Ambetter
from Superior HealthPlan

Provider Training

6/8/2020

Agenda

- Overview
- Verification of Eligibility, Benefits and Cost Shares
- Prior Authorization
- Complaints and Appeals
- Claims
- Provider Resources
- Contact Information
- Questions

Overview

The Affordable Care Act

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Key Objectives of the Affordable Care Act (ACA):

- Increase access to quality health insurance.
- Improve affordability.

Additional Parameters:

- Dependent coverage to age 26
- Pre-existing condition insurance plan (high-risk pools)
- No lifetime maximum benefits
- Preventive care covered at 100%
- Insurer minimum loss ratio (80% for individual coverage)

The Affordable Care Act

Reform the commercial insurance market – Marketplace or Exchanges:

- No more underwriting – guaranteed issue
- Minimum standards for coverage:
  - Benefits and cost sharing limits
- Subsidies for lower incomes (100% - 138% FPL)
- Learn more at www.healthcare.gov/.

Health Insurance Marketplace

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Subsidies come in the form of:

- Advanced Premium Tax Credits (APTC)

All plans have cost shares in the form of copays, coinsurance and deductibles:

- Some members will qualify for assistance with their cost shares based on their income level.
- This assistance would be paid directly from the government to Ambetter.

Health Insurance Marketplace

- The Health Insurance Marketplace is the only way to purchase insurance and receive subsidies. Exchanges may be state-based, federally facilitated or state partnership. Texas is a Federally Facilitated Marketplace.
- Health Insurance Marketplace is the only online marketplace for purchasing health insurance.
- Potential members can:
  - Register.
  - Determine eligibility for all health insurance programs (including Medicaid).
  - Shop for plans.
  - Enroll in a plan.

Ambetter's Footprint

Ambetter operates in 20 states across the country:

- Arizona, Arkansas, California, Florida, Georgia, Illinois, Indiana, Kansas, Mississippi, Missouri, Nevada, New Hampshire, New York, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee, Texas and Washington

Every year Ambetter expands its footprint in Texas.

- In 2014 Ambetter launched in just 11 counties.
- In 2020, Ambetter will serve 48 counties in the state of Texas.

Ambetter Counties in Texas

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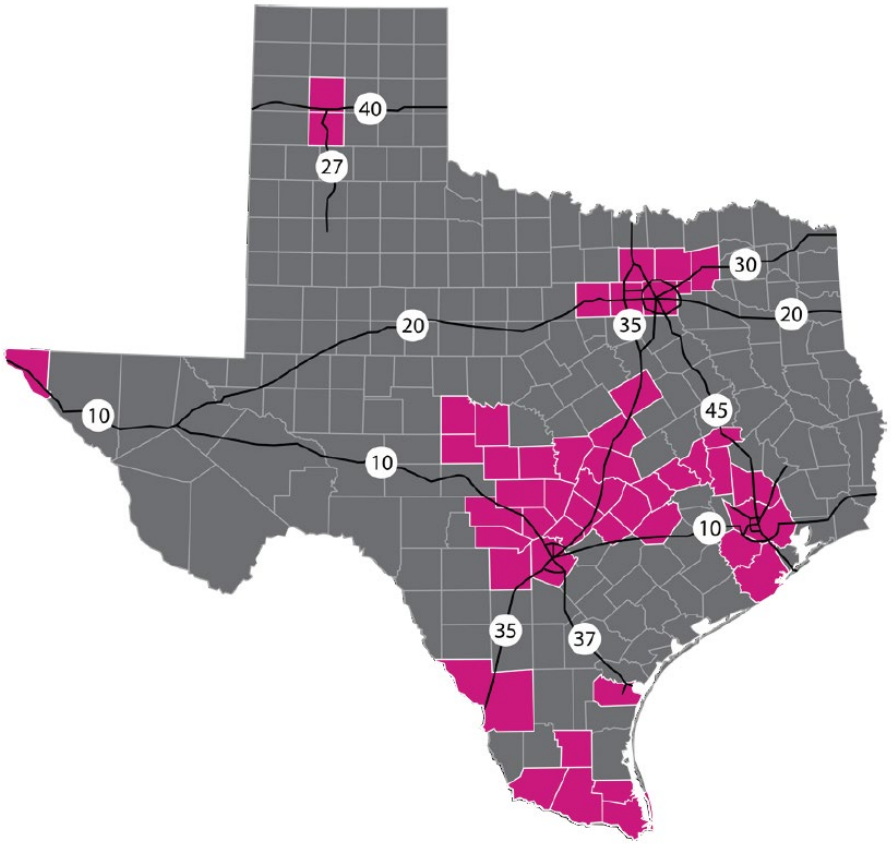
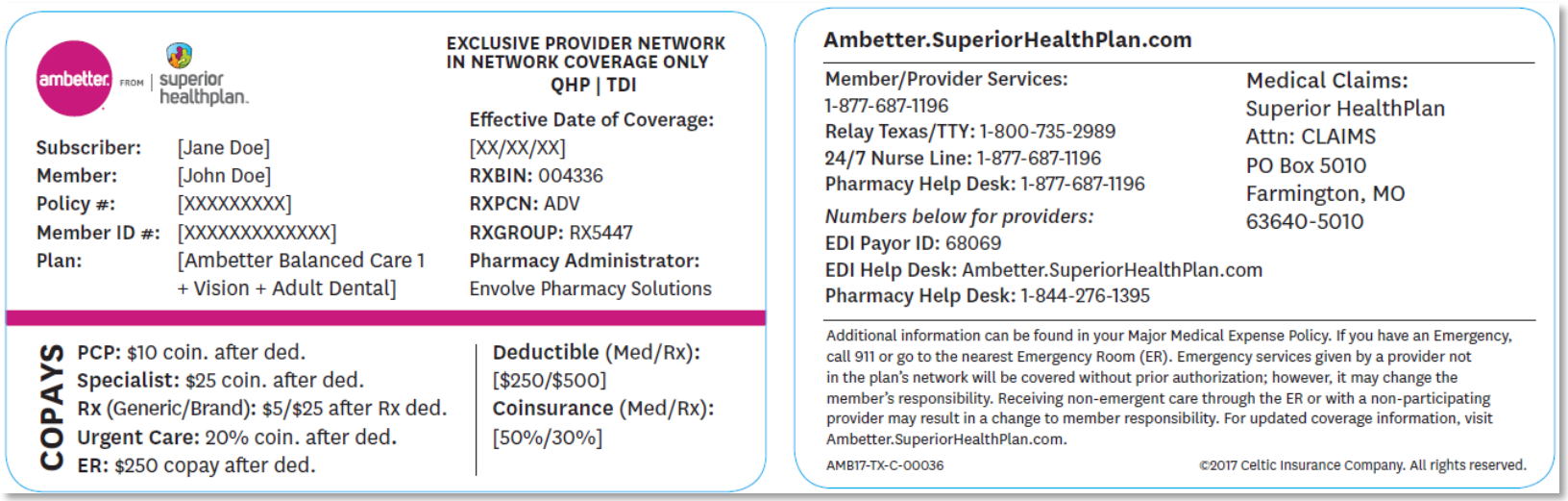
Coverage is available in the following counties:

Bandera, Bastrop, Bell, Bexar, Blanco, Brazoria, Brazos, Brooks, Burleson, Burnet, Caldwell, Cameron, Collin, Comal, Concho, Dallas, Denton, El Paso, Fayette, Fort Bend, Gillespie, Grimes, Harris, Hays, Hidalgo, Hunt, Kendall, Kerr, Lee, Llano, Madison, Mason, McCulloch, McLennan, Medina, Menard, Montgomery, Nueces, Parker, Potter, Randall, Rockwall, Starr, Tarrant, Travis, Webb, Willacy, Williamson



Member ID Card

Member ID Card:



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EXCLUSIVE PROVIDER NETWORK
IN NETWORK COVERAGE ONLY
QHP | TDI

Subscriber: [Jane Doe]
Member: [John Doe]
Policy #: [XXXXXXXXX]
Member ID #: [XXXXXXXXXXXX]
Plan: [Ambetter Balanced Care 1 + Vision + Adult Dental]

Effective Date of Coverage: [XX/XX/XX]
RXBIN: 004336
RXPCN: ADV
RXGROUP: RX5447
Pharmacy Administrator: Envolve Pharmacy Solutions

COPAYS
PCP: $10 coin. after ded.
Specialist: $25 coin. after ded.
Rx (Generic/Brand): $5/$25 after Rx ded.
Urgent Care: 20% coin. after ded.
ER: $250 copay after ded.

Deductible (Med/Rx): [$250/$500]
Coinsurance (Med/Rx): [50%/30%]

Ambetter.SuperiorHealthPlan.com

Member/Provider Services:
1-877-687-1196
Relay Texas/TTY: 1-800-735-2989
24/7 Nurse Line: 1-877-687-1196
Pharmacy Help Desk: 1-877-687-1196

Numbers below for providers:
EDI Payor ID: 68069
EDI Help Desk: Ambetter.SuperiorHealthPlan.com
Pharmacy Help Desk: 1-844-276-1395

Medical Claims:
Superior HealthPlan
Attn: CLAIMS
PO Box 5010
Farmington, MO
63640-5010

Additional information can be found in your Major Medical Expense Policy. If you have an Emergency, call 911 or go to the nearest Emergency Room (ER). Emergency services given by a provider not in the plan's network will be covered without prior authorization; however, it may change the member's responsibility. Receiving non-emergent care through the ER or with a non-participating provider may result in a change to member responsibility. For updated coverage information, visit Ambetter.SuperiorHealthPlan.com.

AMB17-TX-C-00036

Note: Possession of an ID Card does not guarantee eligibility and benefits.

Health Insurance Marketplace

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Providers should always verify member eligibility:

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

Eligibility verification can be completed by:

- Visiting the Secure Provider Portal.
  - Provider.SuperiorHealthPlan.com
- Calling Provider Services.
  - 1-877-687-1196
- Utilizing the 24/7 Interactive Voice Response system.
  - 1-800-964-2777
  - Enter the member ID and the month of service to check eligibility.

Health Insurance Marketplace

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PCP Selection and Panel Status:

- Ambetter emphasizes to members the importance of establishing a medical home (better care, greater appointment availability, consistent care, etc.). Part of that is the selection of a Primary Care Provider (PCP).

- While members may see any provider they choose, Ambetter encourages providers to emphasize the importance of the medical home relationship to members.

- PCPs can still administer service if the member is not assigned to them and may wish to have member assigned to them for future care.

- PCPs should confirm that a member is assigned to their patient panel.
  - This can be done through the Secure Provider Portal.

Verification of Eligibility, Benefits and Cost Shares

Verification of Eligibility, Benefits and Cost Shares

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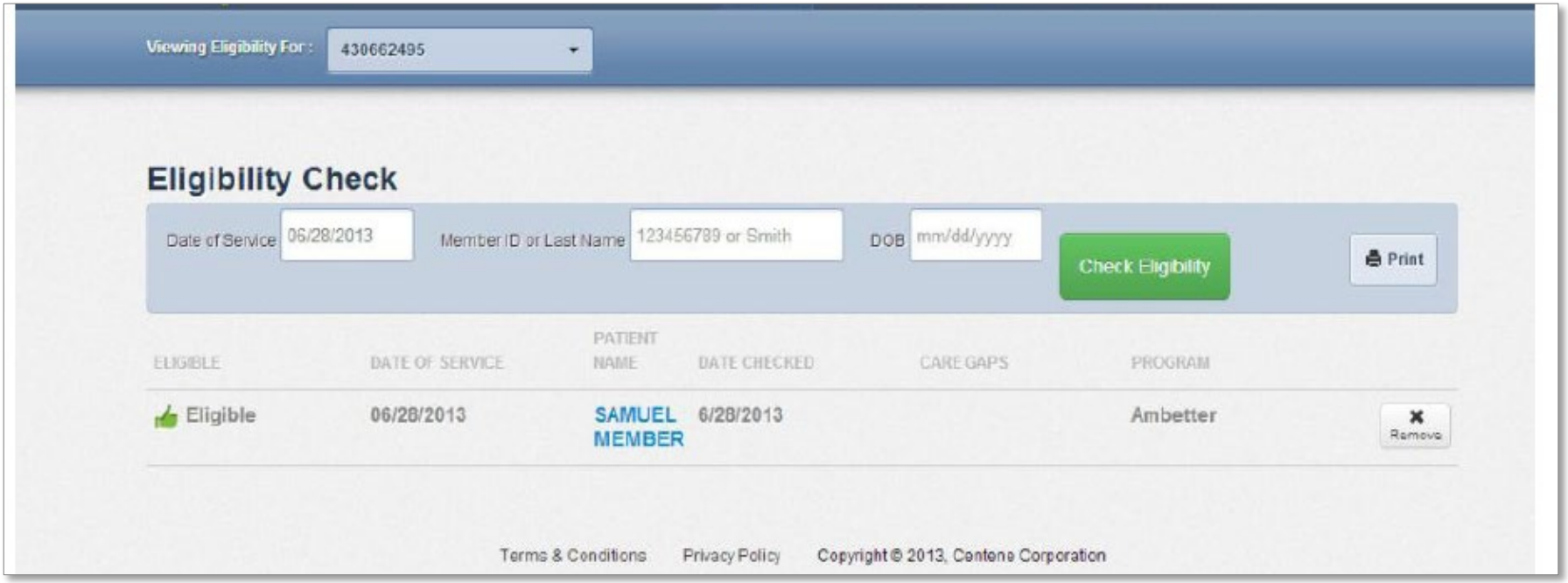
Eligibility, Benefits and Cost Shares can be verified in 3 ways:

1. Visit the Secure Provider Portal found at Provider.SuperiorHealthPlan.com.
   - If you are already a registered user of the Secure Provider Portal, you do not need a separate registration.

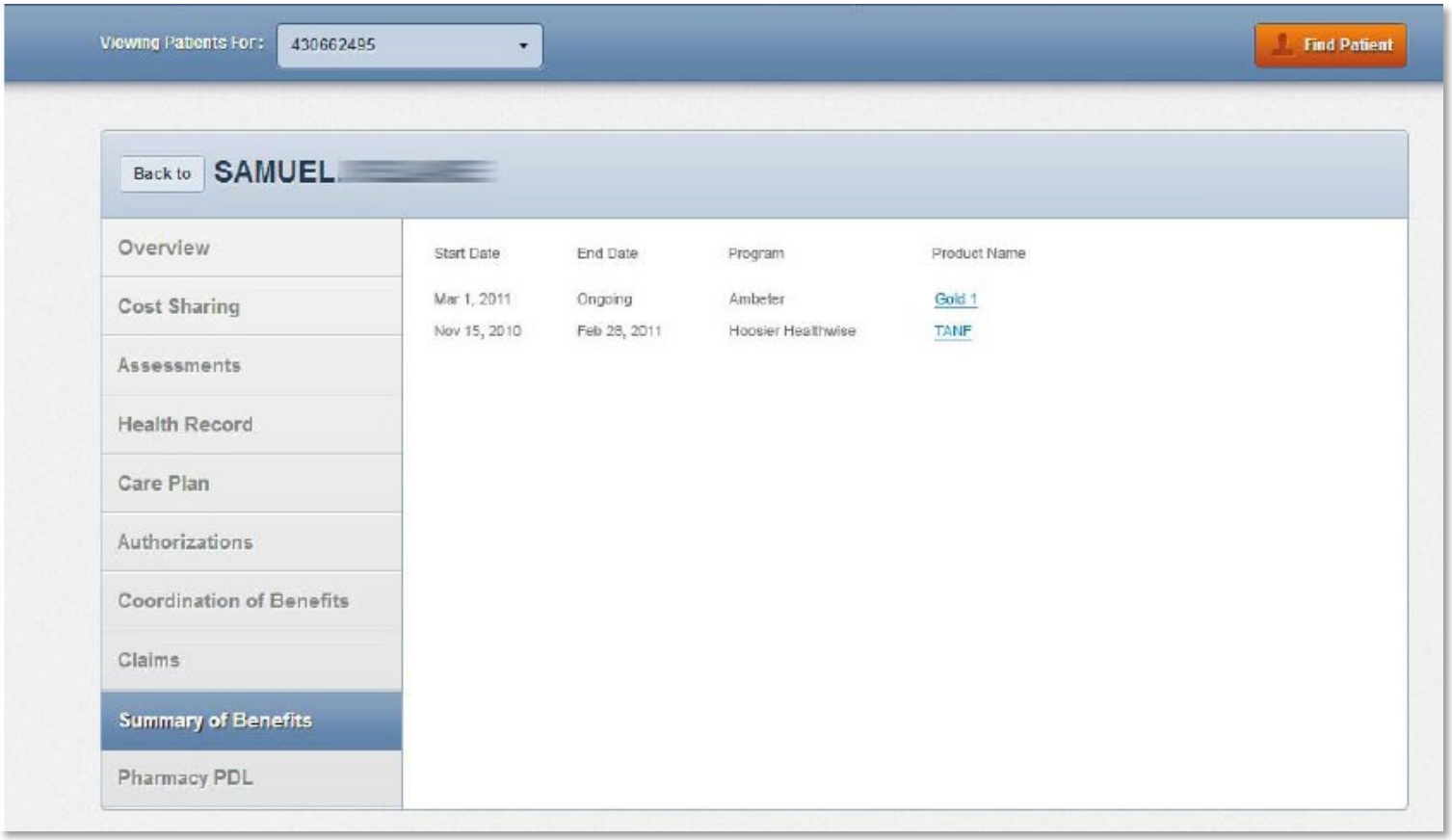
2. Utilize the 24/7 Interactive Voice Response system at 1-800-964-2777.
   - Enter the Member ID Number and the month of service to check eligibility.

3. Contact Provider Services at 1-877-687-1196.
   - Available Monday – Friday, 8:00 a.m. – 6:00 p.m. CST.

Verification of Eligibility



Verification of Benefits



Verification of Cost Shares

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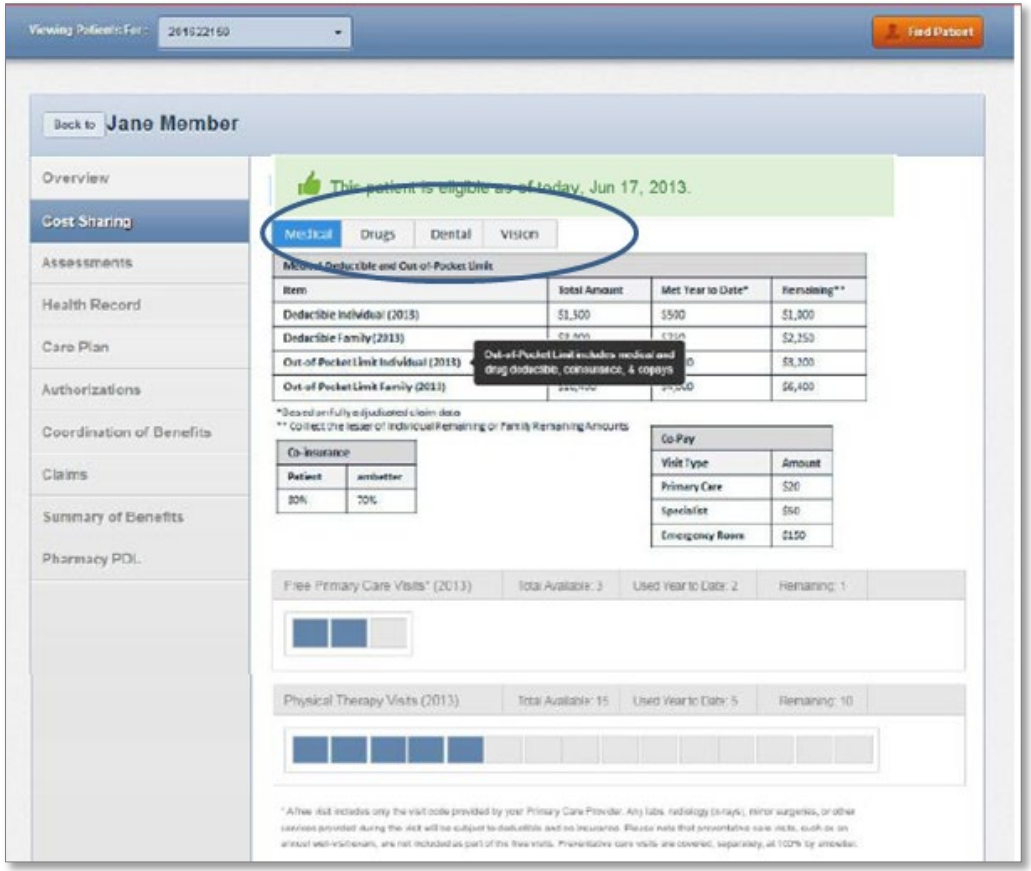

Prior Authorization

Specialty Referrals

- Members are educated to seek care or consultation with their PCP first.
- When medically necessary care is needed beyond the scope of what a PCP provides, PCPs should initiate and coordinate the care members receive from specialist providers.
- Paper referrals are not required for members to seek care with in-network specialists.

Prior Authorization

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Procedures / Services*:

- Potentially Cosmetic
- Experimental or Investigational
- High-Tech Imaging (i.e., CT, MRI, PET)
- Infertility
- Obstetrical Ultrasound
  - Two allowed in a nine month period. Any additional ultrasounds will require prior authorization (unless rendered by a Perinatologist).
  - For urgent/emergent ultrasounds, treat using best clinical judgment and authorizations will be reviewed retrospectively.
- Pain Management

**Please note: This is not meant to be an all-inclusive list and exclusions apply.*

Prior Authorization

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Inpatient Authorization*:

- All elective/scheduled admission notifications requested at least 5 business days prior to the scheduled date of admit including:
  - All services performed in out-of-network facilities.
  - Behavioral health/substance use.
  - Hospice care.
  - Rehabilitation facilities.
  - Transplants, including evaluation.
- Observation stays exceeding 23 hours require Inpatient Authorization.
- Urgent/Emergent Admissions
  - Within one business day following the date of admission.
  - Newborn deliveries must include birth outcomes.
- Partial Inpatient, Psychiatric Residential Treatment Facility (PRTF) and/or Intensive Outpatient Programs

**This is not meant as an all-inclusive list.*

Prior Authorization

Ancillary Services*:

- Air Ambulance Transport
- Durable Medical Equipment (DME)
- Hearing Aid Devices (including cochlear implants)
- Genetic Testing
- Quantitative Urine Drug Screen
- Orthotics/Prosthetics
- Home Health Care Services (including Home Infusion Skilled Nursing and Therapy)
  - Home Health Services
  - Private Duty Nursing
  - Adult Medical Day Care
  - Hospice
  - Furnished Medical Supplies and DME
  - Occupational Therapy
  - Physical Therapy
  - Speech Therapy

**This is not meant to be an all-inclusive list. As a reminder, Ambetter has no out-of-network benefits or coverage unless prior authorization is obtained.*

Prior Authorization

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Service Type*	Timeframe
Scheduled admissions	Prior Authorization required 5 business days prior to the scheduled admission date.
Elective outpatient services	Prior Authorization required 5 business days prior to the elective outpatient admission date.
Emergent inpatient admissions	Notification within 1 business day.
Observation – 48 hours or less	Notification within 1 business day for non-participating providers.
Observation – greater than 48 hours	Requires inpatient prior authorization within 1 business day.
Emergency room and post stabilization, urgent care and crisis intervention	Notification within 1 business day.
Maternity admissions	Notification within 1 business day.
Newborn admissions	Notification within 1 business day.
Neonatal Intensive Care Unit (NICU) admissions	Notification within 1 business day.
Outpatient Dialysis	Notification within 1 business day.

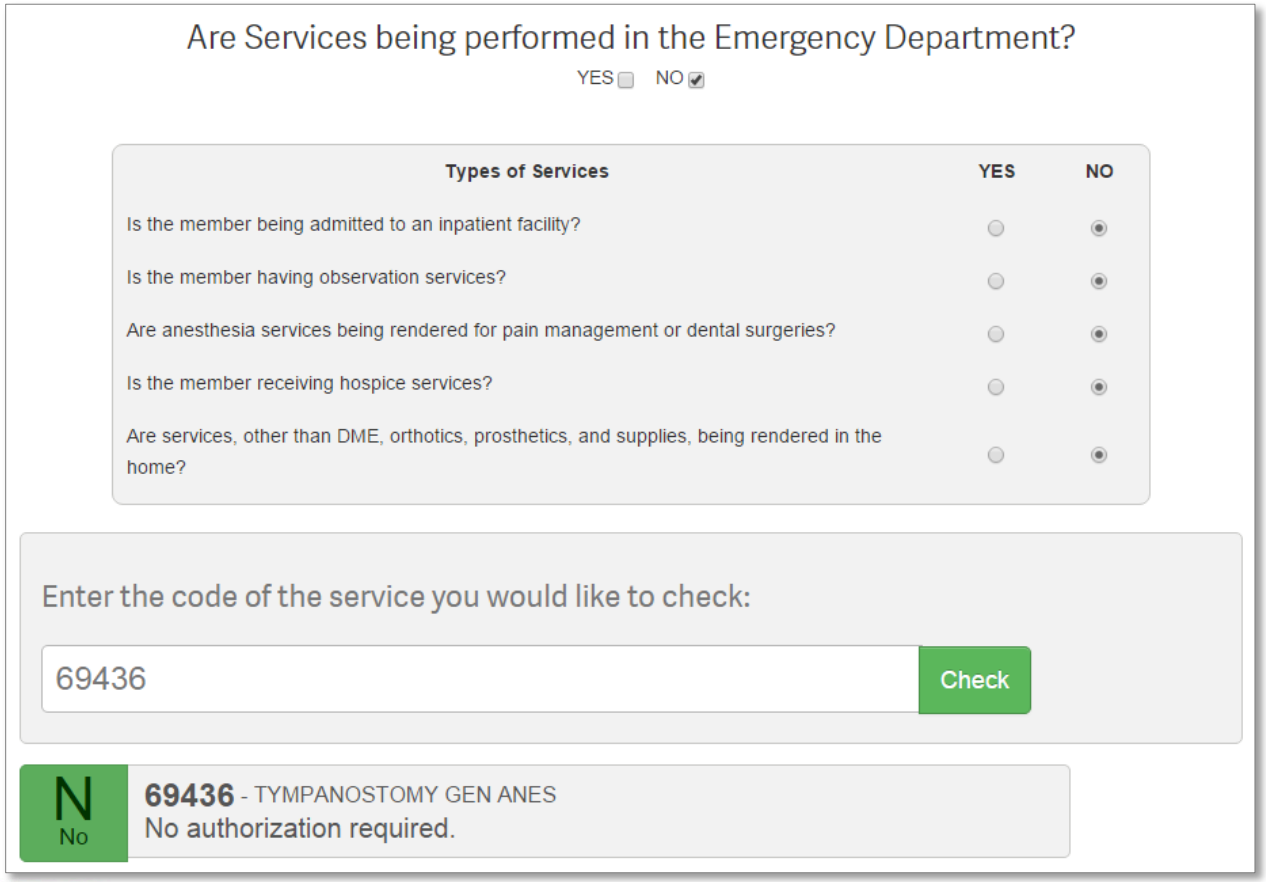
** This is not meant to be an all-inclusive list.*

Utilization Determination Timeframes

Type*	Timeframe
Prospective/Urgent	3 calendar days
Prospective/Non-Urgent	3 calendar days
Emergency Services	60 minutes
Concurrent/Urgent	24 hours (1 calendar day)
Retrospective	30 calendar days

** This is not meant to be an all-inclusive list.*

Pre-Auth Needed Tool



Prior Authorization

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Prior Authorization can be requested in 3 ways:

1. On the Secure Provider Portal at Provider.SuperiorHealthPlan.com.
   - If you are already a registered user of the Secure Provider Portal, you do not need a separate registration.
2. Fax requests to:
   - Outpatient: 1-855-537-3447 (Medical) or 1-844-307-4442 (Behavioral)
   - Inpatient: 1-866-838-7615 (Medical) or 1-866-900-6918 (Behavioral)
     - The fax authorization forms are located at Ambetter.SuperiorHealthPlan.com.
3. Call for Prior Authorization at 1-877-687-1196.

Prior Authorization

Prior Authorization will be granted at the CPT code level:

- If a claim is submitted that contains CPT codes that were not authorized, the services will be denied.
- If additional procedures are performed during the procedure, the provider must contact Ambetter to update the authorization in order to avoid a claim denial.
  - It is recommended that this be done within 72 hours of the procedure; however, it must be done prior to claim submission or the claim will deny.
- Ambetter will update authorizations but will not retro-authorize services.
  - The claim will deny for lack of authorization.
  - If there are extenuating circumstances that led to the lack of authorization, the claim may be appealed.

Complaints and Appeals

Complaints/Appeals

Claims:

- A provider must exhaust the Claims Reconsideration and Claims Dispute process before filing a complaint or appeal.

Complaint:

- Must be filed within 30 calendar days of the Notice of Action.
- Upon receipt of complete information to evaluate the request, Ambetter will provide a written response within 30 calendar days.

Complaints/Appeals

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Appeals:

- For claims, the Claims Reconsideration, Claims Dispute and Complaint process must be exhausted prior to filing an appeal.

Medical Necessity:

- Must be filed within 30 calendar days from the Notice of Action.
- Ambetter will acknowledge receipt within 10 business days of receiving the appeal.
- Ambetter will resolve each appeal and provide written notice as expeditiously as the member's health condition requires, but not to exceed 30 calendar days.
- Expedited appeals may be filed if the time expended in a standard appeal could seriously jeopardize the member's life or health. The timeframe for a decision for an expedited appeal will not exceed 72 hours.

Complaints/Appeals

- Members may designate providers to act as their representative for filing appeals related to Medical Necessity.
  - Ambetter requires that this designation by the member be made in writing and provided to Ambetter.
- No punitive action will be taken against a provider by Ambetter for acting as a member's representative.
- Full details on claim reconsideration, claim dispute, complaints and appeals processes can be found in our provider manual at Ambetter.SuperiorHealthPlan.com.

Claims

Claims

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Clean Claim:

- A claim that is received for adjudication in a nationally accepted format in compliance with standard coding guidelines and does not have any defect, impropriety, lack of any required documentation or particular circumstance requiring special treatment that prevents timely payment.

Exceptions:

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

Claim Submission

The timely filing deadline for initial claims is 95 days from the date of service or date of discharge.

Claims may be submitted in 3 ways:

1. On the Secure Provider Portal at Provider.SuperiorHealthPlan.com.

2. Through an Electronic Clearinghouse:
   - Payor ID 68069
   - For a list of our Clearinghouses, please visit our website at Ambetter.SuperiorHealthPlan.com.

3. By mail, paper claims may be submitted to:
   Ambetter from Superior HealthPlan
   P.O. Box 5010
   Farmington, MO 64640-5010

Note: Effective 1/1/2020, medical eye services provided by an ophthalmologist will be submitted to Superior HealthPlan for processing.

Claim Submission

Claim Reconsiderations:

- A written request from a provider about a disagreement in the manner in which a claim was processed. No specific form is required.
- Must be submitted within 120 days of the Explanation of Payment.
- Claim Reconsiderations may be mailed to:
  P.O. Box 5010
  Farmington, MO 63640-5010

Claim Disputes:

- Must be submitted within 120 days of the Explanation of Payment.
- A Claim Dispute form can be found on our website at Ambetter.SuperiorHealthPlan.com.
- The completed Claim Dispute form may be mailed to:
  P.O. Box 5000
  Farmington, MO 63640-5000

Claim Submission

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Member in Suspended Status:

- A provision of the ACA allows members who are receiving Advanced Premium Tax Credits (APTCs) a 3 month grace period for paying claims.
- While the member is in a suspended status, claims will be pended.
  - After 60 days, the member is placed in a suspended status. The Explanation of Payment will indicate LZ Pend: Non-Payment of Premium.
  - **Note**: While the member is in a suspended status, claims will be paid for the first 60 days. Claims will be denied days 61-90.
- When the premium is paid by the member, the claims will be released and adjudicated.
- If the member does not pay the premium, the provider may bill the member directly for services.

Claim Submission

Member in Suspended Status (APTC Example):

- January 1st
  - Member pays premium.
- February 1st
  - Premium due - member does not pay.
- March 1st
  - Member placed in Suspended Status.
- April 1st
  - Member remains in Suspended Status.
- May 1st
  - If premium remains unpaid, member is terminated. Provider may bill member directly for services rendered.

Note: When checking Eligibility, the Secure Provider Portal will indicate that the member is in a Suspended Status. Claims for members in a Suspended Status are not considered "clean claims."

Claim Submission

Member in Suspended Status (Non-APTC Example)

- January 1st
  - Member pays premium.
- February 1st
  - Premium due - member does not pay.
- March 1st
  - Member placed in Suspended Status.
- April 1st
  - If premium remains unpaid, member is terminated. Provider may bill member directly for services rendered.

Note: When checking Eligibility, the Secure Provider Portal will indicate that the member is in a Suspended Status. Claims for members in a Suspended Status are not considered "clean claims."

Claim Submission

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Rendering Taxonomy Code:

- Claims must be submitted with the rendering provider's taxonomy code.
- The claim will deny if the taxonomy code is not present.
- This is necessary in order to accurately adjudicate the claim.

CLIA Number:

- If the claim contains CLIA certified or CLIA waived services, the CLIA number must be entered in Box 23 of a paper claim form or in the appropriate loop for EDI claims.
- Claims will be rejected if the CLIA number is not on the claim.

Behavioral Health Retrospective Utilization Review

FROM superior healthplan

- Effective July 1, 2020, Superior will transition to retrospective utilization review for inpatient behavioral health admissions for members.
- Notification of admission is still required at the time of admission.
  - Lack of notification may result in a contractual denial for failure to comply.
- To facilitate the retrospective review, clinical documentation to support the medical necessity of the inpatient admission must be submitted with the claim for the inpatient stay.
- Superior will send a request for clinical records if not received with the claim.
  - The facility will be required to submit the records within 5 business days of the request.
  - If medical records are not included with the claim, Superior will review the admission to determine medical necessity based upon any clinical information available for the admission.

Claim Submission

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Billing the Member:

- Copays, coinsurance and any unpaid portion of the deductible may be collected at the time of service.
- The Secure Provider Portal will indicate the amount of the deductible that has been met.
- If the amount collected from the member is higher than the actual amount owed upon claim adjudication, the provider must reimburse the member within 45 days.

Claim Payment

PaySpan:

- Ambetter partners with PaySpan for Electronic Remittance Advice (ERA) and Electronic Funds Transfer.
- If you currently utilize PaySpan, you will need to register specifically for the Ambetter product.
- To register for PaySpan:
  - Call 1-877-331-7154 or visit www.PaySpanHealth.com.

Ophthalmology for Medical Eye Care Services

FROM superior healthplan

Effective for service dates beginning January 1, 2020, Superior HealthPlan assumed the management of medical eye care services delivered by ophthalmologists for all Superior members.

Envolve Vision continues to manage routine eye care services and full-scope of licensure optometric services for Superior HealthPlan.

Ophthalmology for Medical Eye Care Services

- On January 1, 2020, Superior began managing all functions for ophthalmologists providing medical eye care services, including but not limited to:
  - Claim Processing and Appeals
  - Contracting/Credentialing
  - Prior Authorization
  - Retrospective Utilization Review
  - Medical Necessity Appeals
  - Provider Complaints Related to Medical Eye Care Services
  - Provider Relations/Account Management
  - Provider Services
  - Provider Web Portal

- For code-specific details of services requiring prior authorization, refer to Superior's Prior Authorization tool: www.SuperiorHealthPlan.com/providers/preauth-check.html.

Provider Resources

Provider Services

The Provider Services department is available to respond quickly and efficiently to all provider inquiries or requests including, but **not limited to**:

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

Providers are able to access real time assistance for their service needs, Monday – Friday, 8:00 a.m. – 5:00 p.m. CST, by calling Provider Services at 1-877-687-1196.

Account Management

Each provider will have an Account Manager assigned to them. This Account Manager serves as the primary liaison between Ambetter and our provider network. The Account Management team is responsible for:

- Provider education.
- Claims assistance.
- Demographic information update.
- Provider enrollment status.
- Administrative policies, procedures and operational issues.
- Contract clarification.
- Membership/provider roster questions.
- Provider Portal registration and PaySpan.

Provider Tool Kit

The Ambetter Provider Tool Kit includes:

- Welcome Letter
- Ambetter Provider Introductory Brochure
- Secure Portal Setup
- Electronic Funds Transfer Setup
- Prior Authorization Guide
- Quick Reference Guide
- Provider Office Window Decal

Public Website

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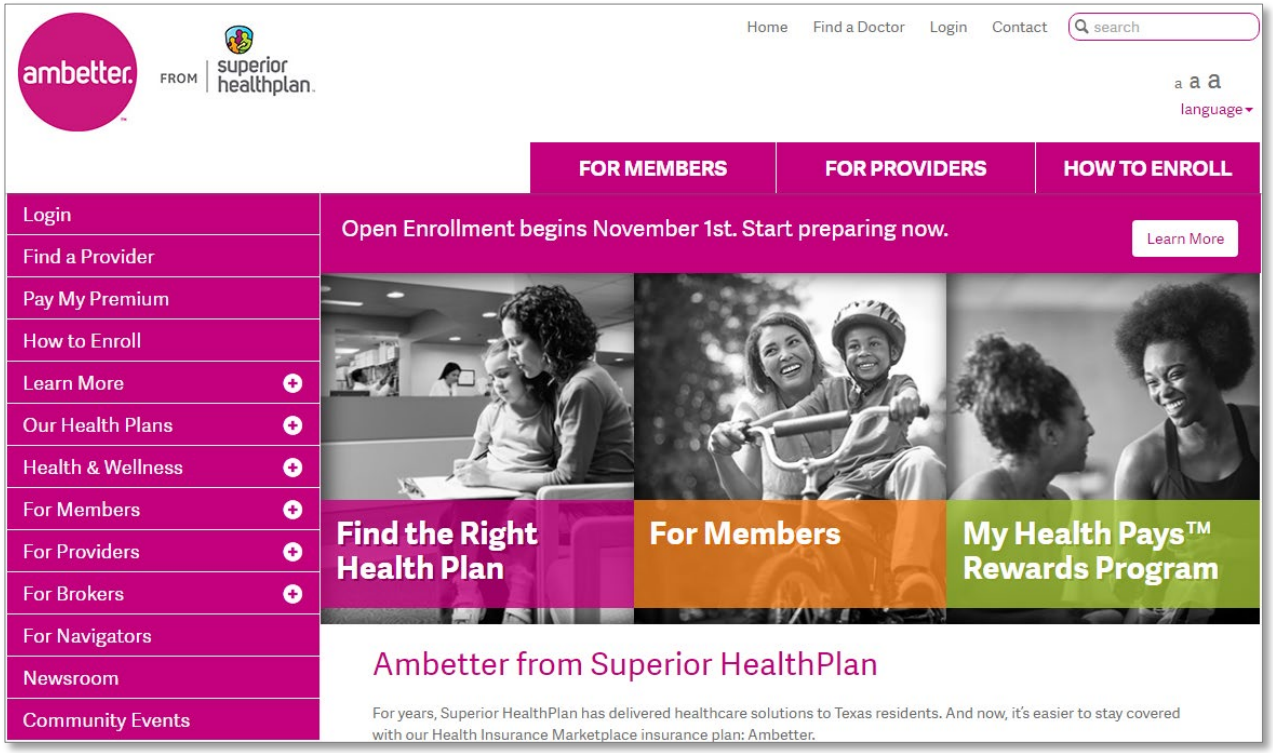
Ambetter.SuperiorHealthPlan.com



Public Website

Provider resources available on the Ambetter website include, but are not limited to:

- The Provider and Billing Manual
- Quick Reference Guides
- Forms (Prior Authorization Fax forms, Behavioral Health forms, etc.)
- The Pre-Auth Needed Tool
- The Pharmacy Preferred Drug Listing
- Trainings
- And much more…

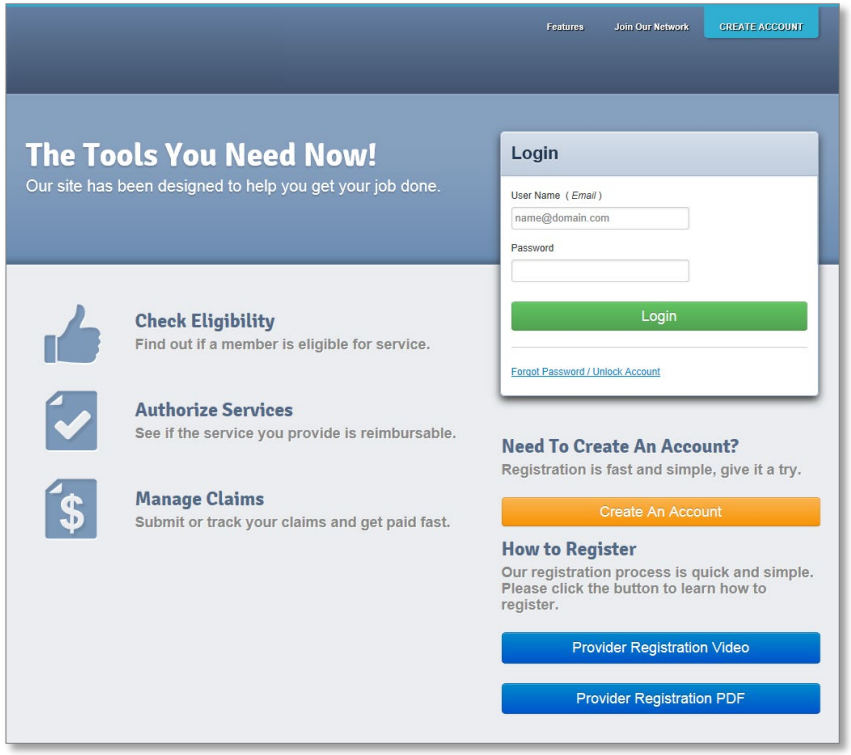
Secure Provider Portal

Information contained on Provider.SuperiorHealthPlan.com includes, but is not limited to:

- Member Eligibility and Benefits and Patient Listings
- Health Records and Care Gaps
- Authorizations
- Claims Submissions and Status
- Corrected Claims and Adjustments
- Payments History
- Monthly PCP Cost Reports - Generated on a monthly basis and can be exported into a PDF or Excel format. Reports Include:
  - Patient List with HEDIS Care Gaps
  - Emergency Room Utilization
  - Rx Claims Report
  - High Cost Claims

Secure Provider Portal

Registration is free and easy. Visit Provider.SuperiorHealthPlan.com to get started.



Contact Information

Specialty Vendor Contacts

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Service	Specialty Company/Vendor	Contact Information
High Tech Imaging Services	National Imaging Associates	1-877-687-1196 RadMD.com
Vision Services	Envolve Vision Services*	1-866-753-5779 visionbenefits.envolvehealth.com/
Pharmacy Services	Envolve Pharmacy Solutions	1-866-399-0928 pharmacy.envolvehealth.com/pharmacists.html
Musculoskeletal Surgical Procedures	TurningPoint HealthCare Solutions**	1-469-310-3104 www.myturningpoint-healthcare.com

* Effective January 1, 2020, Medical Ophthalmology is handled by Superior HealthPlan.
** Effective November 15, 2019.

Specialty Vendor Contacts

- National Imaging Associates
  - Provides specialized utilization management and provider profiling services for radiology and imaging services rendered to Ambetter members.
- Envolve Vision Services
  - Administers fully customizable vision plans to help reduce both provider and member costs while still delivering the highest quality vision benefits available.
  - **Ophthalmologists ONLY:** Effective 1/1/20, only routine vision services will be administered through Envolve. Claims and authorizations for medical eye services will be administered through Superior HealthPlan for dates of services on or after 1/1/20.
- Envolve Pharmacy Solutions
  - Transforms the traditional pharmacy benefit delivery model through innovative, flexible pharmacy solutions, customized care and prescription drug coverage management.
- TurningPoint HealthCare Solutions (Effective 11/15/2019)
  - Processes prior authorization requests for medical necessity and appropriate length of stay (when applicable) for musculoskeletal surgical procedures.

Contact Information

Ambetter from Superior HealthPlan

Phone: 1-877-687-1196

TTY/TDD: 711

Ambetter.SuperiorHealthPlan.com

FROM

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Questions