Welcome To Ambetter From Superior HealthPlan

Your Partner In Better Healthcare

2025 Provider Orientation

AGENDA

OVERVIEW

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

WHAT YOU NEED TO KNOW

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

QUESTIONS & ANSWERS

2025 Provider Orientation

OVERVIEW

WE ARE AMBETTER

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

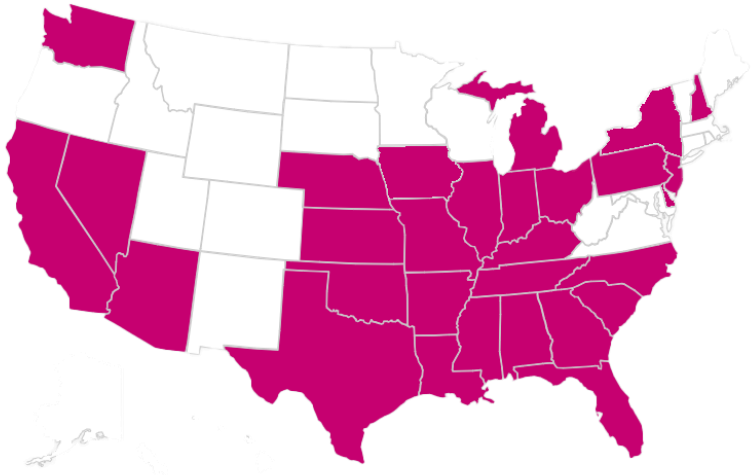
#1 carrier
on the health insurance marketplace*

4.4M+
members insured

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

2014
Year that Ambetter began

28
states



LOCAL APPROACH TO CARE

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

We target a focused demographic

We lower income, underinsured and uninsured

PARTNERSHIP

- The **Ambetter plan design philosophy** is to provide affordable care to individuals or families that need to purchase healthcare coverage on their own.

- **Our products** focus on various cost shares — many with low or no copay amounts — to meet the budget and utilization needs of these consumers. This gives our members the peace of mind that they have full comprehensive medical coverage.

- Additionally, the **emphasis on reducing barriers and improving access to care** mitigates the risk of individuals showing up without insurance (uncompensated care). !mb etter's generous cost-sharing initiatives lower patient financial responsibility while also reducing the amount that providers need to collect at time of service.

- Most importantly, Ambetter plans encourage members to establish relationships with their primary care providers to **achieve favorable health outcomes**.

WE ARE PROUD TO BE YOUR PARTNER

AFFORDABLE CARE ACT

AFFORDABLE CARE ACT (ACA): Key Objectives

- Increase access to quality health insurance
- Improve affordability

ADDITIONAL PARAMETERS:

- Dependent coverage to age 26*
- No lifetime maximum benefits
- Preventative care covered at 100%
- Insurer minimum loss ratio (80%* for individual coverage)

**May be greater based on state requirements*

AFFORDABLE CARE ACT

REFORM OF THE COMMERCIAL INSURANCE MARKET

- No more underwriting – guaranteed issue.
- There is no longer a federal tax penalty associated with not having minimum essential coverage*.
- Minimum standards for coverage: essential health benefits and cost sharing limits.
- The ACA created premium tax credits (also known as subsidies) and cost-sharing reductions (CSR) to help reduce costs for eligible consumers who buy a plan through the Marketplace.
- Subsidies may be available to eligible individuals/families who have a household income between 100 and 400 percent of the Federal Poverty Level (FPL), based on the taxpayer's family size.
    - Currently, the subsidy cap has been eliminated through Plan Year 2025, but that may be extended.
- CSRs are available to eligible individuals/families who have a household income between 100 and 250 percent of the FPL, based on the taxpayer's family size.

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

HEALTH INSURANCE MARKETPLACE

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

The Health Insurance Marketplace provides health plan shopping and enrollment services through websites, call centers, and in-person help. For more information visit, HealthCare.gov.

Potential members can:

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

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

HEALTH INSURANCE MARKETPLACE

FINANCIAL COMES IN THE FORM OF:

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

ALL BENEFIT PLANS HAVE COST SHARES IN THE FORM OF COPAYS, COINSURANCE AND DEDUCTIBLES

- Some members qualify for assistance with their cost shares based on income level

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

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2025 AMBETTER PLANS

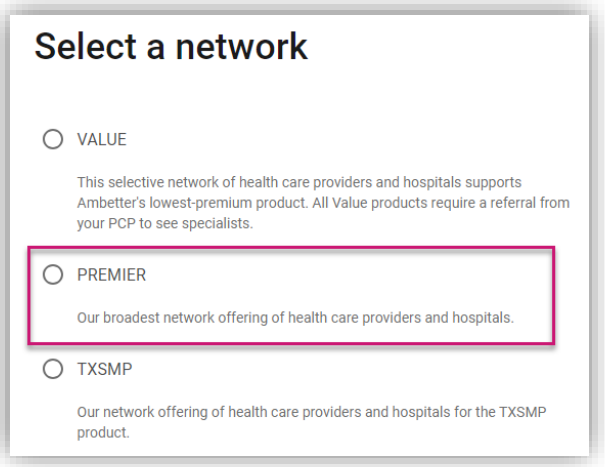
OUR NETWORKS

- Ambetter offers a robust suite of innovative networks that give members more coverage options to fit their needs and budget.
- By offering increased product options, Ambetter also benefits providers by giving them exclusive access to new patient populations.
- Each Ambetter 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 or prior authorization requirements for certain types of care to be covered.
- As a provider, it is important you confirm which network and plan a member is in before extending care. This information is located on the member's ID card and can also be confirmed when verifying the member's eligibility.

NETWORKS BUILD TO OFFER MORE

AMBETTER HEALTH PREMIER

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



OUR INNOVATIVE NETWORKS

PCP SELECTION

- Ambetter Health 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 Silver and Gold members may see any provider they choose, Ambetter Health 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.

AMBETTER VALUE

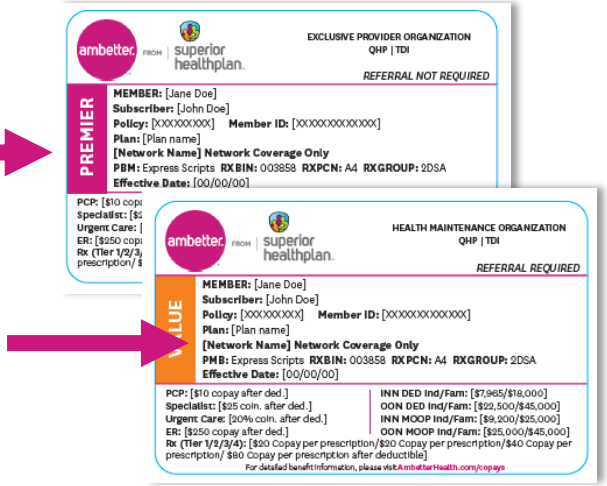
- **VALUE:** This exclusive network of healthcare providers has referral requirements for certain types of care, along with prior authorization requirements for non-Value providers.
- Value has a more restrictive, yet inclusive and adequate network being offered within a limited set of counties:
  -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

HOW TO IDENTIFY A MEMBER'S NETWORK

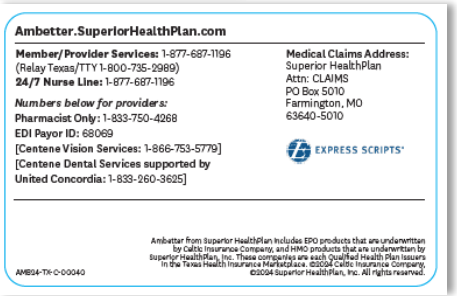
All members receive an Ambetter member identification card. The ID card includes new information that includes:

- The **Ambetter Plan** the member has selected
- The **Provider Network** the member belongs to
- **Referral requirements** based on the member's plan selection.

Note: *Presentation of a member ID card is not a guarantee of eligibility. Providers must verify eligibility on the same day services are rendered.*



Back of Member ID Card



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WHAT YOU NEED TO KNOW

KEY CONTACT INFORMATION

Ambetter from Superior HealthPlan

PHONE
1-877-687-1196

TTY/TDD
1-800-735-2989

WEB
Ambetter.SuperiorHealthPlan.com

PORTAL
Provider.SuperiorHealthPlan.com

AMBETTER PROVIDER MANUAL

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

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

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

The Provider Manual, along with Texas-specific QRGs and resources, can be found under the *Reference Materials* section on !m better's Provider Resources webpage.

PROVIDER SERVICES

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

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

By calling Ambetter Provider Services at 1-877-687-1196 providers can access real time assistance for all their service needs.

Provider Representatives

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

✓Inquiries related to administrative policies, procedures, and operational issues
✓Contract clarification
✓ Membership/provider roster questions
✓ Secure Portal registration and PaySpan/Zelis
✓ Provider education
✓Demographic information updates
✓ Initiate credentialing of a new practitioner

PROVIDER NETWORK OPERATIONS

- Forms to add new practitioners can be found on our website and should be submitted along with all credentialing documentation.
- Enrollments are effective 30 Calendar Days from the date all clean documents are received by Ambetter.

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

- **Contract clarification**
- **Initiate credentialing of a new practitioner**
- **Inquiries related to the status of a new practitioner or Join Our Network request**

PROVIDER DIRECTORY UPDATES

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

To update your provider data:

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

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PUBLIC WEBSITE AND SECURE PORTAL

AMBETTER PUBLIC WEBSITE

WHAT'S ON THE PUBLIC WEBSITE: Ambetter.SuperiorHealthPlan.com?

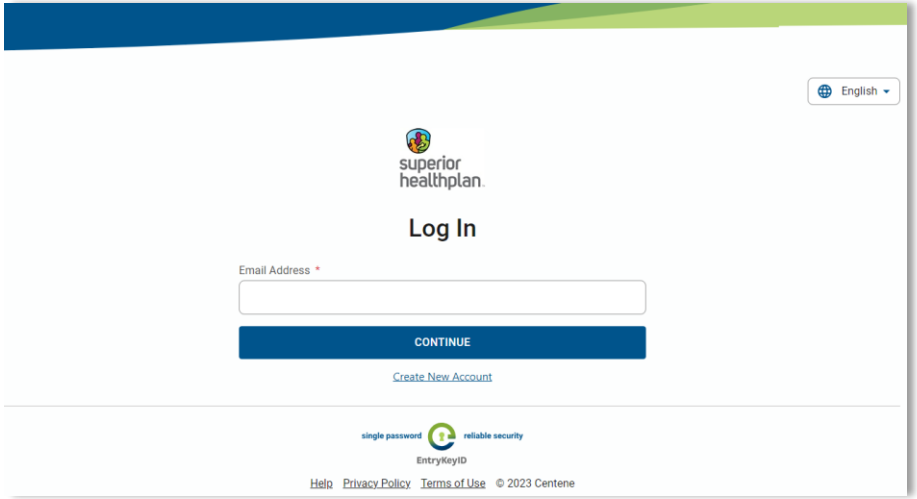
- Provider Manual
- Quick Reference Guides
- Important Forms (Notification of Pregnancy, Prior Authorization Fax forms, etc.)
- Provider Training
- The Pre-Auth Needed Tool
- The Pharmacy Preferred Drug Listing

AMBETTER PUBLIC WEBSITE

SECURE PROVIDER PORTAL

REGISTRATION IS FREE AND EASY!

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



SECURE PROVIDER PORTAL

AVAILITY ESSENTIALS

Centene (a parent company of Superior HealthPlan) has chosen Availity Essentials (Availity) as its new, secure provider portal. Providers can validate eligibility and benefits, submit claims, check claim status, submit authorizations, and access payer resources, via Availity Essentials. A phased rollout schedule by state goes through early 2025.

- Our current secure portal is still available for other functions that providers use today. For providers new to Availity Essentials, getting their Essentials account is the first step toward working on Availity.
- The provider organization's designated !vaility adm inistrator is the person responsible for registering their practice in Essentials, managing user accounts, and should have legal authority to sign agreements for their organization.
- Administrators can register with Availity Essentials here:
  - **Availity Essentials website**
  - Providers needing additional assistance with registration can call Availity Client Services at **1-800-AVAILITY (1-800-282-4548),** Monday through Friday, 8 a.m. – 8 p.m. EST.
- For general questions, providers can reach out to their Provider Representative.

SECURE PROVIDER PORTAL

WHAT'S ON THE SECURE PROVIDER PORTAL?

- Member eligibility and patient listings
- Health records and care gap information
- Authorizations
- Claims submissions and status
- Corrected claims and adjustments
- Payment history
- Monthly PCP cost reports
- Provider analytics reports
- PCP Referrals for Value plans

SECURE PROVIDER PORTAL

INSIGHTFUL REPORTS

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

PCP REPORTS INCLUDE:

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

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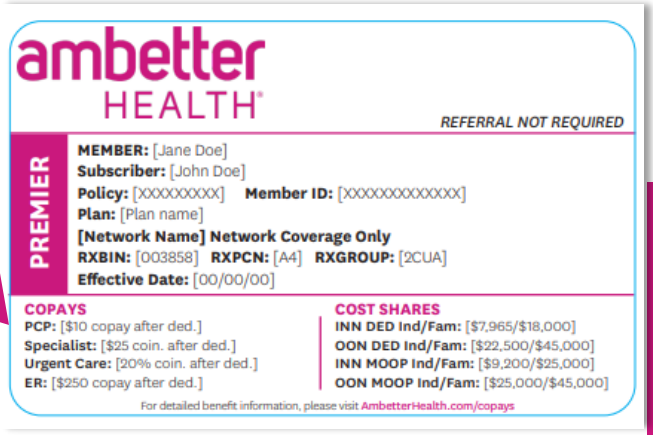
VERIFICATION OF ELIGIBILITY, BENEFITS AND COST SHARES

MEMBER ID CARD



Plans can include:

- PREMIER
- VALUE
- TXSMP

Certain plans may have a referral requirement. Please note:

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

Provider Services Contact Information

Pharmacy Benefit Information

NAVIGATING THE MEMBER ID CARD

ELIGIBILITY, BENEFITS AND COST SHARE

PROVIDER MUST VERIFY MEMBER ELIGIBILITY

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

PANEL STATUS

- PCPs should confirm that a member is assigned to their patient panel.
    - This can be done via our Secure Provider Portal.
- PCPs can still administer service if the member is not on their panel, and they wish to have the member assigned to them for future care.

VERIFICATION OF ELIGIBILITY, BENEFITS AND COST SHARES

ELIGIBILITY, BENEFITS AND COST SHARE

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

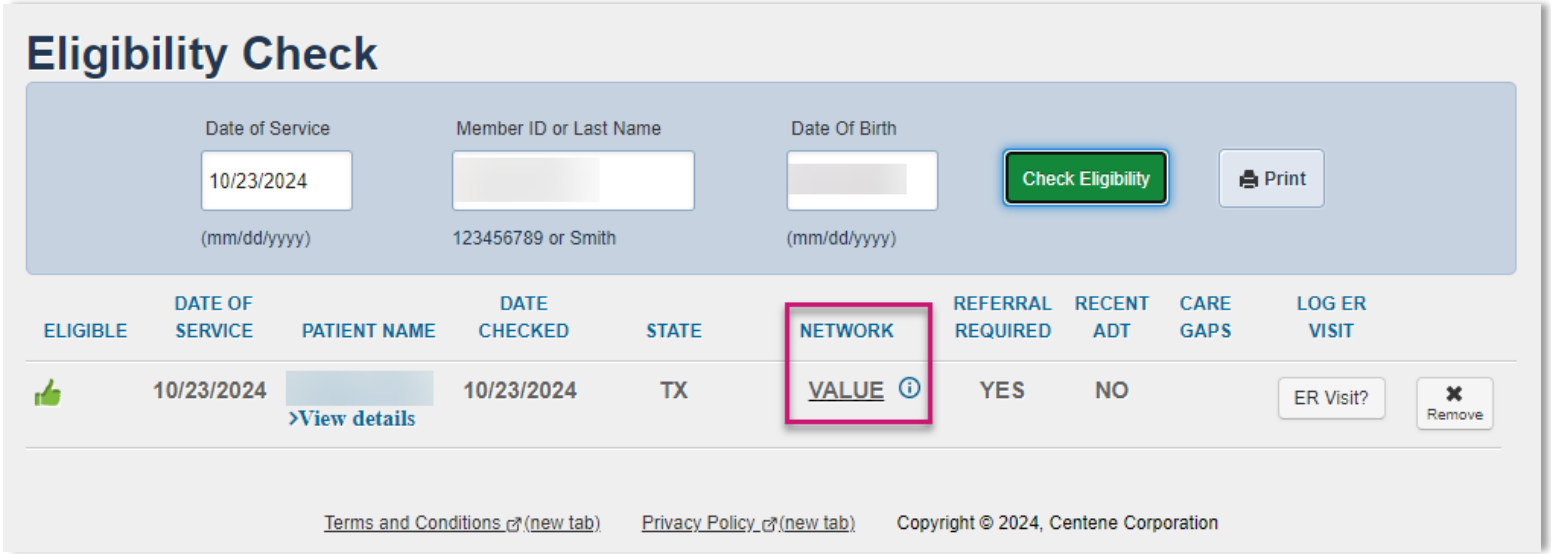
- ✓ **The Secure Provider Portal**
  - If you are already a registered user of Superior HealthPlan's secure provider portal, you do NOT need a separate registration

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

- ✓ **Contact Provider Services: 1-877-687-1196**

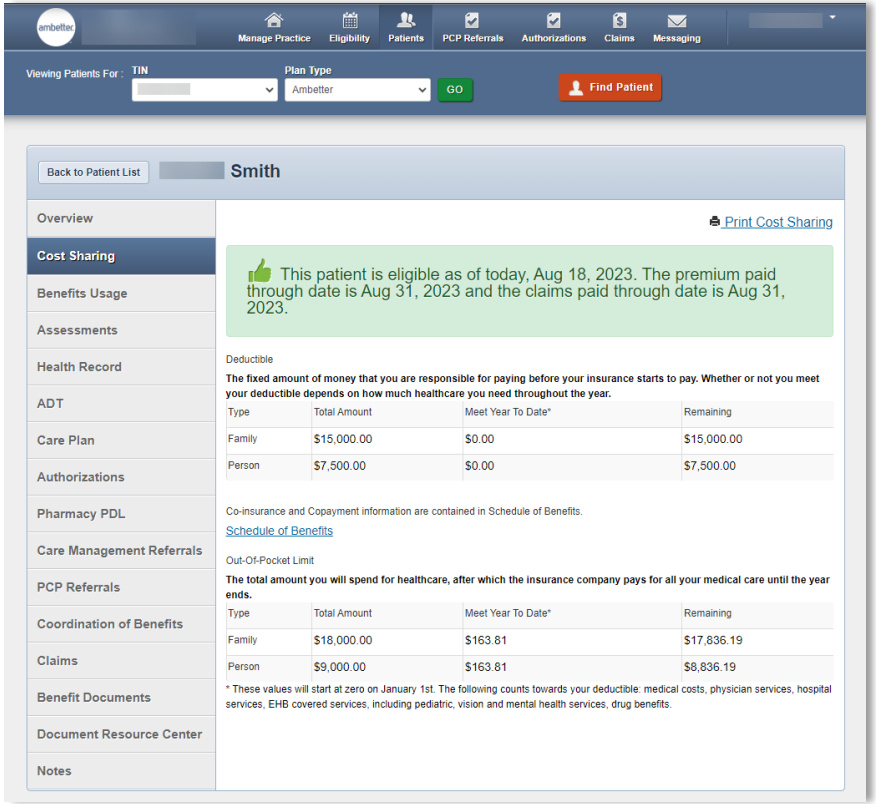
VERIFICATION OF ELIGIBILITY, BENEFITS AND COST SHARES

VERIFICATION OF ELIGIBILITY ON THE PORTAL

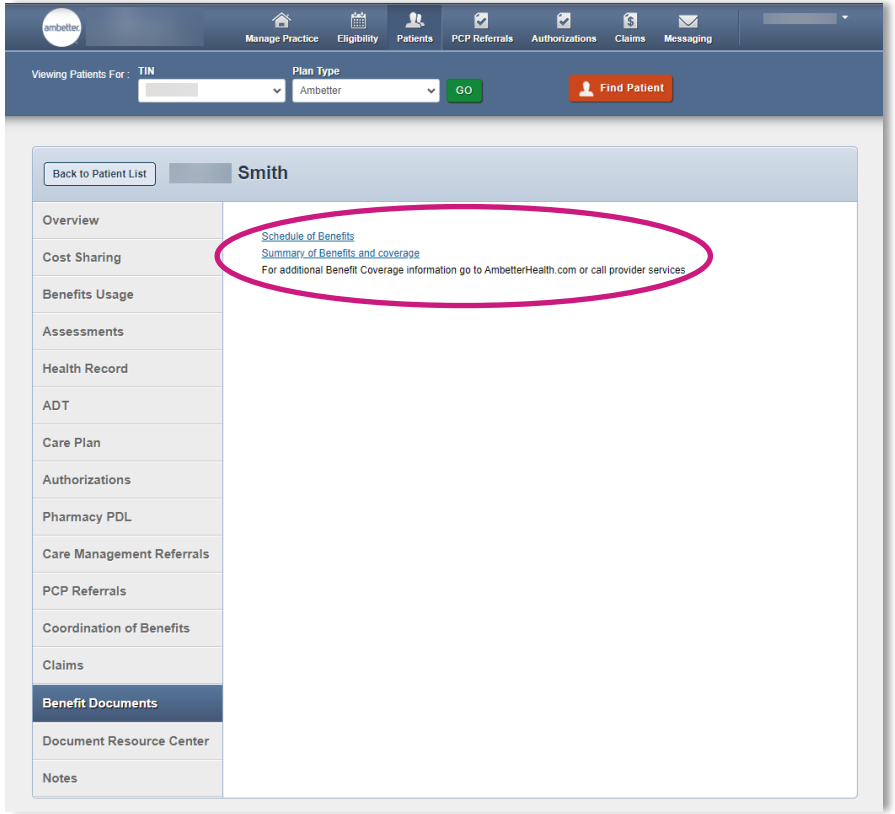


VERIFICATION OF COST SHARES ON THE PORTAL

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

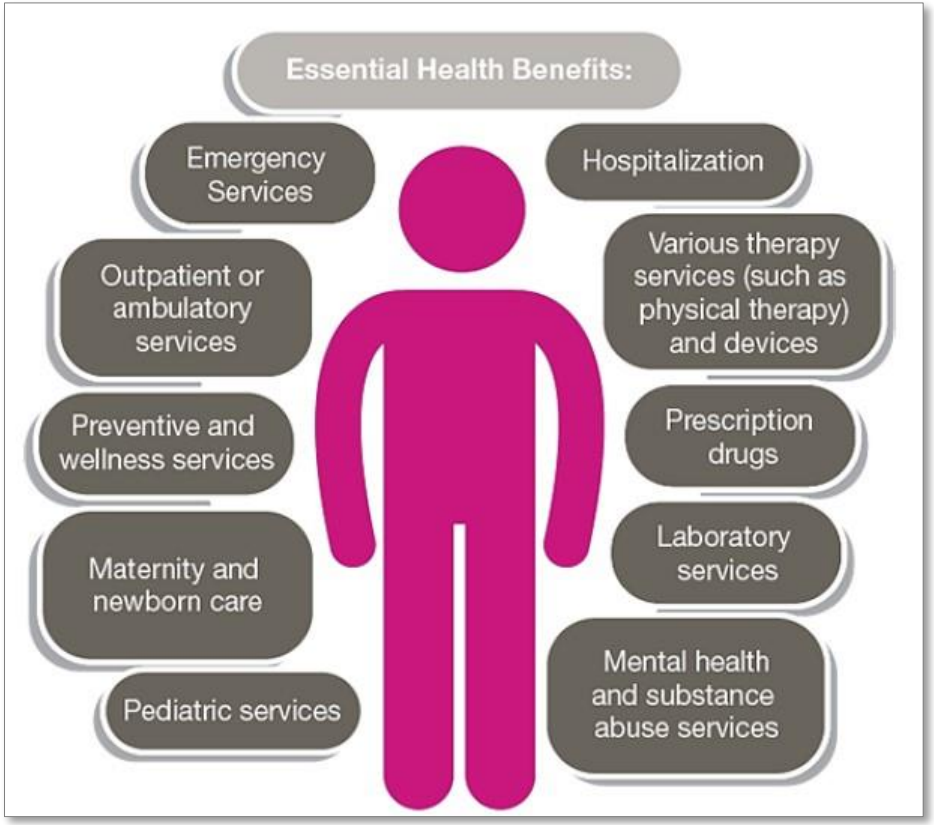


VERIFICATION OF BENEFITS ON THE PORTAL



ESSENTIAL HEALTH BENEFITS

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



OTHER BENEFITS

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

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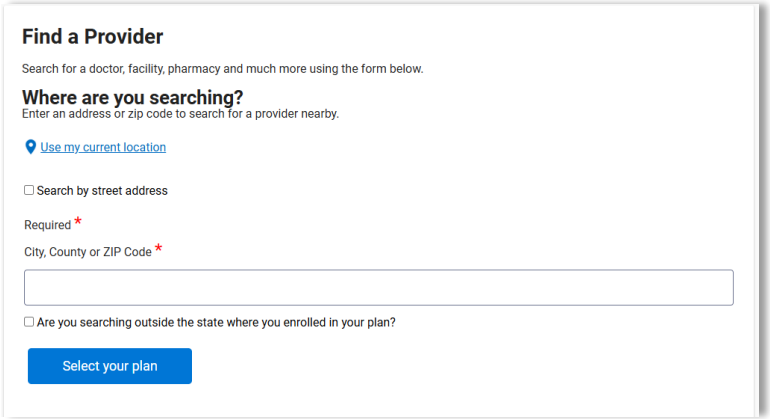
REFERRALS

AMBETTER PCP REFERRAL REQUIREMENTS

- The Ambetter Value plan has referral requirements.
- For services to be covered under these plans, they must be provided by or referred by a PCP.
- If a referral is not initiated, services performed outside of the member's assigned provider or primary care group will be denied.
- Prior authorization requirements will also apply, as necessary.
- Referral requirements are reiterated throughout the Ambetter Guide and member plan materials to ensure members understand the rules associated with their plan.
  Referring providers can use the Ambetter Secure Provider Portal to initiate referrals on behalf of members.

Ambetter Plan	Referral Requirement?
PREMIER	No
VALUE	Yes, for care outside of PCP

MAKING AN AMBETTER VALUE REFERRAL FOR A SPECIALIST



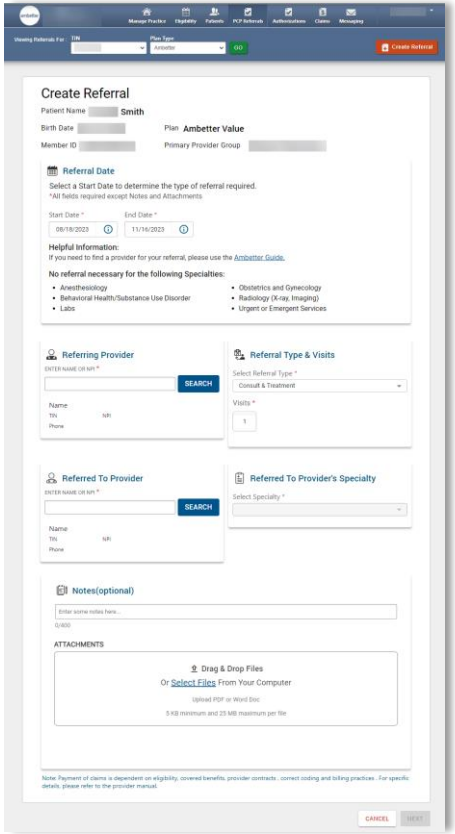
1. Go to the **Ambetter Guide webpage**.
2. Input the City, County or ZIP Code you are searching for and click *Select your plan.*
3. Under “What is your health plan?,” select the !mbett er Value option. Click the *Continue* button to advance.
    1. If you do not see an Ambetter Value option, click on *Change Location* to ensure the information is correct.
4. Search for a specific specialty, facility/group name, provider name or NPI. There is also the option to search by category.
5. Submit the search.
6. On the results page, use the filter options to narrow the results to the specific needs of the member.
7. Click through on any result to see full details about the provider, including their NPI.

MAKING A REFERRAL:
SECURE PROVIDER PORTAL

ONCE YOU IDENTIFY THE SPECIALIST'S NAME AND NPI, SUBMIT THE INFORMATION ON THIS SCREEN.

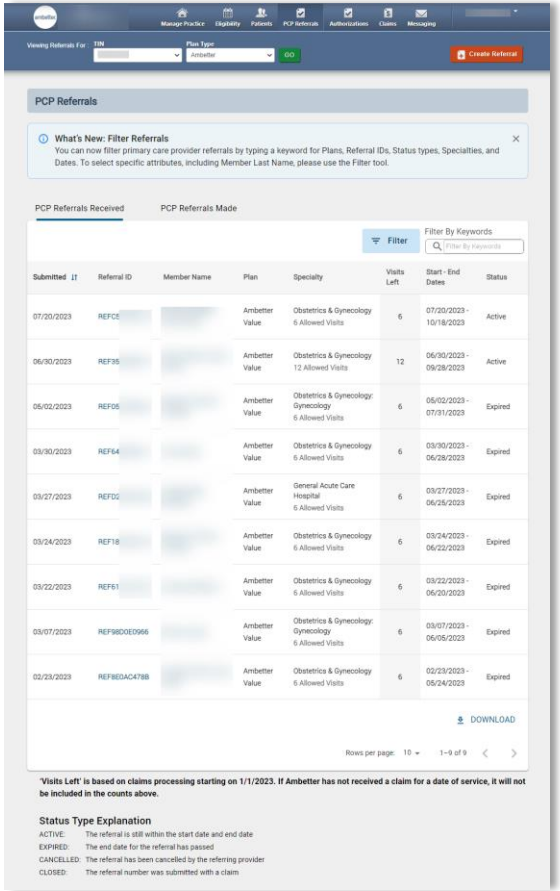
1. Click on **PCP Referrals** tab at the top of the screen.
2. Click the **Create Referral** button.
3. Complete the fields on the PCP Referral form.

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



RECEIVING A REFERRAL

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



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PRIOR AUTHORIZATION

HOW TO SECURE A PRIOR AUTHORIZATION

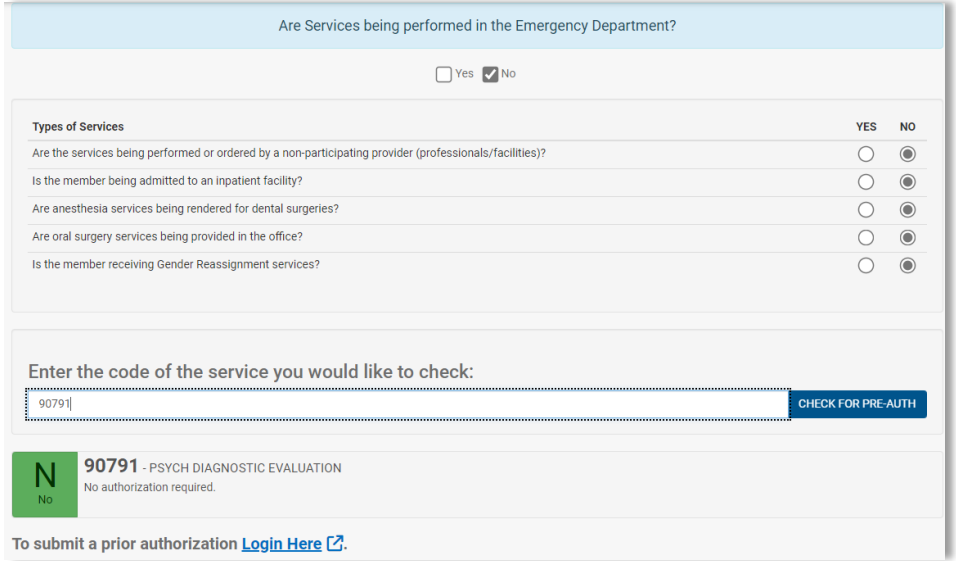
NEED PRIOR AUTHORIZATION?
It can be requested in the following ways:

- ✓ **The Secure Provider Portal** (This is the preferred and fastest method)
- ✓ Phone
  - **1-877-687-1196**
- ✓ Fax
  - 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 on Ambetter's Provider Resources webpage.

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

IS PRIOR AUTHORIZATION NEEDED?

- Use the **Pre-Auth Needed Tool** to quickly determine if a service or procedure requires prior authorization.
- The *Prior Authorization Prescreen Tool* can be found on the **Ambetter's Prior Auth Requirements webpage**.



REQUIREMENTS

PROCEDURES / SERVICES THAT NEED PRIOR AUTHORIZATION INCLUDE*:

- Potentially cosmetic
- Experimental or investigational
- High-tech imaging (e.g. CT, MRI, PET)
- Infertility
- Pain Management

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

PRIOR AUTHORIZATION REQUIREMENTS

REQUIREMENTS

INPATIENT AUTHORIZATION IS NEEDED FOR THE FOLLOWING*:

- All elective/scheduled admission notifications requested at least 5 Business Days prior to the scheduled date of admit including:
  - All services performed in out-of-network facilities
  - Behavioral Health Services:
    - Partial Hospitalization Program (PHP) and/or Intensive Outpatient Program (IOP)
    - Residential Treatment (Mental Health/Substance Use)
  - Hospice care
  - Rehabilitation facilities
  - Transplants, including evaluation
  - Observation stays more than 23 hours require Inpatient Authorization
  - Urgent/Emergent Admissions
    - Within 1 Business Day following the date of admission
    - Newborn deliveries must include birth outcomes

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

PRIOR AUTHORIZATION REQUIREMENTS

REQUIREMENTS

ANCILLARY SERVICES THAT NEED PRIOR AUTHORIZATION INCLUDE*:

- Air ambulance transport (non-emergent fixed-wing airplane)
- Durable medical equipment (DME)
- Home health care services, including:
  - Home infusion
  - Skilled nursing
  - Therapy
  - Private duty nursing
  - Adult medical day care
  - Hospice
  - Furnished medical supplies and DME

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

PRIOR AUTHORIZATION REQUIREMENTS

TIMEFRAMES

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

PRIOR AUTHORIZATION REQUEST TIMEFRAMES

TIMEFRAMES

Type	Timeframe
Prospective/Urgent	3 Calendar Days
Prospective/Non-Urgent	3 Calendar Days
Concurrent/Urgent	24 Hours
Retrospective	30 Calendar Days

UTILIZATION AUTHORIZATION TIMEFRAMES

CORRECT CODING

PRIOR AUTHORIZATION WILL BE GRANTED AT THE CPT CODE LEVEL

- If a claim is submitted that contains CPT codes that were not authorized, the services will be denied.
- If additional procedures are performed during the procedure, the provider **must** contact the health plan to update the authorization in order to avoid a claim denial.
- It is recommended that this be done within 72 hours of the procedure. However, it **must** be done prior to claim submission, or the claim will deny.
- Ambetter 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.

CORRECT CODING FOR PRIOR AUTHORIZATION

PREAUTHORIZATION EXEMPTIONS

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

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CLAIMS, BILLING AND PAYMENTS

CLAIMS

WHAT IS A 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.

ARE THERE ANY EXCEPTIONS?

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

HOW TO SUBMIT A CLAIM

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

CLAIMS MAY BE SUBMITTED IN THREE WAYS:

1. The Secure Provider Portal

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

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

CLAIM RECONSIDERATIONS AND DISPUTES

CLAIM RECONSIDERATIONS

- For reconsideration requests, providers can use the **Reconsider Claim** button on the Claim Details screen within the Secure Provider Portal.
- A written request from a provider about a disagreement in the manner in which a claim was processed. No specific form is required.
- Must be submitted within 120 Calendar Days of the Explanation of Payment.
- Mail claim reconsiderations to:

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

CLAIM DISPUTES

- Must be submitted within 120 Calendar Days of the Explanation of Payment
- A Claim Dispute form can be found on the visit the *Claims and Claims Payments* section of the Ambetter Provider Resources webpage.
- Mail completed Claim Dispute form to:

  Ambetter from Superior HealthPlan:
  Attn: Level II Claim Dispute

  PO Box 5010
  Farmington, MO 63640 5010

CLAIM SUBMISSION SUSPENDED STATUS

WHAT IF A MEMBER IS IN SUSPENDED STATUS?

- After the first 30 Calendar Days, the member is placed in a suspended status. The Explanation of Payment will indicate LZ Pend: Non-Payment of Premium.
- A provision of the Affordable Care Act (ACA) allows members who are receiving Advanced Premium Tax Credits (APTCs) a three-month grace period for paying claims.
- While the member is in a suspended status, claims will be pended.
- When the premium is paid by the member, the claims will be released and adjudicated.
- If the member does not pay the premium, the claims will be released, and the provider may bill the member directly for services.

CLAIM SUBMISSION SUSPENDED STATUS

EXAMPLE TIMELINE OF A MEMBER IN SUSPENDED STATUS

- **January 1st**
  Member pays premium.
- **February 1st**
  Premium due – member does not pay.
- **March 1st**
  Member 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.

Claims for members in a suspended status are not considered "clean claims."

HELPFUL INFORMATION ABOUT CLAIMS

MAKE SURE TO INCLUDE THE 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.

REMINDER: DO NOT FORGET THE 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 Electronic Data Interchange (EDI) claims.
- Claims will be rejected if the CLIA number is not on the claim.

BILLING THE MEMBER

COPAYS, CO-INSURANCE AND DEDUCTIBLES

- Copays, co-insurance and any unpaid portion of the deductible may be collected at the time of service.
- Deductible information, including the amount that has been paid toward the deductible so far, can be accessed via the **Secure Provider Portal**.
- 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 Calendar Days.

CLAIMS PAYMENTS

PAYSPAN®/ZELIS: A FASTER, EASIER WAY TO GET PAID

- Ambetter offers PaySpan® Health, recently acquired by Zelis, a free solution that helps providers transition into electronic payments and automatic reconciliation
- If you currently utilize PaySpan®, you will need to register specifically for Ambetter
- **Set up your PaySpan® account:**
  - Visit **PaySpan Sign In webpage** and click **Register**
  - You may need your National Provider Identifier (NPI) and Provider Tax ID Number (TIN) or Employer Identification Number (EIN)

ELECTRONIC FUNDS TRANSFER

2025 Provider Orientation

COMPLAINTS, GRIEVANCES AND APPEALS

COMPLAINTS, GRIEVANCES AND APPEALS

CLAIMS

- A provider must exhaust the claims reconsideration and claims dispute process before filing a complaint/grievance or appeal.

COMPLAINT/GRIEVANCE

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

COMPLAINTS, GRIEVANCES AND APPEALS

APPEALS

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

MEDICAL NECESSITY

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

COMPLAINTS, GRIEVANCES AND APPEALS

MEMBER REPRESENTATIVES

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

NEED MORE INFORMATION?

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

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SPECIALTY SERVICES & VENDORS

SPECIALTY COMPANIES AND VENDORS

Service	Specialty Company/Vendor	Contact Information
High Tech Imaging Services Cardiovascular Procedures	Evolent	Evolent website Phone: 1-877-687-1196
Vision Services	Envolve Vision	Envolve Vision website Phone: 1-866-753-5779
Dental Services	Envolve Dental	Envolve Dental website Phone: 1-833-260-3625
Pharmacy Services	Express Scripts	Phone: 1-866-399-0928 Fax: 1-866-399-0929

OUR SPECIALTY COMPANIES AND VENDORS

2025 Provider Orientation

Questions & Answers