Allwell from Superior HealthPlan

Provider Orientation

Agenda

- Plan Overview
- Membership
- Covered Services and Additional Benefits
- Providers and Authorizations
- Preventive Care and Screenings
- Model of Care (HMO SNP only)
- Medicare Star Ratings
- Web-Based Tools
- Network Partners
- Billing Overview
- Electronic Funds Transfer and Electronic Medical Records
- Meaningful Use – Electronic Medical Records
- Advance Directives
- Fraud, Waste and Abuse
- CMS Mandatory Trainings

Plan Overview

Medicare 101

Medicare is a federal health insurance program for people ages 65 (under 65 with qualifying disabilities). It is made up of the following parts:

Part A	**Hospital Insurance** 	This portion pays for hospital stays, skilled nursing facilities, and hospice stays	Part C	**Medicare Insurance** 	Medicare Advantage plans such as HMO's and PPO's. MA plans cover the same services as traditional Medicare and may offer prescription drug coverage (Part D), dental, vision, and hearing care
Part B	**Medical Insurance** 	This pays for doctors' services – both inpatient and outpatient –as well as lab services, medical equipment and supplies	Part D	**Rx Coverage** 	This pays for prescription drugs for home use

Medicare 101 – Election Period

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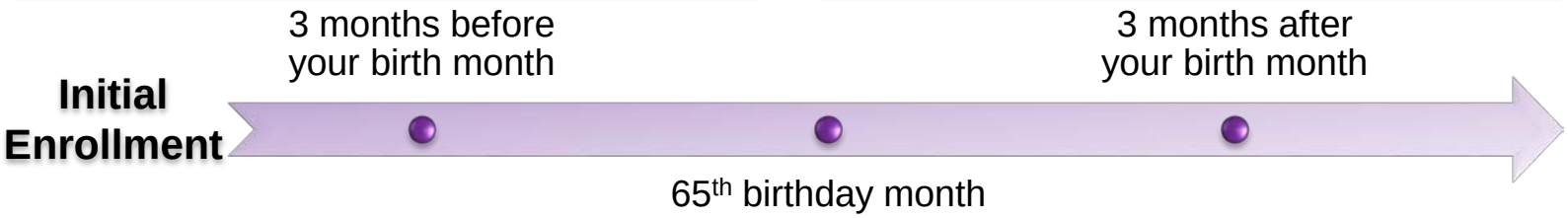
Annual Election Period (AEP)	Special Election Periods (SEP)
October 15 – December 7	Dates vary; Rules are based on the specific SEP
Add, drop, or change Medicare Advantage and/or Prescription Drug Plan (PDP) coverage. Plan changes are effective January 1 of the following year.	Add or change a Medicare Advantage plan or PDP (strictly controlled) *Examples:* • Special Needs Plan (SNP) eligibility • Medicaid or Extra Help eligibility • A move out of a plan's service area • Loss of group insurance



Overview: Allwell Plans

- Allwell from Superior HealthPlan provides complete continuity of care. This includes:
  - Integrated coordination of care
  - Care management
  - Co-location of behavioral health expertise
  - Integration of pharmaceutical services with the Pharmacy Benefit Manager (PBM)
  - Additional services specific to the member's needs

- Superior's approach to care management facilitates the integration of community resources, health education and disease management.
  - It promotes access to care as the beneficiaries are served through a multidisciplinary team including Registered Nurses (RN), social workers, pharmacy technicians and behavioral health case managers all co-located in a single, locally based unit.

Allwell Medicare (HMO)

Superior offers non-dual HMO plans. These HMO plans cover all Medicare-required services, along with a prescription drug benefit. HMO plans (unlike HMO SNP and MMP) do not require Medicaid to enroll.

- Most Medicare plans (sometimes referred to as "Part C") include the Part D prescription drug benefit plan. This is Superior's Allwell Medicare (HMO) plan.
- Superior offers the Allwell Medicare (HMO) program in the following counties:

Bexar	**Cameron**	**Collin**	**Dallas**	**Smith**	**Wilson**	**Denton**	**Guadalupe**
Hidalgo	**Nueces**	**Rockwall**	**Tarrant**	**Fort Bend**	**El Paso**	**Williamson**	

- HMO plans cover the most commonly prescribed drugs. However, each specific Part D plan may determine which drugs are covered.

– The covered drugs are included in the plan's formulary, or list of drugs: https://allwell.superiorhealthplan.com/prescription-drugs-formulary/formulary.html

Allwell Dual Medicare (HMO SNP)

- Allwell Dual Medicare (HMO SNP) is a plan for individuals with specific conditions or financial needs who are eligible for both Medicare and medical assistance from Texas Medicaid.
- Superior offers the Allwell Dual Medicare (HMO SNP) program in the following counties:

Bexar	**Cameron**	**Collin**	**Dallas**	**Smith**	**Wilson**	**Guadalupe**
Hidalgo	**Nueces**	**Rockwall**	**Tarrant**	**Fort Bend**	**El Paso**	**Williamson**

- For HMO SNP members, Medicare is always the primary payor and Medicaid is secondary payor.
- HMO SNP members may have both Superior Medicare and Superior Medicaid but not always, so it is important to verify coverage prior to servicing the member. *Please note: You may see members with Superior Medicare where their Medicaid is under another health plan or traditional Fee-For-Service (FFS) Medicaid or vice versa.*

Membership

Membership

- Medicare beneficiaries have the option to stay in the original Fee-For-Service Medicare plan or choose a Medicare health plan, such as Allwell from Superior HealthPlan.
- Allwell members may change PCPs at any time.
- Providers should verify eligibility before every visit by using one of the options below:
  - Secure Provider Portal: Provider.SuperiorHealthPlan.com
  - 24/7 Interactive Voice Response Line: 1-800-218-7453
  - Provider Services:
    - HMO – 1-844-796-6811 (TTY: 711)
    - HMO SNP – 1-877-935-8023 (TTY: 711)

Allwell Medicare (HMO) Card

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from Superior HealthPlan

HMO
CMS#: XXXXX-XXX
Effective:

MEMBER INFORMATION
Name: <First Last>
Member ID#: <XXXXXXXXX-XX>
Issuer ID: <(80840)> <9151014609>

PROVIDER INFORMATION
PCP Name: < >
PCP Phone: < >

PHARMACY INFORMATION
MedicareRx Prescription Drug Coverage

RX Claims Processor:
<CVS Caremark®>
RXBIN: <004336>
RXPCN: <MEDDADV>
RXGRP: <RX8905>

DRAFT

FOR MEMBERS
Member Services: 1-844-796-6811 (**TTY:** 711)
24-hr Nurse Advice: 1-855-696-2515
https://allwell.superiorhealthplan.com

FOR EMERGENCIES
Dial 911 or go to the nearest Emergency Room (ER).

FOR PROVIDERS
For eligibility: 1-844-796-6811
Prior authorization or case management referrals: 1-844-796-6811
Pharmacy prior auth: 1-844-202-6824
For help: (PHARMACY USE ONLY) 1-888-865-6567

Submit Part D Drug Claims to:
Allwell – Attn:
Pharmacy Claims
P.O. Box 419069
Rancho Cordova, CA
95741-9069

MEDICAL CLAIMS
EDI Payor ID: <68069>
Allwell
P.O. Box 3060, Farmington, MO 63640-3822

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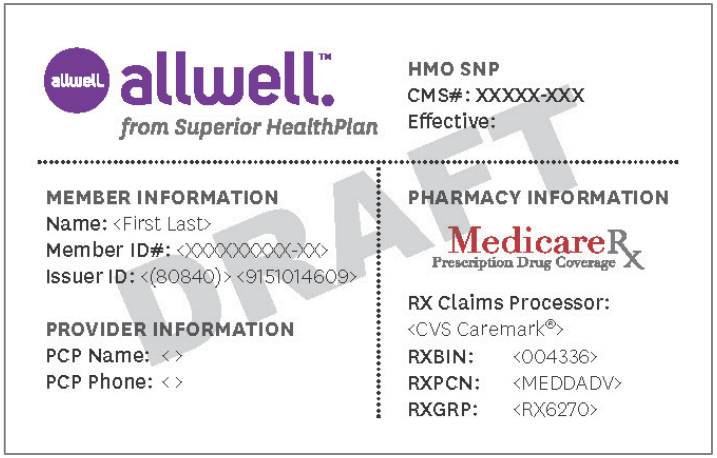
Allwell Dual Medicare (HMO SNP) Card


allwell™
from Superior HealthPlan

HMO SNP
CMS#: XXXXX-XXX
Effective:

MEMBER INFORMATION
Name: <First Last>
Member ID#: <XXXXXXXXX-XX>
Issuer ID: <(80840)> <9151014609>

PROVIDER INFORMATION
PCP Name: < >
PCP Phone: < >

PHARMACY INFORMATION
MedicareRx
Prescription Drug Coverage

RX Claims Processor:
<CVS Caremark®>
RXBIN: <004336>
RXPCN: <MEDDADV>
RXGRP: <RX6270>

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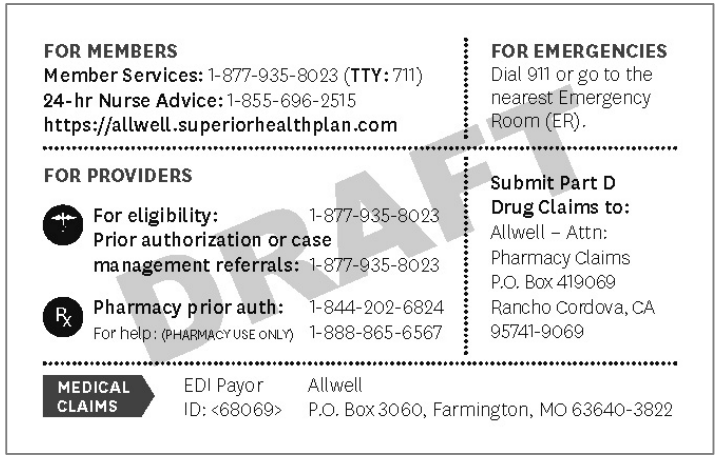
FOR MEMBERS
Member Services: 1-877-935-8023 (TTY: 711)
24-hr Nurse Advice: 1-855-696-2515
https://allwell.superiorhealthplan.com

FOR EMERGENCIES
Dial 911 or go to the nearest Emergency Room (ER).

FOR PROVIDERS
For eligibility: 1-877-935-8023
Prior authorization or case management referrals: 1-877-935-8023
Pharmacy prior auth: 1-844-202-6824
For help: (PHARMACY USE ONLY) 1-888-865-6567

Submit Part D Drug Claims to:
Allwell – Attn: Pharmacy Claims
P.O. Box 419069
Rancho Cordova, CA 95741-9069

MEDICAL CLAIMS
EDI Payor ID: <68069>
Allwell
P.O. Box 3060, Farmington, MO 63640-3822

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Covered Services and Additional Benefits

Plan Coverage

Allwell covers:

- All Part A and Part B benefits by Medicare.
- Part B drugs – such as chemotherapy drugs.
  - Part D drugs – available at network retail pharmacies or mail order (deductibles may apply).
- Additional benefits and services such as wellness programs, over-the-counter items and mental health services. For a summary of plan benefits, visit:
  - https://allwell.superiorhealthplan.com/reference-documents.html

Pharmacy Formulary

- The Allwell formulary is available at:
  - https://allwell.superiorhealthplan.com/prescription-drugs-formulary/formulary.html
  - Please refer to the formulary for specific types of exceptions.
- When requesting a formulary exception, a Drug Coverage Determination form must be submitted:
  - www.SuperiorHealthPlan.com/providers/resources/forms.html (located under “Helpful Medicare Links”)
  - The completed form can be faxed to Envolve Pharmacy Solutions at 844-202-6824.

Covered Services

Covered Services include, but are not limited to:

- Ambulance
- Behavioral Health
- Dental*
- Hearing
- Hospital Inpatient/Outpatient
- Lab and X-Ray
- Medical Equipment and Supplies
- Physician
- Podiatry
- Prescribed Medicines
- Therapy
- Transportation*
- Vision
- Wellness Programs

**Specific counties only.*

Network

- HCA/Methodist
- Texas Tech
- University Hospital –Bexar, El Paso
- El Paso Medical Network
- Christus Santa Rosa Health
- Doctors Hospital at Renaissance (DHR)
- Mission Health
- Baptist
- Southwest General Hospital
- Texas Health Resources (THR)

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HMO Benefit Overview

HMO Benefits – Bexar, Guadalupe, Wilson

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Medical Coverage			
Medical Deductible	$0	**Inpatient Hospital Care**	$175 per day, days 1-7; $0 per day, days 8–90
Maximum Out Of Pocket	$4,000 in-network	**Emergency Room**	$90 (waived if admitted to the hospital within 24 hours)
PCP Visits	$10	**Urgent Care**	$50
Specialist Visits	$35	**Lab Services**	$0
Pharmacy Coverage			
Pharmacy Deductible	$0	**Tier 1**	Preferred generic: $3/$9
		Tier 2	Generic: $12/$36
		Tier 3	Preferred brand: $47/$141
Prescription Drug Costs	1 month/3 month supply	**Tier 4**	Non-preferred brand: $95/$285
		Tier 5	Specialty tier: 33% co-insurance
		Tier 6	Select care drugs: $0/$0
Supplemental Benefits			
Vision	$0 routine eye exam (1 per year) Contact lenses and/or glasses (lenses and frames) maximum allowance $150/year	**Hearing**	$0 routine hearing exam (1 per year) $0 hearing aid fitting/evaluation (1 per year) Up to 2 hearing aids/year, co-payment ranging from $0-$995 per aid
Dental	$0 Preventative Dental: 2 Exams, 2 Cleanings (every 6 months), 1 X-Ray (bitewings only) per year, Comprehensive dental with coinsurance, maximum $1000 per year	**OTC Drugs and Supplies**	$60 every 3 months

HMO Benefits - Nueces

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Medical Coverage			
Medical Deductible	$0	**Inpatient Hospital Care**	$140 per day, days 1-6; $0 per day, days 7–90
Maximum Out Of Pocket	$4,600 in-network	**Emergency Room**	$90 (waived if admitted to the hospital within 24 hours)
PCP Visits	$10	**Urgent Care**	$65
Specialist Visits	$45	**Lab Services**	$0
Pharmacy Coverage			
Pharmacy Deductible	$325 for tiers 4 and 5	**Tier 1**	Preferred generic: $3/$9
		Tier 2	Generic: $14/$42
		Tier 3	Preferred brand: $47/$141
Prescription Drug Costs	1 month/3 month supply	**Tier 4**	Non-preferred brand: $100/$300
		Tier 5	Specialty tier: 26% co-insurance
		Tier 6	Select care drugs: $0/$0
Supplemental Benefits			
Vision	$0 routine vision exam (1 per year) Contact lenses and/or glasses (lenses and frames) maximum allowance $150/year	**Hearing**	$0 routine hearing exam (1 per year) $0 hearing aid fitting/evaluation (1 per year) Up to 2 hearing aids/year, co-payment ranging from $0-$995 per aid
Dental	$0 Preventative Dental: 2 Exams, 2 Cleanings (every 6 months), 1 X-Ray (bitewings only) per year	**OTC Drugs and Supplies**	$60 every 3 months
Wellness Program	$0 fitness membership at participating facility or in-home fitness program		

HMO Benefits - Collin, Dallas, Denton, Smith, Tarrant, Rockwall

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Medical Coverage			
Medical Deductible	$0	**Inpatient Hospital Care**	$250 per day, days 1 -7 $0 per day, days 8–90
Maximum Out Of Pocket	$3,800 in-network	**Emergency Room**	$90 (waived if admitted to the hospital within 24 hours)
PCP Visits	$0	**Urgent Care**	$65
Specialist Visits	$30	**Lab Services**	$0
Pharmacy Coverage			
Pharmacy Deductible	$0	**Tier 1**	Preferred generic: $0/$0
		Tier 2	Generic: $14/$42
		Tier 3	Preferred brand: $47/$141
Prescription Drug Costs	1 month/3 month supply	**Tier 4**	Non-preferred brand: $100/$300
		Tier 5	Specialty tier: 33% co-insurance
		Tier 6	Select Care Drugs: $0/$0
Supplemental Benefits			
Vision	$0 routine vision exam (1 per year) Contact lenses and/or glasses (lenses and frames) maximum allowance $125/year	**Hearing**	$0 Routine hearing exam (1 per year) $0 One hearing aid fitting/evaluation (1 per year) Up to 2 hearing aids/year, co-payment ranging from $0-$995 per aid
Dental	$0 Preventative Dental: 2 Exams, 2 Cleanings (every 6 months), 1 X-Ray (bitewings only) per year, Comprehensive dental with coinsurance, maximum $1000 per year	**OTC Drugs and Supplies**	$100 every 3 months
Wellness Program	$0 fitness membership at participating facility or in-home fitness program		

HMO Benefits - El Paso

Medical Coverage			
Medical Deductible	$0	**Inpatient Hospital Care**	$175 per day, days 1-8 $0 per day, days 9–90
Maximum Out Of Pocket	$3,900 in-network	**Emergency Room**	$90 (waived if admitted to the hospital within 24 hours)
PCP Visits	$0	**Urgent Care**	$65
Specialist Visits	$40	**Lab Services**	$0
Pharmacy Coverage			
Pharmacy Deductible	$0	**Tier 1**	Preferred generic: $3/$9
		Tier 2	Generic: $12/$36
		Tier 3	Preferred brand: $47/$141
Prescription Drug Costs	1 month/3 month supply	**Tier 4**	Non-preferred brand: $95/$285
		Tier 5	Specialty tier: 33% co-insurance
		Tier 6	Select care drugs: $0/$0
Supplemental Benefits			
Vision	$0 routine vision exam (1 per year) Contact lenses and/or glasses (lenses and frames) maximum allowance $100/year	**Hearing**	$0 routine hearing exam (1 per year) $0 hearing aid fitting/evaluation (every year)
OTC Drugs and Supplies	$60 every 3 months	**Transportation**	$0 8 one-way trips per year
Wellness Program	$0 fitness membership at participating facility or in-home fitness program		

HMO Benefits - Cameron and Hidalgo

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Medical Coverage			
Medical Deductible	$0	**Inpatient Hospital Care**	$100 per day, days 1-8 $0 per day, days 9–90
Maximum Out Of Pocket	$3,800 in-network	**Emergency Room**	$90 (waived if admitted to the hospital within 24 hours)
PCP Visits	$0	**Urgent Care**	$35
Specialist Visits	$35	**Lab Services**	$0
Pharmacy Coverage			
Pharmacy Deductible	$0	**Tier 1**	Preferred generic: $2/$6
		Tier 2	Generic: $12/$36
		Tier 3	Preferred brand: $40/$120
Prescription Drug Costs	1 month/3 month supply	**Tier 4**	Non-preferred brand: $95/$285
		Tier 5	Specialty tier: 33% co-insurance
		Tier 6	Select care drugs: $0/$0
Supplemental Benefits			
Vision	$0 routine vision exam (1 per year) Contact lenses and/or glasses (lenses and frames) maximum allowance $100/year	**Hearing**	$0 routine hearing exam (1 per year) $0 hearing aid fitting/evaluation (1 per year) Up to 2 hearing aids/year, co-payment ranging from $0-$995 per aid
Dental	$0 Preventative Dental: 2 Exams, 2 Cleanings, 1 X-Ray (only bitewings) per year. $0 Comprehensive Dental with coinsurance; Max Allowance $1,000 per year	**OTC Drugs and Supplies**	$80 every 3 months
Transportation	$0 16 one-way trips per year	**Wellness Program**	$0 fitness membership at participating facility or in-home fitness program

HMO Benefits – Fort Bend

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Medical Coverage			
Medical Deductible	$0	**Inpatient Hospital Care**	$125 per day, days 1-8 $0 per day, days 9–90
Maximum Out Of Pocket	$3,400 in-network	**Emergency Room**	$120
PCP Visits	$2	**Urgent Care**	$65
Specialist Visits	$35	**Lab Services**	$0
Pharmacy Coverage			
Pharmacy Deductible	$0	**Tier 1**	Preferred generic: $1/$2
		Tier 2	Generic: $8/$16
		Tier 3	Preferred brand: $42/$84
Prescription Drug Costs	1 month/3 month supply	**Tier 4**	Non-preferred brand: $85/$170
		Tier 5	Specialty tier: 33% co-insurance
		Tier 6	Select care drugs: $0/$0
Supplemental Benefits			
Vision	$0 routine vision exam (1 per year) Contact lenses and/or glasses (lenses and frames) maximum allowance $100/year	**Hearing**	$0 routine hearing exam (1 per year) $0 hearing aid fitting/evaluation (1 per year) Up to 2 hearing aids/year, co-payment ranging from $0-$995 per aid
Dental	$0 Preventative Dental: 2 Exams, 2 Cleanings, 1 X-Ray (only bitewings) per year. Comprehensive Dental with coinsurance / deductible, Max Allowance $2,000 per year	**OTC Drugs and Supplies**	$65 every 3 months
Transportation	$0 24 one-way trips per year	**Wellness Program**	$0 fitness membership at participating facility or in-home fitness program

HMO Benefits – Williamson

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Medical Coverage			
Medical Deductible	$0	**Inpatient Hospital Care**	$250 per day, days 1-8 $0 per day, days 9–90
Maximum Out Of Pocket	$5,500 in-network	**Emergency Room**	$90
PCP Visits	$0	**Urgent Care**	$65
Specialist Visits	$35	**Lab Services**	$0
Pharmacy Coverage			
Pharmacy Deductible	$325 for Tiers 4 and 5	**Tier 1**	Preferred generic: $3/$39
		Tier 2	Generic: $14/$42
		Tier 3	Preferred brand: $47/$131
Prescription Drug Costs	1 month/3 month supply	**Tier 4**	Non-preferred brand: $100/$290
		Tier 5	Specialty tier: 26% co-insurance
		Tier 6	Select care drugs: $0/$0
Supplemental Benefits			
Vision	$0 routine vision exam (1 per year) Contact lenses and/or glasses (lenses and frames) maximum allowance $200/year	**Hearing**	$0 routine hearing exam (1 per year) $0 hearing aid fitting/evaluation (1 per year) Up to 2 hearing aids/year, co-payment ranging from $0-$995 per aid
Transportation	$0 16 one-way trips per year	**OTC Drugs and Supplies**	$60 every 3 months
Wellness Program: $0 fitness membership at participating facility or in-home fitness program			

HMO Additional Benefits

Member rewards include:

Member Rewards	
Colorectal Exam	$50 gift card will be mailed after colorectal exam has been completed
Breast Cancer Screening	$20 gift card will be mailed after the breast cancer screening has been completed
Flu Vaccine	$20 gift card will be mailed after vaccine has been administered
Wellness Visit	$20 gift card will be mailed after wellness visit has been completed
HbA1C	$20 gift card will be mailed after HbA1c screening has been completed

Members also receive access to our 24/7 Nurse Advice Line

HMO SNP Benefit Overview

HMO SNP Benefits – Bexar, Nueces, Guadalupe, Wilson

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Medical Coverage			
Medical Deductible	$0	**Inpatient Hospital Care**	$0
Maximum Out Of Pocket	$0	**Emergency Room**	$0
PCP Visits	$0	**Urgent Care**	$0
Specialist Visits	$0	**Lab Services**	$0
Pharmacy Coverage			
Pharmacy Deductible	$0	**Prescription Drug Costs**	Cost sharing levels determined by social security administration and level of eligibility 0, $1.25, $3.40, $8.50 or 15% depending on tier and level of eligibility
Supplemental Benefits			
Vision	$0 Routine Eye Exam (1 per year) Contact Lenses and/or glasses (lenses and frames) maximum allowance $200 every year	**Hearing**	$0 Routing Hearing Exam (1 per year) $0 Hearing Aid Fitting/Evaluation (1 per year) Up to 2 hearing aids/year, co-payment ranging from $0-$995 per aid
Dental	$0 Preventative Dental: 2 Exams, 2 Cleanings, 1 X-Ray (bitewings only) per year Comprehensive Dental, Max Allowance $2,000 per year	**OTC Drugs and Supplies**	$250 every 3 months
Wellness Program	$0 Fitness membership at participating facility or in-home fitness program	**Transportation**	Unlimited

HMO SNP Benefits – Cameron & Hidalgo

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Medical Coverage			
Medical Deductible	$0	**Inpatient Hospital Care**	$0
Maximum Out Of Pocket	$0	**Emergency Room**	$0
PCP Visits	$0	**Urgent Care**	$0
Specialist Visits	$0	**Lab Services**	$0
Pharmacy Coverage			
Pharmacy Deductible	$0	**Prescription Drug Costs**	Cost sharing levels determined by social security administration and level of eligibility 0, $1.25, $3.40, $8.50 or 15% depending on tier and level of eligibility
Supplemental Benefits			
Vision	$0 Routine Eye Exam (1 per year) Contact Lenses and/or glasses (lenses and frames) maximum allowance $300 every year	**Hearing**	$0 Routing Hearing Exam (1 per year) $0 Hearing Aid Fitting/Evaluation (1 per year) Up to 2 hearing aids/year, co-payment ranging from $0-$995 per aid
Dental	$0 Preventative Dental: 2 Exams, 2 Cleanings, 1 X-Ray (bitewings only) per year Comprehensive Dental, Max Allowance $2,000 per year	**OTC Drugs and Supplies**	$325 every 3 months
Wellness Program	$0 Fitness membership at participating facility or in-home fitness program	**Transportation**	$0 48 one-way trips every year

HMO SNP Benefits – Dallas, Tarrant and Smith

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Medical Coverage			
Medical Deductible	$0	**Inpatient Hospital Care**	$0
Maximum Out Of Pocket	$0	**Emergency Room**	$0
PCP Visits	$0	**Urgent Care**	$0
Specialist Visits	$0	**Lab Services**	$0
Pharmacy Coverage			
Pharmacy Deductible	$0	**Prescription Drug Costs**	Cost sharing levels determined by social security administration and level of eligibility 0, $1.25, $3.40, $8.50 or 15% depending on tier and level of eligibility
Supplemental Benefits			
Vision	$0 Routine Eye Exam (1 per year) Contact Lenses and/or glasses (lenses and frames) maximum allowance $100 every year	**Hearing**	$0 Routing Hearing Exam (1 per year) $0 Hearing Aid Fitting/Evaluation (1 per year) Up to 2 hearing aids/year, co-payment ranging from $0-$995 per aid
Dental	$0 Preventative Dental: 2 Exams, 2 Cleanings, 1 X-Ray (bitewings only) per year Comprehensive Dental with coinsurance, Max Allowance $1,500 per year	**OTC Drugs and Supplies**	$325 every 3 months
Wellness Program	$0 Fitness membership at participating facility or in-home fitness program	**Transportation**	$0 24 one-way trips every year

HMO SNP Benefits - Rockwall and Collin

Medical Coverage			
Medical Deductible	$0	**Inpatient Hospital Care**	$0
Maximum Out Of Pocket	$0	**Emergency Room**	$0
PCP Visits	$0	**Urgent Care**	$0
Specialist Visits	$0	**Lab Services**	$0
Pharmacy Coverage			
Pharmacy Deductible	$0	**Prescription Drug Costs**	Cost sharing levels determined by social security administration and level of eligibility 0, $1.25, $3.40, $8.50 or 15% depending on tier and level of eligibility
Supplemental Benefits			
Vision	$0 Routine Eye Exam (1 per year) Contact Lenses and/or glasses (lenses and frames) maximum allowance $100 every year	**Hearing**	$0 Routing Hearing Exam (1 per year) $0 Hearing Aid Fitting/Evaluation (1 per year) Up to 2 hearing aids/year, co-payment ranging from $0-$1580 per aid
Dental	$0 Preventative Dental: 2 Exams, 2 Cleanings, 1 X-Ray (bitewings only) per year	**OTC Drugs and Supplies**	$70 every 3 months
Wellness Program	$0 Fitness membership at participating facility or in-home fitness program	**Transportation**	$0 24 one-way trips every year

HMO SNP Benefits – Fort Bend

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Medical Coverage			
Medical Deductible	$0	**Inpatient Hospital Care**	$0
Maximum Out Of Pocket	$0	**Emergency Room**	$0
PCP Visits	$0	**Urgent Care**	$0
Specialist Visits	$0	**Lab Services**	$0
Pharmacy Coverage			
Pharmacy Deductible	$0	**Prescription Drug Costs**	Cost sharing levels determined by social security administration and level of eligibility 0, $1.25, $3.40, $8.50 or 15% depending on tier and level of eligibility
Supplemental Benefits			
Vision	$0 Routine Eye Exam (1 per year) Contact Lenses and/or glasses (lenses and frames) maximum allowance $150 every year	**Hearing**	$0 Routing Hearing Exam (1 per year) $0 Hearing Aid Fitting/Evaluation (1 per year) Up to 2 hearing aids/year, co-payment ranging from $0-$1580 per aid
Dental	$0 Preventative Dental: 2 Exams, 2 Cleanings, 1 X-Ray (bitewings only) per year Comprehensive Dental, Max Allowance $1000 per year	**OTC Drugs and Supplies**	$250 every 3 months
Wellness Program	$0 Fitness membership at participating facility or in-home fitness program	**Transportation**	$0 24 one-way trips every year

HMO SNP Benefits – El Paso

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Medical Coverage			
Medical Deductible	$0	**Inpatient Hospital Care**	$0
Maximum Out Of Pocket	$0	**Emergency Room**	$0
PCP Visits	$0	**Urgent Care**	$0
Specialist Visits	$0	**Lab Services**	$0
Pharmacy Coverage			
Pharmacy Deductible	$0	**Prescription Drug Costs**	Cost sharing levels determined by social security administration and level of eligibility 0, $1.25, $3.40, $8.50 or 15% depending on tier and level of eligibility
Supplemental Benefits			
Vision	$0 Routine Eye Exam (1 per year) Contact Lenses and/or glasses (lenses and frames) maximum allowance $300 every year	**Hearing**	$0 Routing Hearing Exam (1 per year) $0 Hearing Aid Fitting/Evaluation (1 per year) Up to 2 hearing aids/year, co-payment ranging from $0-$995 per aid
Dental	$0 Preventative Dental: 2 Exams, 2 Cleanings, 1 X-Ray (bitewings only) per year Comprehensive Dental, Max Allowance $2500 per year	**OTC Drugs and Supplies**	$325 every 3 months
Wellness Program	$0 Fitness membership at participating facility or in-home fitness program	**Transportation**	$0 48 one-way trips every year

HMO SNP Benefits – Williamson

FROM superior healthplan

Medical Coverage			
Medical Deductible	$0	**Inpatient Hospital Care**	$0
Maximum Out Of Pocket	$0	**Emergency Room**	$0
PCP Visits	$0	**Urgent Care**	$0
Specialist Visits	$0	**Lab Services**	$0
Pharmacy Coverage			
Pharmacy Deductible	$0	**Prescription Drug Costs**	Cost sharing levels determined by social security administration and level of eligibility 0, $1.25, $3.40, $8.50 or 15% depending on tier and level of eligibility
Supplemental Benefits			
Vision	$0 Routine Eye Exam (1 per year) Contact Lenses and/or glasses (lenses and frames) maximum allowance $150 every year	**Hearing**	$0 Routing Hearing Exam (1 per year) $0 Hearing Aid Fitting/Evaluation (1 per year) Up to 2 hearing aids/year, co-payment ranging from $0-$995 per aid
Dental	$0 Preventative Dental: 2 Exams, 2 Cleanings, 1 X-Ray (bitewings only) per year Comprehensive Dental, Max Allowance $1000 per year	**OTC Drugs and Supplies**	$325 every 3 months
Wellness Program	$0 Fitness membership at participating facility or in-home fitness program	**Transportation**	$0 10 one-way trips every year

HMO SNP Additional Benefits

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Member rewards include:

Member Rewards	
Colorectal Exam	$50 gift card will be mailed after colorectal exam has been completed
Breast Cancer Screening	$20 gift card will be mailed after the breast cancer screening has been completed
Flu Vaccine	$20 gift card will be mailed after vaccine has been administered
Wellness Visit	$20 gift card will be mailed after wellness visit has been completed
HbA1C	$20 gift card will be mailed after HbA1c screening has been completed
Retinal (Eye) Screening	$20 gift card will be mailed after retinal screening has been completed

Members also receive access to our 24/7 Nurse Advice Line

Providers and Authorization

Primary Care Providers (PCPs)

PCPs serve as a medical home and provide the following:

- Sufficient facilities and personnel
- Covered services as needed
  - 24-hours a day, 365 days a year
- Coordination of medical services and specialist referrals
- After-hours accessibility using one of the following methods:
  - Answering service
  - Call center system connecting to a live person
  - Recording directing member to a covering practitioner
  - Live individual who will contact a PCP

Utilization Management

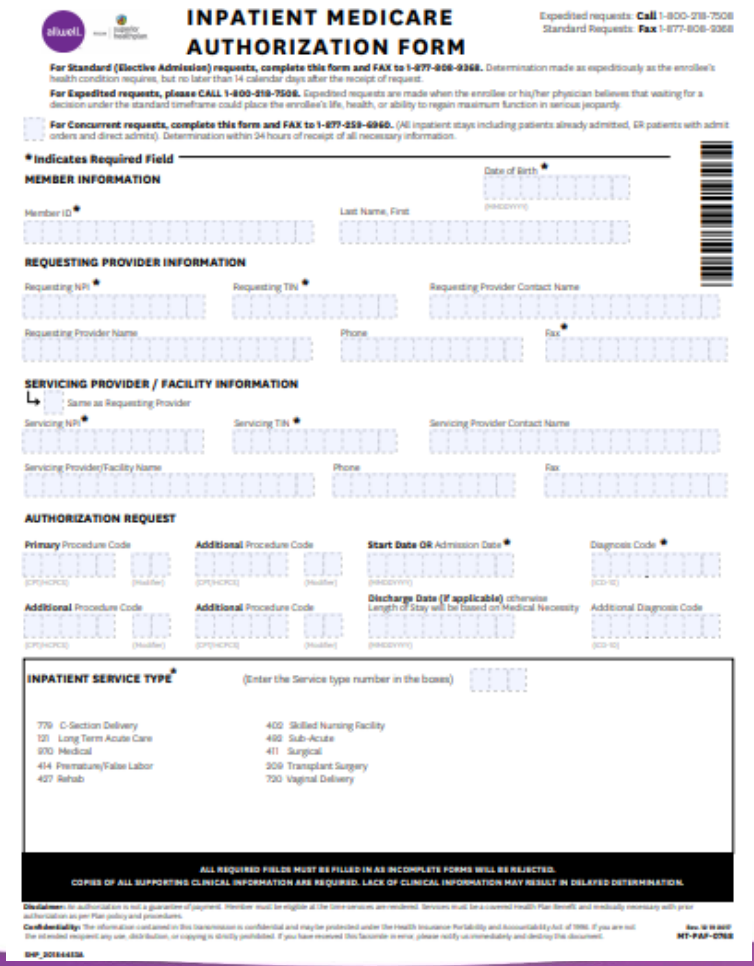
Authorization must be obtained prior to the delivery of certain elective and scheduled services. The preferred method for submitting authorization requests is through the Secure Provider Portal at Provider.SuperiorHealthPlan.com.

Service Type	Time Frame
Elective/scheduled admissions	Required five business days prior to the scheduled admit date
Emergent inpatient admissions	Notification required within one business day
Emergency room and post stabilization	Notification requested within one business day

Prior Authorizations

Prior authorization is required for:

- Inpatient admissions, including observation
- Home health services
- Ancillary services
- Radiology (MRI, MRA, PET, CT)
- Pain management programs
- Outpatient therapy and rehab (OT,PT,ST)
- Transplants
- Surgeries
- Durable Medical Equipment (DME)
- Part B drugs



INPATIENT MEDICARE AUTHORIZATION FORM

Expedited requests: **Call** 1-800-218-7508
Standard Requests: **Fax** 1-877-808-9368

For Standard (Elective Admission) requests, complete this form and FAX to 1-877-808-9368. Determination made as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after the receipt of request.

For Expedited requests, please CALL 1-800-218-7508. Expedited requests are made when the enrollee or his/her physician believes that waiting for a decision under the standard timeframe could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

For Concurrent requests, complete this form and FAX to 1-877-259-6960. (All inpatient stays including patients already admitted, ER patients with admit orders and direct admits). Determination within 24 hours of receipt of all necessary information.

***Indicates Required Field**

MEMBER INFORMATION

Member ID* | Last Name, First | Date of Birth*

REQUESTING PROVIDER INFORMATION

Requesting NPI* | Requesting TIN* | Requesting Provider Contact Name

Requesting Provider Name | Phone | Fax*

SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider

Servicing NPI* | Servicing TIN* | Servicing Provider Contact Name

Servicing Provider/Facility Name | Phone | Fax

AUTHORIZATION REQUEST

Primary Procedure Code | **Additional** Procedure Code | **Start Date OR** Admission Date* | Diagnosis Code*

Additional Procedure Code | **Additional** Procedure Code | **Discharge Date (if applicable)** otherwise Length of Stay will be based on Medical Necessity | Additional Diagnosis Code

INPATIENT SERVICE TYPE* (Enter the Service type number in the boxes)

779 C-Section Delivery	400 Skilled Nursing Facility
121 Long Term Acute Care	490 Sub-Acute
970 Medical	411 Surgical
414 Premature/False Labor	209 Transplant Surgery
427 Rehab	720 Vaginal Delivery

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient, any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

MT-PAF-0768

Prior Authorizations

- Forms are accessible on our website by visiting:
  - www.SuperiorHealthPlan.com/providers/resources/forms.html (located under Medicare Acute Care Services)
- There are three ways to submit requests:
  - Fax: 1-877-808-9368
  - Phone: 1-800-218-7508
  - Secure Web Portal: Provider.SuperiorHealthPlan.com

Out-of-Network Coverage

Plan authorization is required for out-of-network services, except:

- Emergency care.
- Urgently needed care when the network provider is not available (usually due to out-of-area).
- Kidney dialysis at Medicare-certified dialysis center when temporarily out of the service area.

Medical Necessity Determination

- When medical necessity cannot be established, a peer-to-peer review is offered.
- Denial letters will be sent to the member and provider.
- The clinical basis for the denial will be indicated.
- Member appeal rights will be fully explained.

Preventive Care and Screening Tests

Preventive Care

- No copay for all preventive services covered under original Medicare at zero cost-sharing.
- Initial Preventive Physical Exam – Welcome to Medicare:
  - Measurement of height, weight, body mass index, blood pressure, visual acuity screen and other routine measurements. Also includes an electrocardiogram, education and counseling. Does not include lab tests. Limited to one per lifetime.
- Annual Wellness Visit:
  - Available to members after the member has the one-time initial preventive physical exam (Welcome to Medicare Physical).

Preventive Care

- Abdominal Aortic Aneurysm Screening
- Alcohol Misuse Counseling
- Blood Pressure Screening
- BMI, Functional Status
- Bone Mass Measurement
- Breast Cancer Screening (mammogram)
- Cardiovascular Disease (behavioral therapy)
- Cardiovascular Screenings
- Cervical and Vaginal Cancer Screenings
- Colonoscopy
- Colorectal Cancer Screenings
- Depression Screening
- Diabetes Screenings
- Fecal Occult Blood Test
- Flexible Sigmoidoscopy
- HIV Screening
- Medical Nutrition Therapy Services
- Medication Review
- Obesity Screening and Counseling
- Pain Assessment
- Prostate Cancer Screenings (PSA)
- Sexually Transmitted Infections Screening and Counseling
- Tobacco Use Cessation Counseling (counseling for people with no sign of tobacco-related disease)
- Vaccines, Including Flu Shots, Hepatitis B Shots, Pneumococcal Shots

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Medicare Star Ratings

Medicare Star Ratings

What Are CMS Star Ratings?

- The Centers for Medicare and Medicaid Services (CMS) uses a five-star quality rating system to measure Medicare beneficiaries' experience with their health plans and the health-care system. This rating system applies to Allwell plans that cover both health services and prescription drugs (Allwell Medicare [HMO] and Allwell Dual Medicare [HMO SNP]).

- The ratings are posted on the CMS consumer website, www.Medicare.gov. The Star Rating System is designed to promote improvement in quality and recognize PCPs for demonstrating an increase in performance measures over a defined period of time.

Medicare Star Ratings

CMS's Star Rating Program is based on measures in 5 different areas:

1. Staying healthy (screenings, tests and vaccines).
2. Managing chronic (long-term) conditions.
3. Member experience with the health plan.
4. Member complaints (problems getting services and improvement in the health plan's performance).
5. Health plan customer service.

How Can Providers Improve Star Ratings?

- Continue to encourage patients to obtain preventive screenings annually or when recommended.
- Manage chronic conditions, such as hypertension and diabetes, including medication adherence.
- Continue to talk to patients and document interventions regarding topics such as fall prevention, bladder control and the importance of physical activity and emotional health and wellbeing (HOS).
- Create office practices to identify noncompliant patients at the time of their appointment.
- Identify opportunities to have an impact on patient health and well-being.

How Can Providers Improve Star Ratings?

- Submit complete and correct encounters/claims with appropriate codes and properly document medical charts for all members, including availability of medical records for chart abstractions.
- Review the gap in care files that list members with open gaps. These are available on Superior's Secure Provider Portal.
- Review medication and follow up with members within 14 days post hospitalization.
- Make appointments available to patients and reduce wait times (CAHPS).
- Follow up with patients regarding their test results (CAHPS).

Web-Based Tools

SuperiorHealthPlan.com

Superior Website

Through www.SuperiorHealthPlan.com, providers can access:

- Billing Manuals
- Forms
- HEDIS Quick Reference Guides
- Provider News
- “Pre-Auth Needed?” Tool
- Provider Resources

Additional information and resources located at: www.Allwell.SuperiorHealthPlan.com

Superior Secure Provider Portal

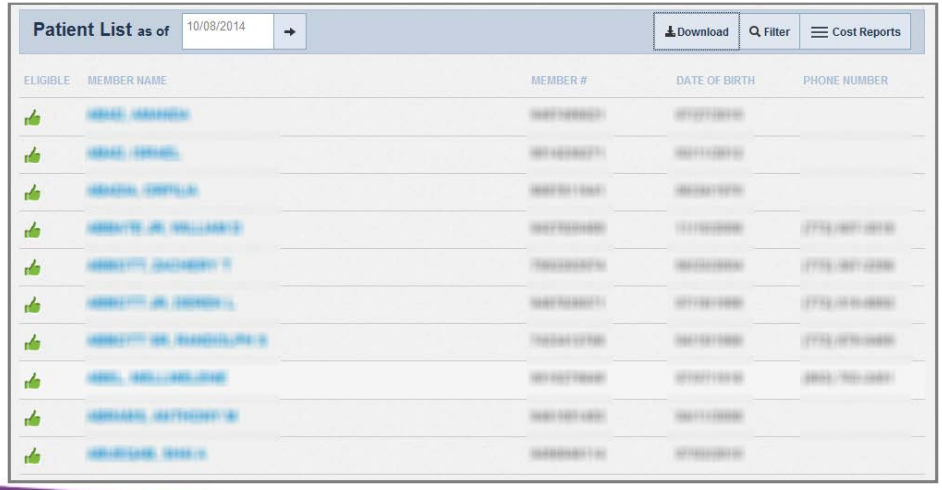
On Superior's Secure Provider Portal, Provider.SuperiorHealthPlan.com, providers can access:

- Authorizations
- Claims
  - Download Payment History
  - Processing Status
  - Submission / Adjustments
  - Clean Claim Connection – Claim Auditing Software
- Health Records
  - Care Gaps*
- Patient Listings* and Member Eligibility

**Available for PCPs only*

Superior Secure Provider Portal

- Primary Care Provider Reports
  - **Patient List** – Located on Provider.SuperiorHealthPlan.com.
    - Includes member's name, ID number, date of birth and telephone number. The Patient List is available to download to Excel or PDF formats and includes additional information such as member's effective date, termination date, product, gender and address.



Superior Secure Provider Portal

Updating Your Data

- Providers can improve member access to care by ensuring that their data is current in Superior's provider directory.
- To update your provider data:
    1. Log in to the Secure Provider Portal.
    2. From the main tool bar select “Account Details”.
    3. Select the provider whose data you want to update.
    4. Choose the appropriate service location.
    5. Make appropriate edits and save.

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Network Partners

Partners and Vendors

- Pharmacy Benefit Manager: Envolve Pharmacy Solutions
  - Phone: 1-866-399-0928
  - Fax (PA requests): 1-866-399-0929
- Vision Benefits: Envolve Vision Services
  - Phone: 1-888-756-8768
  - www.EnvolveVision.com
- Non-emergent, Outpatient High Tech Imaging: National Imaging Associates (NIA)
  - Phone: 1-800-642-7554
  - www.RadMD.com

Please note: As of September 1, 2017, behavioral health providers can contact Superior HealthPlan for authorizations and questions on behavioral health services.

Lab and DME Partners

Lab
Bio Reference
Sequenome Center
MD Labs
Lab Corp
Quest

DME
American Home Patient
Apria
Breg
CCS Medical
Critical Signal Technologies
DJO
EBI
Edge Park
J&B Medical
KCI
Lincare
Hanger Prosthetics and Orthotics
National Seating & Mobility
Numotion
Nextra Health

AcariaHealth - Specialty Pharmacy

AcariaHealth is a national, comprehensive specialty pharmacy providing services in all specialty disease states including:

- Cystic Fibrisis
- Hemophilia
- Hepatitis C
- Multiple Sclerosis
- Oncology
- Rheumatoid Arthritis

Most biopharmaceuticals and injectables require prior authorization at: CustomerCare@acariahealth.com

Billing Overview

Electronic Claims Transmission and Support

- Six clearinghouses for Electronic Data Interchange (EDI) submission:
  - Payer ID 68069
  - Faster processing turn around time than paper submission.
    - Emdeon
    - Gateway
    - Availity/THIN
    - SSI
    - Medavant
    - Smart Data Solution
- Companion guides for EDI billing requirements and loop segments can be found at www.SuperiorHealthPlan.com
- For more information, email EDIBA@centene.com

Claims Filing Timelines

- Allwell claims should be mailed to the following billing address:

  Allwell from Superior HealthPlan
  Attn: Claims
  P. O. Box 3060
  Farmington, MO 63640-3822

- Participating providers have 95 days from the date of service to submit a timely claim.

- All requests for reconsideration or claim disputes must be received within 120 days from last timely processed claim.

Claims Payment

- A clean claim is received in a nationally accepted format in compliance with standard coding guidelines, and requires no further information, adjustment or alteration for payment.
- A claim will be paid or denied with an Explanation of Payment (EOP) mailed to the provider who submitted the original claim.
- Providers may **not** bill members for services when the provider fails to obtain authorization and the claim is denied.
- Dual-eligible members are protected by law from balance billing for Medicare Parts A and B services. This includes deductibles, co-insurance and copayments.
- Providers may not balance bill members for any differential.

Coding Auditing and Editing

Superior uses code editing software based on edits from:

- American Medical Association (AMA)
- Specialty society guidance
- Clinical consultants
- Centers for Medicare and Medicaid Services (CMS)
- National Correct Coding Initiative (NCCI)

Software audits for coding inaccuracies, including:

- Unbundling
- Upcoding
- Invalid codes

Corrected Claims & Requests for Reconsideration

- A corrected claim is submitted when information requires a change from the original claim submission
- A request for reconsideration is submitted when there is a disagreement with the manner in which a claim was processed. Reconsideration request may require medical records if related to code audit, code edit or auth denial.

Submit corrected claims or reconsiderations to:

Allwell from Superior HealthPlan
Attn: Corrections/Reconsiderations
PO Box 3060
Farmington, MO 63640-3822

Claim Disputes

- A claim dispute is to be used only when a provider has received an unsatisfactory response to a request for reconsideration.

Submit claim disputes to:

Allwell from Superior HealthPlan
Attn: Claim Dispute
P. O. Box 4000
Farmington, MO 63640-4000

Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)

EFT/ERA

Electronic payment benefits include:

- Obtaining faster payments, leading to improvements in cash flow.
- Eliminating re-keying of remittance data.
- Matching payments to statements promptly.
- Connecting quickly with any payers that are using Payspan to settle claims.
- Accessing payment services for free: www.PayspanHealth.com

Meaningful Use – Electronic Medical Records

Electronic Medical Records

- Electronic Health Records/Electronic Medical Records (EHR/EMR) allows health-care professionals to provide patient information electronically instead of using paper records.
- EHR/EMR can provide many benefits, including:
  - Complete and accurate information
  - Better access to information
  - Patient empowerment

Please note: Incentive programs may be available.

Advance Directives

Advance Directives

- An advance medical directive helps the PCP understand the member's wishes about their health care in the event they are unable to make decisions on their own behalf. Examples include:
  - Living Will
  - Health Care Power of Attorney
  - "Do Not Resuscitate" Orders
- Member's medical records must be documented to indicate whether an advance directive has been executed.
- Providers must also educate staff on issues concerning advance directives and must maintain written policies that address the rights of members to make decisions about medical care.

Fraud, Waste and Abuse

Fraud, Waste and Abuse

Superior follows the four parallel strategies of the Medicare and Medicaid programs to prevent, detect, report and correct fraud, waste and abuse:

1. Preventing fraud through effective enrollment and education of physicians, providers, suppliers and beneficiaries.
2. Detection through data analytics and medical records review.
3. Reporting any identified or investigated violations to the appropriate partners, including contractors, the NBI-MEDIC and federal and state law enforcement agencies, such as the Office of Inspector General (OIG), Federal Bureau of Investigation (FBI), Department of Justice (DOJ) and Medicaid Fraud Control Unit (MFCU).
4. Correcting fraud, waste or abuse by applying fair and firm enforcement policies, such as pre-payment review, retrospective review and corrective action plan.

Fraud, Waste and Abuse

Superior performs front and back-end audits to ensure compliance with billing regulations.

- **Most common errors:**
  - Use of incorrect billing code
  - Not following the service authorization
  - Procedure code not being consistent with provided service
  - Excessive use of units not authorized by the case manager
  - Lending of insurance card
- **Benefits of stopping Fraud, Waste and Abuse:**
  - Improves patient care
  - Helps save dollars and identify recoupments
  - Decreases wasteful medical expenses

Fraud, Waste and Abuse

Superior expects all providers, contractors and subcontractors to comply with applicable laws and regulations including, but not limited to, the following:

- Federal and State False Claims Act
- Qui Tam Provision (Whistleblower)
- Anti-Kickback Statute
- Physician Self-Referral Law (Stark Law)
- Health Insurance Portability and Accountability Act (HIPAA)
- Social Security Act (SSI)
- US Criminal Codes

Fraud, Waste and Abuse

Effective January 1, 2016:

- First-Tier, Downstream and Related Entities (FDR), as well as delegated entities, will be required to complete training via the Medicare Learning Network (MLN) website.
- The trainings must be completed by each individual provider/practitioner within the group rather than one person representing the group collectively.
- The updated regulation requires all applicable entities (providers, practitioners, administrators) to complete the training within 90 days of contracting or becoming a delegated entity and annually thereafter.
- Once training is complete, each applicable entity will need to complete the certificate(s) of completion or attestation through the CMS MLN and provide a copy to the health plan.

Medicare Reporting

Potential fraud, waste or abuse may be reported by calling:

- Superior's Fraud, Waste and Abuse Hotline:1-866-685-8664
- Superior's Compliance Officer: 1-800-218-7453

To report suspected fraud, waste or abuse in the Medicare program, please use one of the following avenues:

- Office of Inspector General (OIG):
  1-800-HHS-TIPS (1-800-447-8477)
- Medicare: 1-800-Medicare (1-800-633-42273)

CMS Mandatory Trainings

Medicare General Compliance and FWA Training

- Providers are required to complete training via the Medicare Learning Network (MLN) website.
- Must be completed by each individual provider/practitioner within the group rather than one person representing the group collectively.
- Training must be completed within 90 days of contracting and annually thereafter.
- Complete the certificate(s) of completion or attestation through the CMS MLN and provide a copy to Superior.
- Learn more about these required trainings by visiting www.SuperiorHealthPlan.com/newsroom/required-trainings-for-ma-and-starplus-mmp-providers.html

Model of Care

Allwell Dual Medicare (HMO SNP) Only

Model of Care (HMO SNP Only)

The Model of Care is Superior's plan for delivering integrated care management programs to members with special needs. The goals of the Model of Care are to:

- Improve access to medical, mental health and social services.
- Improve access to affordable care.
- Improve coordination of care through an identified point of contact.
- Improve transitions of care across health-care settings and providers.
- Improve access to preventive health services.
- Assure appropriate utilization of services.
- Assure cost-effective service delivery.
- Improve beneficiary health outcomes.

Model of Care (HMO SNP)

Model of Care elements:

- Description of the HMO SNP population
- Care coordination and care transitions protocol
- Provider network
- Quality measurements and performance improvement

Model of Care Process (HMO SNP Only)

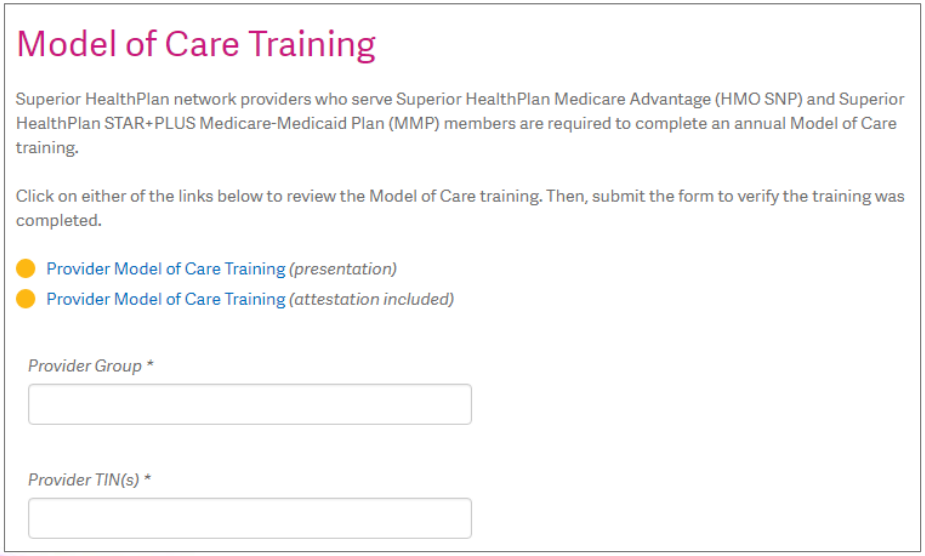
- Every dual member is evaluated with a comprehensive Health Risk Assessment (HRA) within 90 days of enrollment and, at a minimum, annually, or more frequently with any significant change in condition or transition of care.
- The HRA collects information about the member's medical, psychosocial, cognitive and functional needs, and medical and behavioral health history.
- Members are then triaged to the appropriate Superior Case Management Program for follow up.

Model of Care Process (HMO SNP Only)

- Superior values its partnership with network physicians and providers.
- The Model of Care requires that Superior and providers collaborate to benefit members by:
  - Enhancing communication between members, physicians, providers and Superior.
  - Taking an interdisciplinary approach with regard to the member’s special needs.
  - Providing comprehensive coordination with all care partners.
  - Supporting the member's preferences in the Model of Care.
  - Reinforcing the member’s connection with their medical home.

Model of Care Information (HMO SNP Only)

- Model of Care information is available on www.SuperiorHealthPlan.com/providers/training-manuals/model-of-care-form.html
- The Model of Care Training must be completed by providers annually, during each calendar year.



Model of Care Training

Superior HealthPlan network providers who serve Superior HealthPlan Medicare Advantage (HMO SNP) and Superior HealthPlan STAR+PLUS Medicare-Medicaid Plan (MMP) members are required to complete an annual Model of Care training.

Click on either of the links below to review the Model of Care training. Then, submit the form to verify the training was completed.

- Provider Model of Care Training *(presentation)*
- Provider Model of Care Training *(attestation included)*

*Provider Group **

*Provider TIN(s) **

Questions and Answers

Thank you for attending!