25 modifiers are not appended to non-E&M procedure codes, e.g., lab.
- 26 Modifier – should never be appended to an office visit CPT code.
- Use 26 modifier to indicate that the professional component of a test or study is performed using the 70000 (radiology) or 80000 (pathology) series of CPT codes.
- Inappropriate use may result in a claim denial/rejection.
- 96/97 Modifier – used for all habilitative services & rehabilitative services. Note: Must be billed in addition to the GN, GO, GP modifier in the secondary position.
- CQ/CO Modifier- used for assistant therapist. Note: Must be billed in addition to the GN, GO, GP (Primary Modifier) 96 & 97 (Secondary Modifier) CQ or CO (Third Modifier Position).
- TC Modifier – used to indicate the technical component of a test or study is performed.
- Inappropriate use may result in a claim denial/rejection
- 50 Modifier – 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 or quantities greater than one should not be billed when using modifier 50
- GN, GO, GP Modifiers – rehabilitative therapy modifiers required for speech, occupational,

and physical therapy. Note: This must be billed in the primary modifier position.

- TD and TE Modifiers - nursing modifiers required for nursing services
- 73 and 74 - Cancelled procedure before and after anesthesia administered (ASC facilities only).

Present on Admission (POA)

- Present on Admission (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

Beginning March 1, 2024, the billing requirements are changing for Reproductive Health Services in the State of Oklahoma. Claims will adjudicate in accordance with state and federal laws. Claims received prior to the date of this publication will require a corrected claim to accurately reflect the service as detailed below. The below information offers further detail on specifics that are required to review and adjudicate the claim appropriately.

The following procedure codes are impacted by these changes:

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

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 physician as life-threatening.

- Procedures that are elective in nature or the result of incest or rape will not be covered.

Supplies

- Physicians 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

- Physicians at the distant site may bill for telemedicine services and MUST utilize the appropriate modifier to identify 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.

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

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 patient. 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 an anesthesia service.

EKG Payment

EKG Interpretation is separately billable and payable from the actual test. However, the first provider to bill receives payment for services.

Physician Site of Service

Physicians will be paid at 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, SNFs, independent clinic, FQHC, Intermediate HC Facility, Comprehensive OP Rehab facility, ESRD Facility, State or Local Health Clinic, RHC, Indy lab, Other POS.

Hospice SIA Payment

Payments for hospice services do not include Service Intensity Add-on payments.

Diagnostic Testing of Implants

Charges and payments for diagnostic testing of implants following surgery is not included in the global fee for surgery and is reimbursable if the testing is outside the global timeframe. If it is inside the global timeframe, it is not reimbursable.

Hospital-Acquired Conditions and Provider Preventable Conditions

Payment to a contracted Provider under the compensation schedule shall comply with state and federal laws requiring reduction of payment or non-payment to a contracted provider 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

Pay Provider lesser of the Providers allowable charges or the contracted rate. Multiple Procedure Rules for Surgery and Endoscopic where multiple outpatient surgical or scope procedures are performed on a member during a single occasion of surgery, reimbursement will be as follows:

- Multiple procedure surgical codes follow Multiple Procedure reimbursement guidelines: 100%/50%/50%, max three surgical codes.

Multiple Procedure Rules for Radiology

- 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 as part of the compensation for professional fees. 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 either modifier 54, 55, or 56 pay the appropriate percentage of the fee schedule payment as identified by the modifier and procedure code used.

Injection Services

Injection service codes must pay separately if no other physician service is paid and when not billed with 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 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 of longer than 13 months. For the month of death or discontinuance of use, contractors pay the full month rental. After 13 months of rental have been 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 for at least 60 days, medical necessity is presumed to continue. Any lapse greater than 60 days triggers new medical necessity.

If the beneficiary 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 patient 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 patient, contractors pay 10 percent 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 months rental.

Appendix IX: EDI Companion Guide Overview

The Companion Guide provides Ambetter trading partners with guidelines for submitting the ASC X12N/005010x222 Health Care Claim: Professional (837P); and ASC X12N/005010x223 Health Care Claim: Institutional (837I). 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 http://store.x12.org.

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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277CA Health Care Claim Acknowledgement

The X12N005010X214 Health Care 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.**

999 Functional Acknowledgement

The 999 Functional Acknowledgement reports on all Implementation Guide edits from the Functional Group and transaction Sets.

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.

Claims Processing

Acknowledgements

Senders receive four types of acknowledgement transactions: the TA1 transaction to acknowledge the Interchange Control Envelope (ISA/IEA) of a transaction; the 999 transaction to acknowledge the Functional Group (GS/GE) and Transaction Set (ST/SE); the 277CA transaction to acknowledge health care claims; and the Ambetter Audit Report. At the claim level of a transaction, the only acknowledgement 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 patient'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) within birthdates 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 patient's birth date cannot be after the patient's 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 on the 837 Professional Claim; however, monetary or unit amount values that are in negative numbers 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; these 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 97 service lines per CMS 1450 (UB-04) claim.
- 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 837P.
- The Value-Added Network Trace Number (2300-REF02) is limited to 30 characters.

Connectivity Media for Batch Transactions

Encryption

Ambetter offers the following methods of encryption SSH/SFTP, FTPS (Auth TLS), FTP w/PGP, HTTPS (Note this method only applies with connecting to Ambetter's Secure FTP. Ambetter does not support retrieval of files automatically via HTTPS from an external source currently.) If PGP or SSH keys are used, they will be shared with the trading partner. These are not required for connecting via SFTP or HTTPS.

Direct Submission

Ambetter also offers posting an 837-batch file directly on the Secure Provider Portal website 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)

Transaction Structure Level	Type of Error or Problem	Transaction or Report Returned
Detail Segments	HIPAA Implementation Guide violations and Ambetter Business Edits	277CA

Duplicate Batch Check

To ensure that duplicate transmissions have not been sent, Ambetter checks five values within the ISA for redundancy:

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.

Note: ISA08 & GS03 could also be the Single Payer ID

Identification Codes and Numbers

General Identifiers

Sender Identifier

The Sender Identifier is presented at the Interchange Control (ISA06) of a transmission. Ambetter expects to see the sender's Federal Tax Identifier (ISA05, qualifier 30) for this value. In special circumstances, Ambetter will accept a "Mutually Defined" (ZZ) value. Senders wishing to submit a ZZ value must confirm this identifier with Ambetter EDI.

Provider Identifiers

National Provider Identifiers (NPI)

HIPAA regulation mandates that providers 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 will need to be reported in the Rendering Provider Loop (2310B or 2420A) You should only use 2420A when it is different than 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 number, however, if an Atypical Provider has been assigned an NPI, then they need to follow the same requirements as a medical provider. An Atypical Provider which provides non-medical services is not required to have an NPI number (i.e., carpenters, transportation, etc.). Existing Atypical Providers need only send the Provider Tax ID in the REF segment of the Billing Provider loop. *NOTE: 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).

New Trading Partners

New trading partners should access https://sites.edifecs.com/index.jsp?Ambetter, register for access, and perform the steps in the Ambetter trading partner program. The EDI Support Desk (EDIBA@Ambetter.com) will contact you with additional steps necessary upon completing your registration.

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 Health Care 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.

TA1 Interchange Acknowledgement

The TA1 Interchange Acknowledgement provides senders a positive or negative confirmation of the transmission of the ISA/IEA Interchange Control.

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 of Oklahoma 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 of Oklahoma, 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)).

Delaware

STATE REGULATORY REQUIREMENTS

DE-1 Midwife Services Reimbursement (18 Del. C. §3336). Policies providing reimbursement for midwife services or for the cost of birthing facilities, allow the insured or any other covered person to reimbursement for those services or use of the facilities performed by midwife nurse. Whenever these services are performed and reimbursed by a health plan corporation, the nurse midwife is entitled to participation, plan admission and registration in the health plan comparable to a physician or osteopath performing the same service. When payment is made to a nurse midwife for services performed, no payment is payable to a physician or osteopath for the same services performed.

DE-2 Lead Poisoning Screening (18 Del. C. §3337). Individual health insurance policies which provide a benefit for outpatient services shall provide a benefit for a baseline lead poisoning screening or testing. Benefits must also be provided for lead poisoning screening, testing, diagnostic evaluations, screening and testing supplies, and home-visits for children who are at high risk for lead poisoning under guidelines and criteria established by the Division of Public Health. These benefits are a covered service, notwithstanding any policy exclusions for services which are part of or related to annual or routine examinations.

DE-3 Cancer Monitoring Test (18 Del. C. §3338). Individual health policies which provide benefits for outpatient services, must provide a benefit for CA-125 monitoring of ovarian cancer subsequent to treatment. This monitoring shall be a covered service, notwithstanding any policy exclusions for services which are considered experimental or investigative; provided however, that nothing herein shall be deemed to provide coverage for routine screening.

DE-4 Equal Reimbursement for Oral and Intravenous Anticancer Medication (18 Del. C. §3338A). Every individual health insurance policy that provides coverage for anticancer medication, must also provide coverage for orally administered anticancer medication used to kill or slow the growth of cancerous cells, and must apply the lower cost sharing of either anticancer medication under the prescription drug benefit; or intravenous or injected anticancer medications.

DE-5 Obstetrical and Gynecological Coverage (18 Del. C. §3342). All individual health insurance policies must include coverage for fertility care services, including in vitro fertilization services for individuals who suffer from a disease or condition that results in the inability to procreate or to carry a pregnancy to live birth and standard fertility preservation services for individuals who must undergo medically necessary treatment that may cause iatrogenic infertility. Benefits must be provided to covered individuals, including covered spouses, and covered non spouse dependents the same as other pregnancy-related benefits and include In vitro fertilization ("IVF"), including IVF using donor eggs, sperm, or embryos, and IVF where the embryo is transferred to a gestational carrier or surrogate. Policies cannot impose any exclusions, limitations, or other restrictions on coverage of fertility medications that are different from any other prescription medications. Policies cannot impose deductibles, copayments, coinsurance, benefit maximums, waiting periods, or any other limitations on coverage for fertility care services that are different from benefits unrelated to infertility.

DE-6 Contraceptive coverage (18 Del. C. §3342A). Coverage is required for all FDA-approved contraceptive drugs, devise and other products as defined per this section. Coverage offered under this section may not impose unreasonable restrictions or delays except that reasonable medical management techniques may be applied to coverage within a method category, as defined by the FDA, but not across types of methods. Coverage is not subject to any deductible, coinsurance, copayment, or any other cost-sharing requirement except for therapeutic equivalents and per this section.

DE-7 Primary care coverage (18 Del. C. § 3342B). Primary care coverage [For application of this section, see 81 Del. Laws, c. 392, § 12] [Effective until Jan. 1, 2027].
Insurers are required to provide coverage for chronic care management and primary care at a comparable reimbursement rate of the Medicare reimbursement for comparable services. Carriers are mandated to do the following until 1/1/2027:

- By 2022, spend at least 7% of its total cost of medical care on primary care.
- By 2023, spend at least 8.5% of its total cost of medical care on primary care.
- By 2024, spend at least 10% of its total cost of medical care on primary care.
- By 2025, spend at least 11.5% of its total cost of medical care on primary care.

DE-8 Serious mental illness and drug and alcohol dependency (18 Del. C. §3343). Coverage shall be provided for serious mental illnesses and drug and alcohol dependencies per statutory requirements. Coverage for these benefits must be treated as any other illness or disease covered by the health benefit plan. This includes terms for deductibles, co-pays, monetary limits, coinsurance

factors, limits in the numbers of visits, limits in the length of inpatient stays, durational limits, or limits in the coverage of prescription medicines.

DE-9 Diabetes (18 Del. C. §3344). Policy must provide benefits to covered persons for expenses for the following equipment and supplies for the treatment of diabetes, if recommended in writing or prescribed by a physician: insulin pumps, blood glucose meters and strips, urine testing strips, insulin, syringes, and pharmacological agents for controlling blood sugar.

DE-10 Cost Sharing in Prescription Insulin Drugs (18 Del. C. §3344B). Provides for coverage for prescription insulin drugs and following requirements:

- Cap at $100/month for insulin drugs regardless of the amount or types of insulin needed to fill the prescriptions. Cap includes deductible payments and cost-sharing amounts charged once a deductible is met.
- Include at least 1 formulation of each of the following types of prescription insulin drugs on the lowest tier of the drug formulary developed and maintained by the carrier;
    - Rapid acting.
    - Short acting.
    - Intermediate acting.
    - Long acting.

DE-11 Coverage for Insulin Pumps (18 Del. C. §3344C). All individual health insurance policies must provide coverage for a medically necessary insulin pump at no cost including deductible payments and cost-sharing amounts charged once a deductible is met.

DE-12 Cost Sharing in Diabetes Equipment and Supplies (18 Del. C. §3344D). Insurers providing coverage for any diabetes equipment or supplies must cap the total monthly amount at $35 for diabetes equipment and supplies, regardless of the amount or types of diabetes equipment or supplies needed to fill the prescriptions. The $35 per month cap includes deductible payments and cost-sharing amounts charged once a deductible is met, exception includes high-deductible health plans or catastrophic health plans.

DE-13 Pap Smear (18 Del. C. §3345). All individual health insurance policies must provide a benefit for an annual benefit for 1 cervical cancer screening, known as a "pap smear," for all females aged 18 and over.

DE-14 Colorectal screening (18 Del. C. §3346) Colorectal cancer screening is required and includes individuals 50 years or older with annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging or other screening modalities. Colorectal cancer screening must include the use of medically necessary anesthetic agents, including general anesthesia, in connection with colonoscopies and endoscopies performed in accordance with medical practice standards and patient safety laws and regulations.

DE-15 Reconstructive surgery following mastectomies (18 Del. C. §3347). Insurers must provide coverage to an insured who is receiving benefits in connection with such mastectomy for all stages of reconstruction of the breast on which the mastectomy has been performed; surgery

and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications of mastectomy, including lymphedemas. Coverage may be subject to annual deductibles and coinsurance provisions.

DE-16 Emergency care (18 Del. C. §3349) Coverage shall include emergency care services performed by nonnetwork providers at an agreed-upon or negotiated rate, regardless of whether the physician or provider furnishing the services. If a rate cannot be agreed upon, the provider shall be entitled to those charges and rates allowed by the DOI following an arbitration of the dispute.

In the interim and prior to DOI's decision of charges and rates allowed by emergency service providers, insurers pay directly to the non-network emergency care provider the highest allowable charge for each emergency care service allowed by the insurer for any other network or non-network emergency care provider during the full 12-month period immediately prior to the date of each emergency care service performed by the non-network provider.

DE-17 Volunteer ambulance services (18 Del. C. §3349A) Every individual health insurance policy must include coverage for the cost of every ambulance run and associated basic life support (BLS) services provided by a volunteer ambulance company, inclusive of an allowance for uncompensated service such as an allowable charge; 100% payment; or any combination thereof. The volunteer ambulance company is entitled to charges and rates allowed by the DOI following arbitration.

DE-18 Copayment or coinsurance for prescription drugs limited (18 Del. C. §3350B) Insurer may not impose a copayment or coinsurance requirement for a covered prescription drug that exceeds the lesser of one of the following: (1) applicable copayment or coinsurance; (2) amount an individual would pay for the prescription drug if the individual were paying the usual and customary price; and (3) contract price for the prescription drug. Cost-sharing shall be applied with health savings account exception (after min. deductible met).

DE-19 Clinical trials (18 Del. C. §3351) Every policy in this regulatory section must provide for coverage for routine patient care costs for covered persons engaging in clinical trials for treatment of life-threatening diseases subject to certain further requirements within the statute. Coverage for expenses of such clinical trials which are otherwise not covered under the policy or contract is not required.

DE-20 Newborn children (18 Del. C. §3335) The coverage for newly born children shall consist of coverage for injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities as well as routine care furnished any infant from the moment of birth. If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of the birth of a newly born child, and payment of the required premium or fees, must be furnished to the insurer or nonprofit service or indemnity corporation within 31 days after the date of birth in order to have the coverage continued beyond such 31-day period.

DE-21 Newborn and infant hearing screening (18 Del. C. §3352) Coverage for children must include coverage for hearing loss screening tests of newborns and infants provided by a hospital before discharge. The reimbursement amount must be consistent with reimbursement of other medical expenses.

DE-22 Phenylketonuria and other inherited metabolic diseases (18 Del. C. §3355) A health insurance contract shall include coverage under the family member coverage for medical formulas and foods and low protein modified formulas and modified food products for the treatment of inherited metabolic diseases, if medically necessary and administered under the direction of a physician.

DE-23 Scalp hair prosthesis (18 Del. C. §3356) Mandated coverage is required for expenses for a scalp hair prosthesis worn for hair loss suffered as a result of alopecia areata, resulting from an autoimmune disease. Coverage is subject to the same limitations and guidelines as other prostheses, provided that such coverage for alopecia areata shall not exceed $500 per year. Coverage may be subject to annual deductibles and co-insurance provisions.

DE-24 Hearing aid coverage (18 Del. C. §3357) Mandated coverage is required up to $1,000 per individual hearing aid, per ear, every 3 years, for children less than 24 years of age, covered as a dependent by the policy holder. The insured may choose a hearing aid exceeding $1,000 and pay the difference in cost above the amount of coverage required by this section. Insurers may require the policyholder to provide a prescription or show proof of the need for a hearing aid.

DE-25 Dental services for children with severe disabilities (18 Del. C. §3358) Every contract or policy that covers dental services for children shall authorize payment to providers for dental services to a child with a severe disability regardless of contract or network status. Unless otherwise negotiated with the practitioner in advance, the payment will be an amount comparable to the same or similar services in the same geographical area. Nonnetwork practitioners cannot balance bill the insured.

DE-26 Screenings of infants and toddlers (18 Del. C. §3360) Health insurance policies must provide covered children with developmental screenings at ages 9 months, 18 months, and 30 months.

DE-27 Specialty tier prescription coverage (18 Del. C. §3364) Health plan that provides coverage for prescription drugs and utilizes a specialty drug tier must not exceed $150/month for a 30-day supple of any single specialty drug if the drug is on a specialty tier.

DE-28 School-based health centers (18 Del. C. §3365) Benefits provided under insurance contracts delivered, issued for delivery, or renewed in the state shall reimburse SBHCs for covered services provided by SBHCs as if those services were provided by a network provider under the relevant contract of insurance. In the absence of an agreement between a carrier and an SBHC on reimbursement, reimbursement for such services shall be at the rate established by

the Division of Medicaid and Medical Assistance for those services. The services SBHCs are to provide are listed in this section.

DE-29 Autism (18 Del. C. §3366) Individual health benefit plans must provide coverage for the screening and diagnosis of autism spectrum disorders for individuals less than 21 years of age. Insurers cannot terminate coverage or refuse to issue, amend, or renew coverage solely because the individual or a family member is diagnosed with 1 of the autism spectrum disorders or has received treatment for autism spectrum disorders. Coverage for applied behavior analysis services has a maximum benefit of $36,000 per 12-month period per person. Coverage must be comparable to cost-sharing requirements that apply to physical illness under the health benefit plan, except for treatment unrelated to applied behavior analysis. An insurer may request a review of that treatment once every 12 months unless the insurer and the licensed physician or licensed psychologist agree upon more frequent review and per statutory requirements. The insurer will absorb the cost of obtaining any review.

DE-30 Telehealth and telemedicine (18 Del. C. §3370) Reimbursement to treating or consulting providers for the diagnosis, consultation, or treatment of the insured through telemedicine must be comparable to the same rate that the insurer reimburses through in-person consultation.

DE-31 Coverage for epinephrine autoinjectors (18 Del. C. §3370D) Individual health insurance policies must provide coverage for medically necessary epinephrine autoinjectors for individuals who are at least 18 years old by including at least 1 formulation of epinephrine autoinjectors on the lowest tier of the drug formulary.

DE-32 Annual behavioral health well check [Effective Jan. 1, 2024] All carriers shall provide coverage of an annual behavioral health well check and shall be reimbursed through the common procedural terminology (CPT) codes at the same rate that such CPT codes are reimbursed for the provision of other medical care, provided that reimbursement may be adjusted for payment of claims that are billed by a nonphysician clinician so long as the methodology to determine such adjustments is comparable to and applied no more stringently than the methodology for adjustments made for reimbursement of claims billed by nonphysician clinicians for other medical care, in accordance with 45 CFR § 146.136(c)(4).

DE-33 Chiropractic Care The chiropractor is entitled to compensation for that chiropractor's services under the plan or contract and reimbursed at Medicare rate or comparable. The plan or contract may not have annual or lifetime numerical limits on chiropractic visits for the treatment of back pain. The plan or contract may not deny coverage for chiropractic supportive care on the basis that the chiropractic supportive care constitutes maintenance therapy.

DE-34 Physical Therapy If a physical therapist is authorized by law to perform a particular service, the physical therapist is entitled to compensation for that physical therapist's services under such plans and contracts, and such plans and contracts may not have annual or lifetime numerical limits on physical therapy visits for the treatment of back pain. See also 1321-5.0. Unreasonable and Discriminatory Access to Physical Therapy Care or Services Prohibited.

DE-35 Payment for emergency medical services (18 Del. C. §3367) The limitations on balance billing provided in 18 Del. C. §3348 do not apply to billing for emergency medical services within this section provided by volunteer fire companies or emergency medical services provider agencies certified by the Delaware State Fire Prevention Commission.

DE-36 Renewability of coverage (18 Del. C. §3608) A health benefit plan may be discontinued only if the carrier provides notice within 90 days to all individuals of the decision not to renew coverage in each state in which insured lives. Notice to the Commissioner must be provided at least 3 working days prior to the notice to the individuals, and the individuals have an option to purchase other health benefit plans currently being offered by the carrier to individuals in the state.

DE-37 Coverage for Primary Care and Chronic Care Management Services- Incentive Programs 18 Del. Admin. Code § 1322-5.0 A carrier shall reimburse a contracted primary care provider, the provider's care team, and organizations for primary care and chronic care management services on a non-fee-for-service basis by offering the opportunity to participate in one or more primary care incentive programs. *See* statute.

DE-38 Network disclosure and transparency (18 Del. C. §3370A) In addition to existing standards, the state Exchange requires Issuers offering Value Network Plans to meet additional state standards. *See* statute for reference.

DE-39 Telehealth and telemedicine (18 Del. C. §3370) Insurers must reimburse the treating provider or the consulting provider for the diagnosis, consultation, or treatment of the insured through telemedicine services on the same basis and rates that the insurer applies to the same service through in-person consultation or contact. Payment for telemedicine interactions includes reasonable compensation to the originating or distant site for the transmission cost incurred during the delivery of health-care services.

DE-40 Rating factors (18 Del. C. §3613) The rate may vary with respect to the particular plan or coverage involved. See statute for specifics. The rate established must not vary with respect to the particular plan or coverage involved by any other factor not described in this subsection. A health insurer must charge the same premium rate without regard to whether the plan is offered through the state health exchange or whether the plan is offered directly from the health insurer or through an agent. All health insurers offering health plans in the individual market shall use a single rating area that applies to the entire State. *See* additional rating factors found in Rating factors (18 Del. C. §3613) 2023 Medical Issuer QHP Submission Guide.

DE-41 Unfair or Deceptive Acts or Practices Defined 18 Del. C. §2301-20.

DE-42 Accident and Sickness Insurance Advertisements 18 Del. Admin. C. §1302 An advertisement shall not create the impression directly or indirectly that the insurer, its financial condition or status, or the payment of its claims, or the merits, desirability, or advisability of its policy forms or kinds or plans of insurance are approved, endorsed, or accredited by any division or agency of this State or the United States Government.

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.
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 Hampshire

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.

NH-1 Notice of Changes. Each Participating Provider shall notify the Health Plan of changes in the status of any items listed in N. H. REV. STAT. § 420-J:4 at any time. The Provider Manual should be consulted for the appropriate individual or department of Health Plan to whom such change should be reported. (N. H. REV. STAT. §420-J:4. (IV)).

NH-2 Hold Harmless. Each Participating Provider agrees that in no event, including but not limited to nonpayment by the Payor, insolvency of the Payor, or breach of the Agreement or this Product Attachment, shall the Participating Provider bill, charge, collect a deposit from, seek payment or reimbursement from, or have recourse against a Covered Person or a person acting on behalf of the Covered Person (other than the Payor) for services provided pursuant to the Agreement and this Product Attachment. Neither the Agreement nor this Product Attachment prohibit the Participating Provider from collecting coinsurance, deductibles, or copayments, as specifically provided in the Coverage Agreement, or fees for services that are not Covered Services delivered on a fee-for-service basis to Covered Persons. Nor does the Agreement or this Product Attachment prohibit the Participating Provider and a Covered Person from agreeing to continue services solely at the expense of the Covered Person if the Participating Provider has clearly informed the Covered Person that the Payor may not cover or continue to cover a specific service or services. Except as provided in this Section, neither the Agreement nor this Product Attachment prohibit the Participating Provider from pursuing any available legal remedy. Each Participating Provider further agrees that: (a) this Section will survive the termination of the Agreement or its, their participation under 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 Section supersedes any oral or written contrary agreement now existing or hereafter entered between the Participating Provider and a Covered Person or persons acting on their behalf. Any modifications, additions or deletions to this Section will become effective on a date no earlier than fifteen (15) business days after the Commissioner has received written notice of such proposed changes. (N. H. REV. STAT. § 420-J:8(I)).

NH-3 Fee Schedule Changes. Health Plan shall not make a material change to the Compensation Schedule set forth at Exhibit 2 to this Product Attachment without providing the Participating Provider with at least sixty (60) days' notice prior to the effective date of such change. (N. H. REV. STAT. § 420-J:8(VIII)(d)).

NH-4 Participating in Reviews. Health Plan shall not remove the Participating Provider from its network or refuse to renew the Participating Provider with its network for participating in a Covered Person's internal grievance procedure or external review. (N. H. REV. STAT. § 420-J:8(X)).

NH-5 Continuity of Care. Each Participating Provider shall continue to provide Covered Services to Covered Persons for a period of sixty (60) days following the date of termination of the Agreement or its, their participation under this Product Attachment, except if such termination is for unprofessional behavior. Each Participating Provider agrees that such services will be provided and

paid for in accordance with the terms and conditions of the Covered Person's Coverage Agreement and the Agreement and this Product Attachment. (N. H. REV. STAT. § 420-J:8(XI)).

NH-6 Referrals. Each Participating Provider acknowledges that neither the Agreement nor this Product Attachment requires any Participating Provider that is employed by a hospital or any affiliate to refer patients to providers also employed or under contract with the hospital or any affiliate. Nothing in this Section will be construed to prohibit the Payor from providing coverage for only those services that are Medically Necessary and subject to the terms and conditions of the Covered Person's Coverage Agreement. (N. H. REV. STAT. § 420-J:8(XIV).

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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