HealthTeam Advantage Provider Manual

HealthTeam Advantage Plan I (PPO)
HealthTeam Advantage Plan II (PPO)

March, 2018

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Welcome to HealthTeam Advantage

Thank you for your participation in the HealthTeam Advantage network of physicians and providers. We are pleased to provide you with this edition of the HealthTeam Advantage Provider Manual. We hope this information will make it easier for you and your staff to find the information you need to provide service to your HealthTeam Advantage patients.

Please spend some time reviewing this manual. It is meant to supplement your HealthTeam Advantage network service agreement; nothing in this manual is intended to alter the terms and conditions of your HealthTeam Advantage network participation agreement.

From time to time, HealthTeam Advantage may revise the terms of this Provider Manual. You will be notified of any such changes and a current Provider Manual will also be available on the HealthTeam Advantage website at www.healthteamadvantage.com. If you are contracted through a medical group or an IPA participation agreement, the medical group or IPA will notify you of changes to the HealthTeam Advantage Provider Manual.

If you have any questions regarding HealthTeam Advantage, please contact us at 336-554-8752. Also, feel free to share any specific suggestions for making the HealthTeam Advantage Provider Manual a more useful tool. Thank you for your continued support of HealthTeam Advantage. We value your feedback and look forward to hearing from you.

Sincerely,

Steve Neorr
Chief Executive Officer

HealthTeam Advantage Information & Requirements

Important Contact Information

HealthTeam Advantage Hours of Operation	October 1 – February 14, 8AM- 8PM EST, 7 days a week; February 15 – September 30, 8AM-8PM EST, Monday - Friday
Phone	888-965-1965
Website	www.healthteamadvantage.com
Address	HealthTeam Advantage Insurance Company, Inc. 7800 McCloud Rd, Suite 100 Greensboro, NC 27409
Concierge Services for Members (Claims, Billing, Appeals or Member Questions)	October 1 – February 14, 8AM-8PM EST, 7 days a week February 15 – September 30, 8AM-8PM EST, Monday - Friday
Phone	888-965-1965
TTY	711
Email Healthcare Concierge	conciergehta@healthteamadvantage.com
Utilization Management	
Phone	844-873-2905
Fax	844-873-3163
Acuity Connect Portal	https://acuityconnect.conehealth.com/production
Care Management	
Referrals	844-873-9947
Fax	844-873-9948
Provider Benefits & Eligibility Verification	
Interactive Voice Response (IVR)	855-621-0401
Provider Support Benefits & Eligibility	844-806-8219
Email Benefits & Eligibility	providerbenefitseligibility@healthteamadvantage.com
Payer ID:	SLVBK
Provider Concierge	
Phone	336-554-8752
Email Provider Concierge	providerconcierge@healthteamadvantage.com
Claims	
Claims Portal	https://claims.silverbacktpa.com/claims/#/login
Claims Inquiry	844-806-8217
Fax	844-644-5374
Mailing Address	HealthTeam Advantage Claims Department P. O. Box 164579 Fort Worth, TX 76161
Email	providerclaims@healthteamadvantage.com

Change Healthcare Clearinghouse	
Payer ID#	37228
Customer Service	888-363-3361
Pharmacy Services (EnvisionRx Options)	
Phone	800-361-4542
Prior Authorizations	866-250-2005
Online	https://envisionrx.com/prescribersandproviders/prescribers
Fax	330-405-8081
Pharmacy Appeals	844-846-8003
Dental Services (Avesis)	
Phone	855-214-6777
Website	www.avesis.com
Vision Services (Avesis)	
Phone	855-214-6777
Website	www.avesis.com
Hearing (Avesis)	
Phone	855-214-6777
Website	www.avesis.com
Appeals & Grievances	
	HealthTeam Advantage Insurance, Inc. Appeals & Grievances Department 7800 McCloud Rd, Suite 100 Greensboro, NC 27409 888-965-1965 Fax: 1-800-845-4104
Compliance, Ethics, Fraud Waste and Abuse (FWA)	
Phone	855-741-4518
Website	www.hta.ethicspoint.com
Medicare (CMS) Contact Information	
Phone	800-MEDICARE or 800-633-4227
TTY	877-486-2048
Website	www.medicare.gov

Unless otherwise specified in your contract with HealthTeam Advantage, the information contained in this document will apply. We reserve the right to make changes to this manual as needed to remain compliant with the Centers for Medicare & Medicaid Services (CMS) guidelines. The most current version of our provider operations manual is available on our website www.healthteamadvantage.com.

HealthTeam Advantage Product Lines

HealthTeam Advantage offers North Carolina residents affordable, flexible health coverage through a variety of Medicare Advantage plans. HealthTeam Advantage offers two PPO plans for its members and prospective members. The coverage service areas for our PPO product lines are: Alamance, Guilford, Randolph, and Rockingham counties. Members have the option to obtain optional supplemental benefits which include dental, vision, and hearing benefits. Our plans also provide Fitness Services to our members. PPO Evidence of Coverage and Summary of Benefits can be found at www.healthteamadvantage.com.

Network Provider Requirements

HealthTeam Advantage must follow certain regulations and requirements as mandated by the Centers for Medicare & Medicaid Services (CMS). CMS considers a contracted provider to be an extension of the Plan. As a contracted network provider, you must also follow certain regulations and requirements. These regulations and requirements are specifically outlined in this manual. Additional regulations and requirements may be described in your provider services agreement with HealthTeam Advantage, whether directly with HealthTeam Advantage or through an IPA or group agreement.

Some of the regulations you will need to be aware of are as follows:

- HealthTeam Advantage will assist providers with enhanced case management for their patients who have complex or serious medical conditions. Case managers will assist providers to assess conditions, establish and implement a treatment plan.
- Providers may not deny, limit or apply conditions to the coverage or furnishing of covered services to members enrolled in HealthTeam Advantage based on any condition related to the member's current health status.
- Will not discriminate against Members because of their participation as Members, their source of payment, age, race, color, national origin, religion, sex, sexual preference or disability.
- Providers may not impose any cost sharing to HealthTeam Advantage members for influenza or pneumococcal vaccine and any other preventative service as mandated by CMS.
- Providers agree to provide all claims encounter data necessary to characterize the context and purpose of each encounter with a HealthTeam Advantage member and a physician, other health care professionals or health care facility.
- Physicians, other health care professionals and facilities agree that all encounter data will be used by HealthTeam Advantage in validating its rates with CMS and that all encounter data and other information submitted to HealthTeam Advantage and ultimately CMS is accurate, complete, and truthful and is based on the physician's, other health care professional's or facility's best knowledge, information and belief.
- Physicians, other health care professionals and facilities acknowledge that misrepresentations about the accuracy of encounter data may result in federal/civil

action and/or criminal prosecution.

- Providers agree not to bill HealthTeam Advantage members for covered services (except for applicable deductibles, copayments or coinsurance) if payment has been denied because the provider has failed to comply with the terms of this manual or the agreement between the provider and HealthTeam Advantage.
- Providers must notify all HealthTeam Advantage members of their financial obligation for non-covered services in writing.
- Physicians, other health care professionals and facilities and entities delegated by them to perform administrative services are covered entities under Federal and state privacy laws.
- To the extent required by law, providers and their contracted business associates will keep all medical records containing patient-identifiable information confidential and will not disclose any patient-identifiable information to any third party without the prior written consent of the member.
- Providers shall ensure services provided are documented and incorporated into the member's primary care medical record. It is important for specialty physicians and other providers to advise the referring physician when follow-up care is necessary.
- Providers are responsible for the education and training of all individuals working within their medical practice to ensure that procedures outlined in this provider manual are followed correctly. You may contact provider relations to request staff training that may include, but is not limited to, billing procedures and administrative policies.
- Physicians, other health care professionals and facilities will make individual medical records available to patients or their legally designated representative upon request.
- At all reasonable times, physicians, other health care professionals and facilities will provide HealthTeam Advantage, CMS, the Office of Inspector General, and their duly authorized representatives the right of access to its facilities and to its financial and medical records which are directly pertinent to HealthTeam Advantage members in order to monitor and evaluate cost, performance, compliance measures reporting, quality improvement activities, appropriateness, and timeliness of services provided.
- Physicians, other health care professionals and facilities may not give out or accept applications for enrollment. If an announcement is made to patients of their participation with HealthTeam Advantage, this may only be made one time without mentioning other Medicare health plans with which they participate.
- Provide timely notification to Provider Concierge Department of any practice changes, additions or terms.
- Providers are to verify their demographic information on the on-line Provider Directories on a quarterly basis and email providerconcierge@healthteamadvantage.com confirming their information.
- Assure access and availability to HealthTeam Advantage members.
- Primary Care Providers must be available to members 24 hours a day, 7 days a week.
- After hour service providers must have an answering service or answering machine directing member with a phone number of how to reach their PCP or on-call provider.

- Appointments are ***not required*** when:
    - Emergency Services such as life threatening or serious illness, must be provided upon member presentation at office or facility.
    - Urgent Care, requires prompt attention but isn't life threatening, including specialty urgent care must be provided within 24 hours of request.
- Appointments are ***required*** when:
    - Non-Urgent must be able to schedule an appointment within a week's request.
    - Routine Primary Care is for new medical concern that is not considered urgent and must be provided within 30 days of requests.
    - Routine Specialty Care referrals must be provided within 30 days of requests.
    - Preventative Health Services appointments for wellness check-ups must be provided within 90 days of requests.
    - Initial Outpatient Behavioral Health must be provided within 14 days of request.

HealthTeam Advantage appreciates your dedication to serving the Medicare Advantage population. If you have any questions above listed requirements, please contact your Provider Concierge Representative by email at providerconcierge@healthteamadvantage.com or by calling 336-554-8752.

Provider Concierge & Provider Changes or Updates

Practice Relations is the liaison between the community providers and health plan. Under Practice Relations, the Provider Concierge Department offers support, guidance, education, resources, training and conduct Provider site visits.

Providers are encouraged to contact their assigned Provider Concierge Representative who will be their primary contact for any issues or concerns they may have regarding HealthTeam Advantage health plan. Issues or concerns can pertain to demographic updates/changes, claims, authorizations, eligibility, contracting, and credentialing, etc.

Providers can contact their assigned Provider Concierge Representative or Provider Concierge Department at 336-554-8752 or by emailing providerconcierge@healthteamadvantage.com.

Provider Additions, Changes, Terminations and Panel Closure

HealthTeam Advantage adheres to regulatory guidelines when evaluating requests to add, change or terminate providers and expects providers will provide accurate and timely provider data. Please send all provider adds, changes, and termination requests in writing to providerconcierge@healthteamadvantage.com.

Provider changes and updates include, but are not limited to the following:

- Change in practice location;

- Change in practice affiliation;
- Change of address, phone or fax number;
- Change in hours of operation;
- Retirement or leave of absence exceeding 30 days;
- Leaving network area

Any change to a provider's status should be communicated immediately to HealthTeam Advantage Provider Concierge Department. All provider profiles are reviewed for credentialing requirements, including but not limited to the following:

- Provider specialty(ies) and credentials (e.g., MD, DO, MFT, etc.);
- Medical license number and expiration date;
- DEA number and expiration date;
- NPI number;
- Board certification status;
- Professional liability insurance.

The following applies to PPO except Provider Sponsored Plans (PSPs). PSP provider termination timelines are documented in the Provider Agreement between HealthTeam Advantage and the physician group:

- Termination notice must be submitted to providerconcierge@healthteamadvantage.com.
- Non-PCP provider add, change and termination requests received by the 10th of the current month are processed and will become effective by the 1st of the month.
- Non-PCP provider add, change and termination requests received after the 10th of the month are processed and will become effective the 1st of the subsequent month.
- PCP terminations with effective dates of the 1st of the following month are processed as soon as possible, regardless of submission date. PCP terminations with effective dates after the 1st of the following month are processed within 30 days prior to the effective date of the termination.

Incomplete requests, or those requiring further attention, will be returned to senders with details regarding the issue(s) found and/or notice of action/additional information needed.

To obtain provider ID#s, provider organizations are expected to check the Find a Doctor or Find a Specialist section of the HealthTeam Advantage website at www.healthteamadvantage.com on or after the 1st of the appropriate month according to the timeline established above.

HealthTeam Advantage will notify members of PCP and/or hospital changes, using CMS approved member letters.

Corporate Information Changes

Corporate information includes but is not limited to organization name and/or dba, organization ownership, tax identification number (TIN), and payee name and address.

Changes to corporate information impacts provider reimbursement and requires a written letter on letterhead from the physician group that identifies the requested change and is signed by an administrator of the organization. In addition to the letter, a copy of the physician group's Articles of Incorporation, or Service Agreement must also be provided to verify administrators' names. If the request includes a TIN change, a W-9 must be provided. This information can be emailed to providerconcierge@healthteamadvantage.com or you may contact your assigned Provider Concierge Representative.

Provider Directory

HealthTeam Advantage provider directory information is available online at the HealthTeam Advantage website at www.healthteamadvantage.com . If a printed directory is required, please contact our Provider Concierge Department at 336-554-8752 or email providerconcierge@healthteamadvantage.com and request a copy.

HealthTeam Advantage Member Information

Member Eligibility

For an individual to enroll in HealthTeam Advantage Medicare Advantage Plan, the individual must be entitled to Medicare Parts A and B in addition to living within the service area the plan is offered. The HealthTeam Advantage service area for the PPO product lines are: Alamance, Guilford, Randolph, and Rockingham counties. Medicare Advantage eligible beneficiaries who request enrollment with HealthTeam Advantage will be effective the first day of the month following the date a complete application for enrollment is accepted by the Enrollment Department.

Prospective members may not request future enrollment dates. Beneficiaries who are receiving services in a Hospice facility are eligible to enroll with HealthTeam Advantage. Beneficiaries who have been medically determined to have End Stage Renal Disease (ESRD) are not eligible for enrollment into HealthTeam Advantage. An individual who receives a kidney transplant, and who no longer requires a regular course of dialysis to maintain life, is not considered to have ESRD for purposes of eligibility and may enroll into HealthTeam Advantage.

Verifying Eligibility

A member's eligibility status can change at any time during a plan year. All providers should consider verifying a member's eligibility upon each visit to their office or facility. There are several options to verify eligibility for HealthTeam Advantage members.

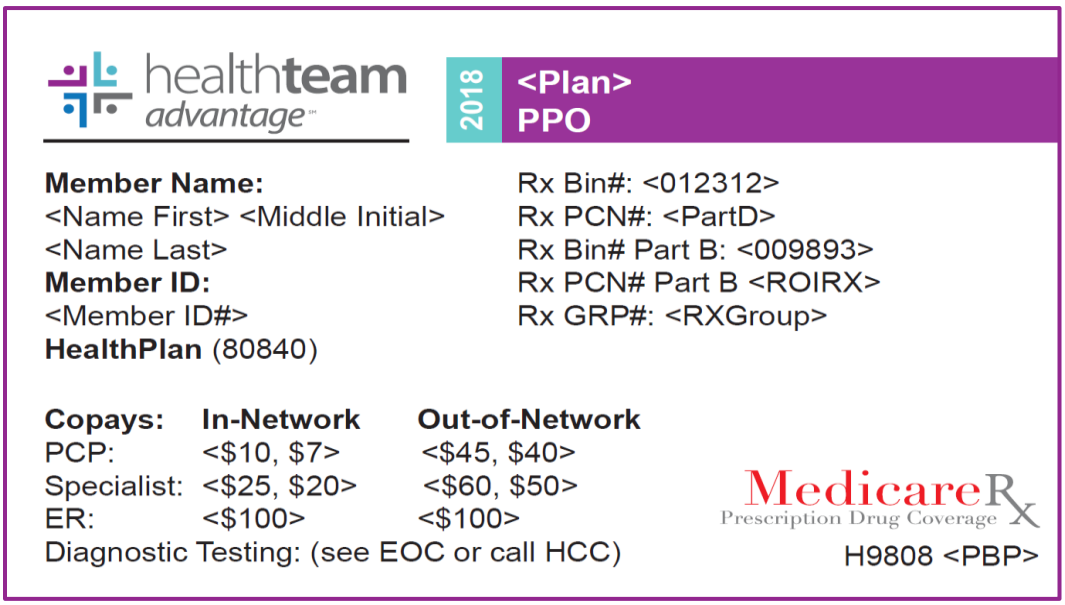
Interactive Voice Response (IVR) Eligibility Verification

Providers can verify member eligibility using our IVR system at 855-621-0401. Users have access to real-time eligibility data and have the option to listen to pending eligibility changes available 24 hours a day, 7 days a week. IVR provides the following data:

- Member name and ID number;
- Member effective date;
- Member termination date;
- Benefit plan effective date;
- Benefit information;
- Co-payment amounts for the following: PCP visits, specialist visits, DME, hospital, emergency room, Home Health, Skilled Nursing Facility, Physical Therapy,

Eligibility ID Cards

All members enrolled in HealthTeam Advantage's MAPD plans receive a member ID card. A sample of the ID card is below:



A new identification (ID) card is automatically sent when:

- A new Medicare Advantage plan member enrolls
- A member changes his or her name
- The member changes Medicare Advantage plans

Members enrolled in HealthTeam Advantage's Medicare Advantage Part D receive a member ID card that contains medical and prescription medication information.

Remember, eligibility data is based upon the best available data to the health plan and may not always be current at the time of request. Verification of eligibility does not guarantee payment.

Note: Beginning in April 2018, CMS is issuing all Medicare recipients new identification cards. These cards will no longer carry the member's social security number, but instead a unique MBI (Medicare Beneficiary Identifier). All Medicare members, even those enrolled in a Medicare Advantage (MA) plan, are still issued a Medicare card separate from the MA issued plan benefit card. Any member enrolled under HealthTeam Advantage, must present their HealthTeam Advantage card at the time of service and all claims must be filed using their HealthTeam Advantage member ID; not their CMS issued MBI.

Dual Eligible Members

Dually eligible members are those members who qualify for both Medicare and Medicaid. There are different types of eligibility as explained below.

Full Benefit Dual-Eligible

Full benefit dual-eligible beneficiaries include those individuals who have coverage under both Medicare and Medicaid. In accordance with CMS guidelines, dual-eligible beneficiaries must enroll in a qualified Medicare prescription drug program to receive prescription medication coverage. Dual-eligible beneficiaries automatically qualify for extra assistance and do not need to apply separately. Beneficiaries who qualify for full dual benefit dual-eligible status may voluntarily choose to enroll in a Medicare Advantage plan, another Medicare health plan that offers prescription coverage or a stand-alone Prescription Drug Plan (PDP). Beneficiaries who do not enroll in a qualified Medicare Prescription Drug Program are automatically enrolled in one to ensure there is no loss of prescription medication coverage. Full benefit dual-eligible beneficiaries enrolled in a Medicare Advantage plan are enrolled into a Medicare Prescription Drug Program offered by the same Medicare Advantage organization. The Centers for Medicare and Medicaid Services (CMS) facilitates the enrollment.

Other full subsidy eligible beneficiaries who may receive assistance include:

- Recipients of Medicare and Supplemental Security Income (SSI) only.
- Recipients of Medicare Savings Programs (MSPS), such as Qualified Medicare Beneficiaries (QMB only), Specified Low- Income Medicare Beneficiaries (SLMB only) or Qualifying Individuals (QI).

MSP recipients receive additional assistance from the beneficiary's state, paying for Medicare premiums and member cost sharing or copayments. The full subsidy eligible member listed above automatically qualifies for extra assistance and do not need to apply separately. These beneficiaries generally have slightly higher incomes than full benefit dual-eligible beneficiaries. Medicaid pays for cost sharing associated with Medicare, including member premiums.

Other Low-Income Beneficiaries:

Beneficiaries with limited income and resources who do not fall into one of the subsidy programs discussed above may still qualify for assistance in paying for Medicare premiums and/or cost-sharing.

These beneficiaries must apply for the Low-Income Subsidy (LIS). Beneficiaries may apply for LIS by contacting the Social Security Administration or state of North Carolina Medicaid office. You may visit the website at: www.ncdhhs.gov .

Generally, the guidelines apply to beneficiaries with incomes less than 150 percent of federal poverty level and limited assets. The type of income considered is based on the rules of the SSI program. Monthly prescription medication plan premium, annual deductible and prescription medication copayments depend on the beneficiary's annual income and resources, in accordance with the United States Health and Human services (HHS) Poverty Guidelines.

For further information regarding Medicare Savings Programs, you may visit:
http://www.cms.hhs.gov/center/PeopleWithMedicareCenter.asp

Member Rights & Responsibilities

A HealthTeam Advantage member has the right to:

- Choose a Primary Care Physician (PCP);
- A discussion of medically necessary treatment options for his or her condition, regardless of cost or benefit coverage;
- Timely access to Primary Care Providers (PCPs) and referrals to specialists when medically necessary;
- Timely access to all covered services, both clinical and non-clinical;
- Access to emergency services without prior authorization when the member, as a prudent layperson, acts reasonably, believing that an emergent medical condition exists;
- Actively participate in decisions regarding his or her health and treatment options;
- Receive urgently needed services when traveling out of his or her Medical Advantage plan service area, or within his or her Medical Advantage plan service area when unusual or extenuating circumstances prevent the member from obtaining care from his or her PCP, if applicable;
- Be treated with dignity and respect and to have his or her right to privacy recognized;
- Exercise these rights regardless of the member's race, physical or mental disability, ethnicity, gender, sexual orientation, creed, age, religion, national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for care; and to expect these rights to be upheld by HealthTeam Advantage participating providers;
- Confidential treatment of all communications and records pertaining to his or her care. The member has the right to access his or her own medical records. HealthTeam Advantage and its participating providers must provide to members timely access to their medical records and any information that pertains to them. Except as authorized by state law, written permission from the member or the member's authorized representative must be obtained before medical records can be made available to any person not directly concerned with the member's care or responsible for making payments for the cost of such care;
- Extend these rights to any person who may have legal responsibility to make decisions on the member's behalf regarding the member's medical care;
- Refuse treatment or leave a medical facility, even against the advice of physicians (providing the member accepts the responsibility and consequences of the decision);
- Be involved in decisions to withhold resuscitative service, or forego or withdraw life-sustaining treatment;
- Complete an advance directive, living will or other directive to his or her medical providers;
- Information about his or her Medical Advantage plan and covered services;
- Know the names and qualifications of physicians and health care professionals involved in the member's medical treatment;
- Receive information about an illness, the course of treatment and prospects for recovery in terms the member can understand;

- Information regarding how medical treatment decisions are made by the contracting medical group or HealthTeam Advantage, including payment structure;
- Information about his or her medications – what they are, how to take them and possible side effects;
- Receive as much information about any proposed treatment or procedure as he or she may need to give an informed consent or to refuse a course of treatment. Except in cases of emergency services, this information shall include a description of the procedure or treatment, the medically significant risks involved, any alternate course of treatment or non-treatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment;
- Reasonable continuity of care and to know in advance the time and location of an appointment, as well as the physician providing care;
- Be advised if a physician proposes to engage in experimentation affecting the member's care or treatment. The member has the right to refuse to participate in such research projects;
- Be informed of continuing health care requirements following discharge from inpatient or outpatient facilities;
- Examine and receive an explanation of any bills for non-covered services, regardless of payment source;
- General coverage and plan comparison information;
- Utilization of control procedures;
- Statistical data on grievances and appeals;
- The financial condition of HealthTeam Advantage;
- Summary of provider compensation agreements

A HealthTeam Advantage member has the responsibility for:

- Providing his or her physicians or other care providers the information needed to care for him or her;
- Doing his or her part to improve his or her own health condition by following treatment plans, instructions and care that he or she has agreed on with his or her physician(s);
- Behaving in a manner that supports the care provided to other patients and the general functioning of the facility;
- Accepting the financial responsibility for any copayment or coinsurance associated with covered services received while under the care of a physician or while a patient at a facility;
- Accepting the financial responsibility for any premiums associated with membership in a HealthTeam Advantage Medicare Advantage plan;
- Accepting the financial responsibility for any non-covered service;
- Reviewing information regarding covered services, policies and procedures as stated in the member's Evidence of Coverage (EOC);
- Asking questions of his or her PCP or participating provider, as applicable, and/or HealthTeam Advantage Healthcare Concierge Department.

HealthTeam Advantage Benefits

This Provider Manual provides participating providers necessary information to ensure members enrolled in HealthTeam Advantage's Medicare Advantage plan receive appropriate, timely covered services when needed.

The Summary of Benefits and Evidence of Coverage detail the benefits of the HealthTeam Advantage Medicare Advantage plan and all applicable copayments/cost sharing. Plan documents may be reviewed online at www.www.healthteamadvantage.com.

Benefits and policies listed in this provider manual apply to all providers, unless specified otherwise in the written Provider Agreement or the member's Evidence of Coverage (EOC).

As a HealthTeam Advantage participating provider, you are required to comply with applicable federal and state laws and all requirements set forth by the Centers for Medicare and Medicaid Services (CMS), which governs the Medicare Program. You are also required to comply with HealthTeam Advantage policies and procedures that may not be listed within this manual. Some services will require prior authorization/ precertification. Please contact your Provider Concierge Representative for further information or with any questions at 336-554-8752.

Preventive Services

In accordance with Medicare coverage guidelines, the following preventive services are covered as part of the HealthTeam Advantage Medicare Advantage Plans. Some preventive services are covered at 100% and do not have a copay or cost sharing for the member.

- Health facility membership program through Silver & Fit;
- "Welcome to Medicare" preventive visit, one time only within the first 12 months of Part B eligibility;
- Abdominal Aortic Aneurysm screening for people at risk so long as the member gets an in-network referral for this test because of their "Welcome to Medicare visit";
- Annual wellness visit if the member has had Part B longer than 12 months. This visit cannot take place within 12 months of a "Welcome to Medicare" preventive visit;
- Annual glaucoma screening once per year, for Medicare beneficiaries who are at high risk, have a family history of the disease, or have diabetes;
- A baseline mammogram for female Medicare beneficiaries ages 35-40. One mammogram every twelve months for female Medicare beneficiaries over age 40; and a clinical breast exam once every 24 months;
- Medical nutrition therapy by registered dietitians or other qualified nutrition professionals for Medicare beneficiaries diagnosed with diabetes or chronic renal disease and for post-transplant patients;
- Bone mass measurements are covered for those at risk once every 24 months. Medicare covers procedures to identify bone mass, detect bone loss or determine bone quality, including a physician's interpretation of the results;

- Prostate cancer screening exams for male Medicare beneficiaries age 50 and over once every 12 months. These exams include a digital rectal exam and a Prostate Specific Antigen (PSA) test;
- HIV screening once every 12 months;
- Diabetes self-management, provides coverage for diabetes outpatient self-management training to include services furnished in non-hospital based programs. As the physician managing the member's condition, you must certify that the services are needed under a comprehensive plan of care. Services are covered with no copayment. This also provides coverage for blood glucose monitors and testing strips for all diabetics (already covered for insulin-dependent diabetics); Manufacture Freestyle, Precision and One-Touch devices.
- Pap test and pelvic exam is covered every 24 months with no copayment or deductible. For female Medicare beneficiaries at high risk for uterine or vaginal cancers, a pap test and pelvic exam is covered annually with no copayment or deductible;
- Colorectal cancer screening for people 50 and older, the following are covered:
    - Flexible sigmoidoscopy every 48 months;
    - Fecal occult blood test every 12 months; or
    - Fecal immunochemical test (FIT) every 12 months;
    - Screening colonoscopy every 24 months for high risk members;
    - Screening colonoscopy every 10 years for members not at high risk.
- Limited preventive dental services. See our EOC for specific coverages;
- Depression screening once per year in a primary care setting;
- Screening and counseling to reduce alcohol misuse, up to 4 brief face to face counseling sessions per year provided by a qualified primary care doctor in a primary care setting;
- Screening for sexually transmitted infections and counseling to prevent sexually transmitted diseases when the tests are ordered by a primary care provider, once every 12 months;
- Obesity Screening and therapy to promote weight loss. If a member has a body mass index of 30+, this counseling is covered if it is given in a primary care setting where it is coordinated with a comprehensive care plan;
- For smoking and tobacco cessation, we cover two counseling quit attempts, each equaling four face to face visits, within a 12-month period;

Immunizations

Specified immunizations and adult boosters are covered as described below. Part B covered immunizations include:

- Pneumonia and Influenza Vaccine - In accordance with the federal regulations governing Medicare, members may self- refer for influenza and pneumococcal vaccines with no copayments. Participating providers who do not provide vaccines should provide the member with a list of affiliated clinics who can provide these vaccines;
- Hepatitis B if a member is at high risk and they meet Medicare Part B coverage rules. If the condition falls into one of the categories listed below, the vaccine is covered. No

copayment applies if this is the only service provided;

- End-stage renal disease (ESRD) members;
- Hemophiliacs receiving Factor VIII or IX concentrates;
- Mentally handicapped institutionalized residents;
- Persons living in the same household as hepatitis B carriers;
- Homosexual men;
- IV drug abusers;
- Staff in institutions for the mentally retarded;
- Health care workers who have contact with blood or blood-derived body fluids.

Immunizations required for foreign travel are not covered. Immunizations fulfilling occupational-related requirements are not covered.

Part D covered vaccines are listed in our formulary's List of Covered Drugs. You can review this on our website at www.healthteamadvantage.com.

Best Available Evidence

Best Available Evidence (BAE) policy is used when the low-income subsidy information in CMS' systems is not correct. CMS relies on monthly files from the states and social security to establish an individual's low-income subsidy deemed eligibility and appropriate cost-sharing level. In certain cases, CMS systems do not reflect a beneficiary's correct low-income subsidy deemed status. This may occur, for example, because a state has been unable to successfully report the beneficiary as Medicaid eligible or is not reporting him/her as institutionalized.

Plans may initially rely on evidence presented at the pharmacy to provide a lower cost-sharing status at point-of-sale but must follow up with additional documentation within a specified period. We recommend that sponsors consider this approach to address urgent situations. The Best Available Evidence process will allow CMS and plan subsidy level records to be synchronized for those beneficiaries for whom Medicaid status has not been updated.

Part D plans must accept any one of the following forms of evidence from beneficiaries or pharmacists to make a change to a beneficiary's low-income status:

- A copy of the member's Medicaid card which includes the member's name and an eligibility date during the discrepant period;
- A report of contact including the date a verification call was made to the State Medicaid agency and the name, title and telephone number of the state staff person who verified the Medicaid status during the discrepant period;
- A copy of a state document that confirms Medicaid payment to the facility for a full calendar month on behalf of the individual; or
- A screen print from the State's Medicaid systems showing that individual's institutional status based on at least a full calendar month stay for Medicaid payment purposes during the discrepant period.
- Other Medical provided by the State showing Medicaid status during the discrepant period.

In addition, Part D plans must accept any one of the following forms of evidence from beneficiaries or pharmacists to establish that a beneficiary is institutionalized and qualifies for zero cost-sharing:

- A remittance from the facility showing Medicaid payment for a full calendar month for that individual during the discrepant period;
- A copy of a state document that confirms Medicaid payment to the facility for a full calendar month on behalf of the individual; or
- A screen print from the State's Medicaid systems showing that individual's institutional status based on at least a full calendar month stay for Medicaid payment purposes during the discrepant period.

Prescription Drug Program (Part D)

A formulary is a list of the drugs covered by HealthTeam Advantage. HealthTeam Advantage will generally cover the drugs listed in our formulary if the drug is medically necessary, the prescription is filled at a network pharmacy and other coverage rules are followed. For certain prescription drugs, we have additional requirements for coverage or limits on our coverage.

The drugs on the formulary are selected by our Plan with the help of a team of health care providers. Both brand-name drugs and generic drugs are included on the formulary. A generic drug is a prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

*Not all Drugs are covered by our plan.

Formulary Changes

HealthTeam Advantage may make certain changes to our formulary during the year. Changes in the formulary may affect which drugs are covered and how much members will pay when filling a prescription. Examples of formulary changes we may make include:

- Adding or removing drugs from the formulary;
- Adding prior authorizations, quantity limits, and/or step-therapy restrictions on a drug;
- Moving a drug to a higher or lower cost- sharing tier;

If HealthTeam Advantage removes drugs from the formulary, or adds prior authorizations, quantity limits and/or step therapy restrictions on a drug or moves a drug to a higher cost-sharing tier and a member is taking the drug affected by the change, they will be permitted to continue taking that drug at the same level of cost sharing for the remainder of the plan year. However, if a brand name drug is replaced with a new generic drug, or our formulary is changed because of new information on a drug's safety or effectiveness, the member may be affected by this change. HealthTeam Advantage will notify the member of the change at least 60 days before the date that the change becomes effective or provide them with a 60-day supply at the pharmacy. This will give them an opportunity to work with their physician to switch to a different drug that HealthTeam Advantage covers or request an exception. If a drug is removed from our formulary because the drug has been recalled from the pharmacies, we will not give 60-day notice before removing the drug from the formulary. Instead, HealthTeam Advantage will remove the drug immediately and notify members taking the drug about the change as soon as possible.

Non-Formulary and Prior Authorization/Exception Requests

For certain prescription drugs and all non- formulary drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits ensure that our members

use these drugs in the most effective way and help us control drug plan costs. A team of doctors and/or pharmacists developed these requirements and limits for our Plan to help us provide quality coverage to our members. Please consult the formulary for more information about these requirements and limits.

The requirements for coverage or limits on certain drugs are listed as follows:

Non-Formulary Drugs

Sometimes a physician may determine a non-formulary drug is necessary to treat a member's medical condition.

HealthTeam Advantage has established a process for the physician to request a non-formulary drug be eligible for coverage.

Prior Authorization

HealthTeam Advantage requires prior authorization (prior approval) for certain drugs. This means that the physician must contact us before writing the prescription. If HealthTeam Advantage does not receive the necessary information to satisfy the prior authorization, we may not cover the drug.

NOTE: The prior authorization information for prescription drugs is located on the HealthTeam Advantage website at www.www.healthteamadvantage.com

Quantity Limits

For certain drugs, HealthTeam Advantage limits the amount of the drug that we will cover per prescription or for a defined period.

Step Therapy

In some cases, HealthTeam Advantage requires the member to first try one drug to treat their medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat a medical condition, we may require the member's physician to prescribe Drug A first. If Drug A does not work for the member, then we will cover Drug B.

Generic Substitution

When there is a generic version of a brand-name drug available, our network pharmacies may recommend and/or provide a member with the generic version, unless their physician has advised us that the member must take the brand-name drug and HealthTeam Advantage has approved this request.
If a physician determines that a member is not able to meet an additional restriction or limit for medical necessity reasons or a non-formulary drug is necessary to treat a member, the physician may request an exception (which is a type of coverage determination).

For information on exceptions related to non-formulary drugs, prior authorization, quantity limits, step therapy and generic substitution you may submit a coverage determination request online at https://envision.promptpa.com or utilize the Prior Authorization/Exception Request Form at www.healthteamadvantage.com . For additional questions or assistance, please contact the EnvisionRx Options Customer Service Department at 1-800-361-4542.

Transition Policy

New members to HealthTeam Advantage may be taking drugs that aren't on our formulary or that are subject to certain restrictions, such as prior authorization or step therapy. Current members may also be affected by changes in our formulary from one year to the next.

Physicians should talk to the member to decide if they should switch to a different drug that we cover or request a formulary exception to get coverage for the drug. During the period a physician is talking to the member to determine the right course of action, we may provide a temporary supply of the non-formulary drug if those members need a refill for the drug during the first 90 days of new membership in our Plan. If you are a physician with a current member affected by a formulary change from one year to the next, the physician should request a formulary exception.

Medication Therapy Management Program

HealthTeam Advantage offers medication management programs at no additional cost to members who have multiple medical conditions, who are taking many prescription drugs and who have high drug costs. These programs were developed for us by a team of pharmacists and physicians. We use these medication therapy management programs to help us provide better coverage for our members. For example, these programs help us make sure that our members are using appropriate drugs to treat their medical conditions and help us identify possible medication errors.

We may contact members who qualify for these programs. If we contact your patient, we hope they will join so that we can help manage their medications. Remember, the patient will not need to pay anything extra to participate.

If they are selected to join a medication therapy management program, we will send them information about the specific program, including information about how to access the program.

Exclusions

Certain medications or medication categories are excluded from coverage for Medicare Part D members, including:

- Non-prescription medications;
- Medications when used for anorexia, weight loss, or weight gain;
- Medications when used to promote fertility;
- Experimental or investigational medications;
- Medications when used for cosmetic purposes or hair growth;
- Medications when used for the symptomatic relief of cough or colds;
- Be purchased exclusively from the manufacturer as a condition of sale;
- Barbiturates (except when used to treat epilepsy, cancer, or a chronic mental health diagnosis);
- Smoking cessation medications that do not require a prescription;
- Medications that are covered under Medicare Part A or Part B.

HealthTeam Advantage Compliance

Compliance Program

HealthTeam Advantage has a strong commitment to compliance, integrity, and ethical values. Additionally, the company understands that participation in federal programs is a tremendous responsibility and is committed to following the best practices and guidance from the United States Sentencing Guidelines and CMS. This is demonstrated by HealthTeam Advantage compliance program and includes the following elements:

- Written policies, procedures, and standards of conduct;
- The designation of a Medicare Compliance officer or designee and compliance committee;
- Effective training and education;
- Effective lines of communication between the Medicare Compliance officer or designee, the organization's employees, contractors, subcontractors, agents, directors;
- Enforcement of standards;
- Provision for internal monitoring and auditing;
- Procedures for ensuring prompt response to detected offenses and development of corrective action initiatives;
- Reporting of violations and potential violations;
- Fraud, waste, and abuse.

It is the policy of the company to comply with all applicable federal, state and local laws and regulations. The company maintains ultimate responsibility for fulfilling the terms and conditions of its contract with CMS, and for meeting the Medicare program requirements.

For additional information on HealthTeam Advantage's commitment to compliance, integrity and ethical values, visit our website at https://healthteamadvantage.com/compliance-integrity/.

Fraud, Waste and Abuse

Eliminating Fraud, Waste, and Abuse (FWA) in the delivery of health care is an obligation, responsibility and legal requirement of all HealthTeam Advantage employees and our contracted providers and their employees. This section provides important requirements and expectations in delivering service to members while minimizing risks to yourself and HealthTeam Advantage.

Medicare Advantage/Part D FWA Education and Training Requirements

The Centers for Medicare & Medicaid Services (CMS) require Medicare Advantage Prescription Drug Plans (MAPD) to provide effective training to all employees, first tier and downstream, and related entities upon initial hire and annually thereafter.

First tier entities are those who have contracted with HealthTeam Advantage to provide administrative or prescription drug services to our members. Downstream entities are companies that first-tier entities subcontract with to provide these services.

Medicare Providers and Suppliers Deemed Compliant

Under revised CMS guidance, effective December 28, 2015, first tier, downstream and related (FDR) entities who are enrolled in Parts A or B of the Medicare program are "deemed" to have satisfied Fraud, Waste and Abuse (FWA) training requirements; however, FDRs are NOT exempt from the general compliance training requirement. That is, if you hold a valid Medicare provider agreement or supplier approval and can bill Medicare directly and receive payment, you are deemed compliant with the FWA training requirement. You are still obligated to complete general compliance training.

As a HealthTeam Advantage contracted provider, if you are not "deemed" compliant as indicated above, you are required to meet CMS FWA and general compliance training requirements. For more information on the CMS required trainings, visit our website www.healthteamadvantage.com/fraud-waste-abuse/.

FDRs have three (3) options for ensuring they have satisfied general compliance and FWA training requirements that must be completed 90 days after initial hire/contracting and annually thereafter:

- FDRs Complete the general compliance and/or FWA training modules located on the CMS Medicare Learning Network (MLN) and retain the system-generated certificate of completion as proof of completion;

- FDRs can download and incorporate the content of the CMS standard training modules from the CMS website to include in existing compliance training materials and systems;
- FDRs can incorporate the content of the CMS training modules into written documents for providers (e.g., Provider Guides, Participation Manuals, Business Associate Agreements, etc.).

You must also maintain training records or logs of FWA training participants from your organization for 10 years. These logs are subject to HealthTeam Advantage and government audit upon request.

FWA Government Regulations

Deficit Reduction Act: The Deficit Reduction Act (DRA) of 2005 is intended to reduce federal expenditures and, in turn, reduce federal deficits. DRA requirements are applicable to HealthTeam Advantage as a Medicare Advantage organization and apply to our contracted providers by contracting with HealthTeam Advantage for the provision of Medicare Services.

False Claims Act (FCA): As health care providers furnishing services under government programs, you and HealthTeam Advantage are vulnerable to substantial legal risk under the FCA. The FCA prohibits the submission of false or fraudulent claims to the government. For example:

- Knowingly presenting a false record or statement to get a false claim paid or approved by the government;
- Conspiring to defraud the government by getting a false claim allowed or paid;
- Knowingly retaining any government overpayment. These can now be pursued by the government, even if initial receipt of the overpayment or the submission that caused the overpayment were not at the time knowingly false;
- Concealing, improperly avoiding, or decreasing an obligation to pay money to the government. Liability attaches regardless of whether the provider ever submitted a false claim to get government money or used a false statement to hide it.

Fraud Enforcement and Recovery Act (FERA): Signed into law in 2009, FERA boosts the federal government's power to investigate and prosecute any financial fraud against the government and expands liability under the FCA. Under Section 4 of FERA, liability may attach whether there is intent to defraud the government. Therefore, many types of innocuous overpayments could now potentially lead to liability under the FCA.

Office of the Investigator General (OIG): The OIG has targeted Medicare Advantage plans for investigations to ensure compliance with all the rules and regulations that govern managed care organizations. OIG civil and monetary penalties codified in the Social Security Act adopt by reference many of the provisions of Civil Monetary Penalties Law (CMPL). For more information about criminal and civil enforcement actions visit the OIG website at www.oig.hhsc.gov.

Anti-Kickback Statute: It is a felony to knowingly and willfully offer, pay, solicit or receive any remuneration to induce or reward referrals of items or services paid in whole or in part by a federal health care program.

Remuneration includes transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind.

Physician Self-Referral Prohibition Statue: The "Stark Law" prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or member of his or her family) has an ownership/investment interest or with which he or she has a compensation arrangement, unless an exception applies (for example, bona fide employment, FMV compensation arrangement, etc.)

Health Insurance Portability and Accountability Act (HIPAA): HIPAA established health care fraud as a federal criminal offense and increased the penalties. HIPAA 203(b)(1) created the Medicare Incentive Reward Program (IRP) to encourage reporting of sanctionable activities. IRP will pay a reward for information that leads to a minimum recovery of $100 from a party determined by CMS to have committed sanctionable offenses.

Patient Protection and Affordable Care Act and Health Care & Education Reconciliation Act: Adds funding to the Health Care Fraud and Abuse Control Funds and integrity programs to fight FWA. Among the other integrity efforts, the reform laws:

- Create a data repository for CMS to match claims with agencies such as the Social Security Administration and Veteran's Affairs to identify FWA;
- Require that overpayments be reported and returned 60 days after they are identified;
- Withhold deferral Medicaid matching payments for states that fail to report enrollee encounter data; Require that orders for items or services be prescribed by a Medicare enrolled physician or other eligible professional for goods or services on or after 7/1/2010;
- Require physicians to maintain and provide upon request documentation for certification for DME and Home Health services for orders made on or after January 1, 2010;
- Require physicians to have a face-to-face encounter with a patient before prescribing DME or home health services for those prescribed after January 1, 2010;
- Increase civil monetary penalties for making false statements to federal health care programs or for delaying inspections ($50,000 for each false record or statement);
- Suspend payment during fraud investigations;
- Allow the U.S. Department of Health & Human Services Secretary to place a temporary moratorium on enrollment of new providers or suppliers if it is determined that this will prevent or combat FWA.

Balanced Budget Act of 1997: Mandated a risk adjustment payment methodology for what is now the Medicare Advantage program, to increase payment accuracy. Risk adjustment strengthens the Medicare program by ensuring that accurate payments are made to Medicare Advantage organizations based on the health status of their enrolled beneficiaries.

Risk Adjustment Data Validation (RADV): Utilizes coding and documentation audits to ensure HealthTeam Advantage's risk adjustment payment integrity and accuracy. The RADV audit occurs after final risk adjustment data submission deadline for the Medicare Advantage contract year. Therefore, proper medical record documentation is key to accurate payment and successful data validation.

Penalties

Penalties for violating FWA laws include:

- Denial of payment: You will not be paid for un-allowed services provided;
- Monetary penalties for violating the FCA include three times the amount of damages which the government sustained plus civil penalties between $5,500 and $11,000 per claim. Each separate bill, voucher or other false payment demand constitutes a separate claim;
- Exclusion: Excluded individuals or entities cannot be paid, directly or indirectly, by the federal health care programs, for any items or services they provide.

Expectations

- Document patient's medical records properly and accurately. A claim for services must be supported by proper documentation in the medical record;
- Do not falsify or misrepresent information on prescriptions;
- Do not dispense expired or altered prescription drugs;
- Know and abide by all applicable laws and regulations;
- Have appropriate policies and procedures to address FWA in your organization;
- Educate yourself and attend scheduled FWA and compliance training opportunities;
- Provide general compliance, FWA and HIPAA training to your staff upon hire or contracting with the first 30 days and annually as well as upon discovery of non-compliance;
- Require attendance in training programs as a condition of employment/contracting;
- Provide specialized compliance training at least annually that meets CMS training guidelines to employees that have specific responsibilities in Medicare business areas;
- Protect patient information;
- Retain adequate records of employee training for 10 years;
- Strive for accuracy and excellence in service, coding and billing:
    - Do not up-code;
    - Do not unbundle services;
    - Provide only medically necessary services;

    - Do not bill for services not rendered;
    - Do not bill for worthless services;
    - Do not submit duplicate billing.
- Always use your NPI number. Protect your information;
- Watch for suspicious activity and red flags;
- Do not retaliate against your own employees who report FWA concerns in good faith.
- Screen all employees and Downstream Entities against federal government exclusion lists, including the Office of Inspector General ("OIG") list of Excluded Individuals and Entities and the General Services Administration ("GSA") Excluded Parties Lists System. Anyone listed on one or both lists is not eligible to support HealthTeam Advantage's Medicare Advantage and Prescription Drug Plans, and must be removed immediately from providing services or support to HealthTeam Advantage, and HealthTeam Advantage must be notified upon such identification.

Reporting FWA Concerns

Report concerns of suspected FWA in a timely manner. When in doubt, report it. Reporting potential FWA may be done through the compliance hotline, email, or letter via fax or mail at:

Helpline: 855-741-4518
Website: www.hta.ethicspoint.com
Address: HealthTeam Advantage
Compliance Department
7800 McCloud Rd, Suite 100
Greensboro, North Carolina 27409

Potential or actual FWA may also be reported directly to Medicare or the Office of the Inspector General at:

1-800-MEDICARE (1-800-633-4227)
1-800-HHS-TIPS (1-800-447-8477)

Whistleblower Protection

HealthTeam Advantage policies and procedures include the following protections for "good faith reporters of suspected or actual non-compliance, including FWA:

- Confidentiality
- Anonymity
- Non-retaliation

Monitoring FWA Prevention Practices

As part of the annual delegation oversight audit, all delegated entities will present evidence of up-to-date FWA prevention practices, including but not limited to:

- Updated policies and procedures meeting federal and state requirements;
- Updated staff training logs and sign-in sheets.

HealthTeam Advantage Covered Services

Medical Services

All medical services provided under the HealthTeam Advantage Medicare Advantage plans are done so in accordance with Medicare Guidelines. It is always less costly for members to receive their care from an in-network provider; however, our PPO members may choose an out of network provider. Please note that due to Medicare Guidelines, HealthTeam Advantage is unable to pay for services from a non-Medicare out of network provider. While the services may be covered, we cannot reimburse a provider who does not participate in the Medicare program.

If you are unsure of the network status of a provider you may be referring to, please consult our provider directory at www.healthteamadvantage.com or contact our Provider Concierge Representatives or Provider Concierge Department at 336-554-8752 or via email at providerconcierge@healthteamadvantage.com.

Pre-Authorization Request

As defined in Chapter 13, Section 10.1 the CMS Managed Care Manual defines organization determination as: any determination made by a Medicare health plan with respect to any of the following:

- Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services;
- Payment for any other health services furnished by a provider other than the Medicare health plan that the enrollee believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by the Medicare health plan;
- The Medicare health plan's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the Medicare health plan;
- Reduction, or premature discontinuation of a previously authorized ongoing course of treatment;
- Failure of the Medicare health plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee; or
- Medicare Savings Accounts (MSA) only: Decisions regarding whether expenses, paid for with money from the MSA Bank Account or paid for out of pocket, constitute Medicare expenses that count towards the deductible; and, prior to satisfying the deductible, decisions as to the amount the enrollee had to pay for a service.

Additionally, some of our services require prior authorization. Prior authorization is not a guarantee of payment. Prior authorizations are managed by our Utilization Management (UM) company, Triad HealthCare Network.

Below is a list of the Prior Authorization forms available. Please visit the **For Provider** section of our website, www.healthteamadvantage.com, to download the most current forms.

- Pre-Authorization Guidelines and Summary
- Specialty Drug Pre-Authorization List
- Instructions on How to Submit a Pre-Authorization
- Authorization Request Form
- Home Health Pre-Authorization Request Form
- DME Pre-Authorization Request Form
- Skilled Nursing Facility and Long Term Acute Care Rehabilitation Pre-Authorization Request Form
- Pharmacy Authorization Exception Form

HealthTeam Advantage members have the right to request prior authorization on their own behalf.

Failure to obtain the required authorization may result in a denied claim or reduction in payment.

When applicable, medical records may be requested by the delegated agent, or HealthTeam Advantage. Providers are required to submit requested documentation with in the timeframe outlined on the request.

Unless an organization determination is requested as expedited, and the clinical justification is provided that applying the standard time for making a determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, all organization determinations received will be processed as standard, within the allowed 14 calendar day timeframe as determined by CMS.

Expedited Organization Determinations

As defined by CMS in Chapter 13, Section 50 in the Managed Care Manual: An enrollee, or any physician (regardless of whether the physician is affiliated with the Medicare health plan), may request that a Medicare health plan expedite an organization determination when the enrollee or his/her physician believes that waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

Expedited organization determinations may not be requested for cases in which the only issue involves a claim for payment for services that the enrollee has already received. However, if a

case includes both a payment denial and a pre-service denial, the enrollee has a right to request an expedited appeal for the pre-service denial.

An expedited organization determination is a decision to authorize or deny a time-sensitive service that meets the criteria for an expedited review of 72 hours.

Laboratory Services

All laboratory services provided under the HealthTeam Advantage Medicare Advantage plans are done so in accordance with Medicare coverage guidelines.

HealthTeam Advantage Laboratory services may be obtained from a provider/facility of lab services that is contracted with HealthTeam Advantage or from a non-contracted provider/facility at a higher cost sharing for the member.

Some HealthTeam Advantage providers may do laboratory work in their offices; however, some services are considered "bundled charges" and are not paid in addition to an office visit fee.

A copayment may be charged for laboratory services received in an office or outpatient hospital setting. For the most current copayment, please refer to the summary of benefits, laboratory services section.

Radiology Services

All radiology services provided under the HealthTeam Advantage Medicare Advantage plans are done so in accordance with Medicare coverage guidelines.

HealthTeam Advantage Radiology services may be obtained from a provider/facility of radiology services that is contracted with HealthTeam Advantage or from a non-contracted provider/facility at a higher cost sharing for the member. For a current listing of radiology service providers, please visit the HealthTeam Advantage website at www.healthteamadvantage.com. When ordering radiology services, please complete the entire prior authorization form, including all patient information.

Some HealthTeam Advantage providers may perform radiology services in their offices; however, some services are considered "bundled charges" and are not paid in addition to an office visit fee.

A copayment may be charged for radiology services received in an office or outpatient hospital setting. For the most current copayment, please refer to the summary of benefits, Radiology services section.

HealthTeam Advantage requires prospective review of all outpatient Magnetic Resonance (MR),

Computed Tomography (CT) and Positron Emission Tomography (PET) imaging procedures except for:

- Inpatient radiology services;
- Emergency room radiology services;
- Outpatient radiology services other than MR, CT and PET imaging studies.

All outpatient MR, CT and PET imaging procedures require prior authorization/precertification. The list of these services is can be found on our website. Physicians and specialty providers can request prior authorization/precertification by faxing a completed request form to 844-873-3163.

A copy of the form may be obtained by calling 844-873-2905 or downloaded from the HealthTeam Advantage website at www.healthteamadvantage.com.

When a provider requests authorization of services, it is important to provide the following information:

- Member demographic information including the identification number and date of birth;
- Current diagnosis and clinical information including treatment history, treatment plan and medications;
- Member's chart and previous imaging study results if applicable.

After the receipt of all necessary information, prior authorization requests are generally processed within five (5) business days of the receipt of the request by the delegated UM Department. Note, per CMS guidelines, the turnaround time for standard requests is fourteen (14) days. All reasonable efforts will be made to process requests sooner than set guidelines. Failure to receive prior authorization for these services will result in a denial of payment and the member cannot be billed for the services. The provider may have appropriate appeal rights.

The notification process should be addressed by calling our delegated UM Department, at 844-873-2905 or faxing the appropriate prior authorization form to 844-873-3163.

For urgent prior authorization or precertification requests, contact our delegated UM Department at 844-873-2905 by telephone and indicate that the prior authorization request is for medically urgent care. After normal business hours, the Utilization Management department can be reached by calling 336-604-1589. HealthTeam Advantage will render a decision within 72 hours after receipt of all necessary information. An enrollee, or any physician (regardless of whether the physician is affiliated with the Medicare Advantage Organization), may request that a Medicare Advantage Organization expedite an organization determination when the enrollee or his/her physician believes that waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

Skilled Nursing

Coverage care and treatment in a Skilled Nursing Facility (SNF) is provided when medically necessary and approved through the prior authorization process by HealthTeam Advantage's delegated UM Department. Skilled nursing care in a sub-acute unit or facility is subject to a 100-day limit per benefit period. Custodial care in a skilled facility or any other facility is not a covered benefit by Medicare or HealthTeam Advantage.

Skilled nursing and/or skilled rehabilitation services are those services, furnished pursuant to physician orders, that:

- Require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech language pathologists or audiologists; and
- Must be provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result.

Custodial care is defined as care that assists an individual with their daily activities of living, i.e., bathing, eating, dressing, using the rest room, etc. This also includes simple diets and medication routines. Even though HealthTeam Advantage's Medicare Advantage plans do not cover custodial care, services that fall under Medicare Part B will be covered. A copayment per day will be charged for skilled nursing facility care received from a HealthTeam Advantage network provider. For the most current cost share, please refer to the summary of benefits. For a current listing of skilled nursing care providers, visit the HealthTeam Advantage website at www.healthteamadvantage.com.

Home Health

Home Health services must receive prior authorization from HealthTeam Advantage. Providers requesting for Home Health Services for members are to fax the Home Health Pre-Certification Form to our delegated UM department at 844-873-3163. The HealthTeam Advantage Home Health Prior Authorization Form is available on the HealthTeam Advantage website at www.healthteamadvantage.com. All Home Health care services provided under the HealthTeam Advantage Medicare Advantage plan are done so in accordance with Medicare coverage guidelines.

To qualify for the Medicare Home Health benefit, a Medicare beneficiary must meet the following requirements:

- Be confined to the home;
- Under the care of a physician;
- Receiving services under a plan of care established and periodically reviewed by a physician;
- Needs skilled nursing care on an intermittent basis or physical therapy or speech-language pathology; or

- Have a continuing need for occupational therapy.

Home Health services provided by a non-contracting provider or facility are covered at a higher cost sharing for PPO members only.

Please refer to the summary of benefits for cost sharing information. For a current listing of Home Health care providers, please visit the HealthTeam Advantage website at www.healthteamadvantage.com.

Durable Medical Equipment (DME)

All Durable Medical Equipment services provided under the HealthTeam Advantage Medicare Advantage plans are done so in accordance with Medicare coverage guidelines. Providers requesting Durable Medical Equipment for members are to fax the DME Prior Authorization Form to our delegated UM department at 844-873-3163. The DME Prior Authorization Form is available on the HealthTeam Advantage website at www.healthteamadvantage.com**.** HealthTeam Advantage will not cover Durable Medical Equipment unless criteria has been met.

Durable Medical Equipment is equipment which:

- Can withstand repeated use;
- Is primarily and customarily used to serve a medical purpose;
- Generally is not useful to a person in the absence of an illness or injury; and
- Is appropriate for use in the home.

HealthTeam Advantage requires prior authorization and shall cover Durable Medical Equipment when:

- The equipment meets the definition of Durable Medical Equipment as listed above;
- The equipment is necessary and reasonable for the treatment of the patient's illness or injury or to improve the functioning of his or her malformed body part; and
- The equipment is used in the patient's home.

HealthTeam Advantage contracted providers are required to refer Durable Medical Equipment services to in-network Durable Medical Equipment providers.

Durable Medical Equipment services provided by a non-contracting provider or facility are covered at a higher cost sharing for the PPO members only. Please refer to the summary of benefits for cost sharing information. For a current listing of DME providers, visit the HealthTeam Advantage website at www.healthteamadvantage.com.

Outpatient Services

Outpatient services include such services as physician office visits, and chiropractic services as well as outpatient hospital services, non-dental services and second opinions. Some of these services will require prior authorization.

All outpatient services provided under the HealthTeam Advantage Medicare Advantage plans are done so in accordance with Medicare coverage guidelines.

HealthTeam Advantage Outpatient services may be obtained from a provider/facility of outpatient services that is contracted with HealthTeam Advantage or from a non-contracted provider/facility at a higher cost sharing for PPO members only. For a current listing of outpatient specialty providers/hospital facility providers, please visit the HealthTeam Advantage website at www.healthteamadvantage.com.

Emergency and Urgent Care

HealthTeam Advantage Medicare Advantage plans covers medical emergencies 24 hours a day, 7 days a week, from any provider in or out of network. Emergency care can be defined as a condition that would lead a prudent lay-person possessing an average knowledge of medicine and health to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in placing the person's health in serious jeopardy; danger of serious impairment of the individual's bodily functions; serious dysfunction of any of the individual's bodily organs or parts; in the case of a pregnant woman, serious jeopardy to the health of the fetus; or serious disfigurement.

HealthTeam Advantage does not require prior authorization for emergency services to be covered. However, notification is requested.

Urgently needed care can be defined as non-emergency, unforeseen medical illness, injury or condition that requires immediate medical care. If the member is in the plan's service area and network providers are temporarily unavailable or inaccessible, urgent care services will be covered from an out-of-network provider at the lower in-network cost sharing amount. If the member is outside of the plan's service area and cannot get urgent care from a network provider, the plan will cover such care at the lower in-network cost sharing amount.

For both emergency and urgently needed care, the hospital must provide notification to the HealthTeam Advantage delegated UM Department at 844-873-2905 or the number located on the back of the Member ID card within 48 hours of providing services or as soon as reasonably possible. If a network HealthTeam Advantage facility fails to provide notification within 48 hours or the next business day, the emergency admission will not be covered, and the member cannot be balanced billed.

Inpatient Hospital Services

HealthTeam Advantage Medicare Advantage plan provides coverage for inpatient hospital services in a network acute care facility. Inpatient hospital services require prior authorization/notification, from a provider or facility that a member of HealthTeam Advantage has been admitted or that services have been rendered. When planning an "elective" admission to a network facility, please follow the process outlined in the Utilization Management (UM)/Prior Authorization section of this manual.

When the HealthTeam Advantage delegated UM Department is notified of hospital admissions, the UM Department verifies eligibility, attending physician and assigns a concurrent nurse reviewer. The UM Department will enter the notification in the system to generate a case number and issues the number. The facility is responsible for obtaining the permanent authorization number by contacting the HealthTeam Advantage delegated UM Department prior to claim submission.

All elective, urgent and emergent, inpatient and skilled nursing admissions must be reported to HealthTeam Advantage's delegated UM Department by the next business day, unless otherwise stated in the facility contract. To notify HealthTeam Advantage delegated UM Department you may call 844-873-2905.

Please have the following information ready to provide:

- Facility name;
- Name of caller reporting admission;
- Phone number of caller reporting admission;
- Member's full name;
- Member's identification (ID) number;
- Member's date of birth;
- Admission date;
- Admission time;
- Room number (for emergency room notifications there may not be a room number assigned, as these are potential admission and room numbers have not been assigned);
- Admit type (how member arrived at inpatient stay – elective, direct, urgent, or emergent);
- Admitting diagnosis or chief complaint;
- Type of admission (medical, surgical, telemetry, or intensive care);
- Admitting or attending physician;
- Other insurance if available;
- Status of admission (inpatient, skilled nursing or sub-acute rehabilitation) services may be reviewed after they are provided to determine medical appropriateness. Payment is not made for services that are inappropriate or not medically necessary.

Services denied for late or non-notification are considered non-reimbursable services and

cannot be billed to the member.

Behavioral Health Services

HealthTeam Advantage Medicare Advantage plans provide coverage for inpatient psychiatric care in a network acute care facility. When planning an "elective" admission to a network facility, when authorized by HealthTeam Advantage, for up to 190 days (lifetime benefit limit per member according to Medicare guidelines. Please follow the process outlined in the Utilization Management (UM)/Prior Authorization section of this manual.

If the member has used part of the 190-day Medicare lifetime benefit prior to enrolling in Medicare Advantage, the member is only entitled to receive coverage for the difference between the number of days already used and the Medicare Advantage authorized benefit.

Psychiatric care in a contracting hospital is subject to the benefits for hospital services. Please refer to the summary of benefits, Inpatient Psychiatric section.
When the HealthTeam Advantage UM Department is notified of hospital admission, the UM Department verifies eligibility, hospitalist or attending physician assignment, and assigns a concurrent nurse reviewer. The UM Department will enter the notification in the system to generate a case tracking number and issues the number to the caller. The facility is responsible for obtaining the permanent tracking number by contacting the HealthTeam Advantage UM Department prior to claim submission.

All elective, urgent and emergent care, inpatient admissions must be reported to HealthTeam Advantage's UM Department within 24 hours or the next business day, unless otherwise stated in the facility contract. To notify HealthTeam Advantage's delegated UM Department you may call 844-873-2905. Please have the following information ready:

- Facility name;
- Name of caller reporting admission;
- Phone number of caller reporting admission;
- Member's full name;
- Member's identification (ID) number;
- Member's date of birth;
- Admission date;
- Admission time;
- Room number (for emergency room (ER) notifications there may not be a room number assigned, as these are potential admission and room numbers have not been assigned);
- Admit type (how member arrived at inpatient stay – elective, direct, urgent, or emergent);
- Admitting diagnosis or chief complaint;
- Type of admission (medical, surgical, telemetry, or intensive care);
- Admitting or attending physician;
- Other insurance, if available;

- Status of admission (inpatient, skilled nursing or sub-acute rehabilitation).

Services may be reviewed after they are provided to determine medical appropriateness. Payment is not made for services that are inappropriate or not medically necessary. Services denied for late or non-notification are considered non-reimbursable services and cannot be billed to the member.
Coverage for inpatient psychiatric care in a network psychiatric hospital is provided when authorized by HealthTeam Advantage UM Department for up to 190 days, which is the lifetime benefit limit per member according to Medicare guidelines.

HealthTeam Advantage does provide outpatient behavioral health service coverage for its members. These services may be obtained by contracted providers/facilities at a set cost sharing and at non-contracted providers/facilities at a higher cost sharing for PPO members only. Outpatient behavioral health services include those provided by a specialty provider, individual or group counseling sessions, visits to a clinical psychologist or social worker. Outpatient behavioral health also includes partial hospitalization program, which is defined as a structured program of active treatment that is more intense than the care received in your doctor or therapist's office and is an alternative to inpatient hospitalization. These services require prior authorization.

A HealthTeam Advantage PPO member may self-refer to any of these behavioral health providers and will be charged the applicable cost sharing for the setting in which care is rendered. For a further explanation of benefits, copayments and the most current directory of Outpatient Behavioral Health providers, please visit the HealthTeam Advantage website at www.healthteamadvantage.com.

NOTE: The coverage for mental health counseling does not include relationship or communication issues or behavioral problems not related to an illness or injury and are subject to payment under the Medicare coverage guidelines.

HealthTeam Advantage Non-Covered Services

As outlined by CMS, advanced beneficiary notice of non-coverage (ABN's) and any like waivers of notice for non-covered service do not apply to Medicare Advantage Organizations (MAO), therefore they are not appropriate for use to MAO members. MAO members have the right under the terms of the health plan to request organization determination for non-covered services.

Providers are required to notify HealthTeam Advantage members prior to the delivery of any non-covered service, along with the member's financial responsibility and to document the notification within the medical record. Should the determination be decided by the member to proceed with the delivery of a non-covered service, HealthTeam Advantage's Utilization Management (UM) department should be contacted for organization determination. The member or the provider can request the organization determination.

For further understanding of, and compliance with these requirements, review Chapter 4 of the CMS Medicare Managed Care Manual.

Claims

To be reimbursed for services rendered to a HealthTeam Advantage member, providers must submit a clean claim within the timely filing guidelines. All claims for medical services provided under the HealthTeam Advantage Medicare Advantage plans are processed in accordance with Medicare Guidelines by our third-party administrator, Silverback Claims Management. HealthTeam Advantage requests that providers file claims electronically for faster service. When submitting claims, please include all required information. HealthTeam Advantage requires that all claims be submitted electronically on a UB-04 for facilities and a current CMS-1500 claim Form for professional services. If you are filing claims manually, you must submit an original UB-04 or CMS-1500 claim Form. Copies of claim Forms are not accepted. All providers will receive an Explanation of Payment (EOP) each time a claim is processed that details the payment determinations along with any applicable reason codes.

Timely Filing

When HealthTeam Advantage is the primary payer, providers must make their best effort to submit claims within 45 calendar days from the date of service or date of payment received by primary payer unless it is otherwise stated in your contract with HealthTeam Advantage.

When HealthTeam Advantage is the secondary payer, claims must be submitted within 45 days of the date on the primary payer's EOP receipt date. A copy of the primary carrier's EOP must be attached to the claim Form to process the claim.

If payment is denied due to a provider's failure to comply with timely filing requirements, the claim is treated as a non-reimbursable service and cannot be balance billed to the member. You can appeal a decision of denial for timely filing.

If you believe you have filed a claim timely, you may request reconsideration for payment in writing along with supporting proof of timely filing which may include:

- EOP from another insurance carrier dated within HealthTeam Advantage's timely filing limits for secondary payments only;
- If the claim was submitted to the incorrect payor the denial of payment letter from the insurance carrier, dated within HealthTeam Advantage's timely filing limits;
- Electronic Data Interchange (EDI) rejection letter, including batch number (showing date received versus date of service) that reflects the claim was submitted within HealthTeam Advantage's timely filing limits.

Unacceptable proof of timely filing includes:

- Screen-print of claim invoices;
- Copies of an original claim;
- Record of billing in an Excel spreadsheet.

Clean Claims

HealthTeam Advantage follows all the CMS claims policies for the Medicare program administration. A copy of the Medicare Claims Manual may be referenced at www.cms.hhs.gov.

A “clean claim” is defined as a claim that contains all necessary information and can be processed as submitted without requiring additional information from the submitting physician, practitioner or facility.

At least 95% of "clean" Medicare Advantage claims from unaffiliated (non-contracted) providers are to be paid within 30 calendar days of the earliest date received.

Submitted claims that do not meet the clean claims requirements may be pended for additional information or denied if the information submitted is invalid. Providers must submit only the missing information along with a copy of the notification letter, not a corrected claim. Submitting a corrected or second claim only creates duplicates and does not allow the original claim to be processed timely.

If HealthTeam Advantage determines that additional information is necessary to process the claim, the following steps may occur:

- The claim is pended and on the next business day, a notification letter requesting additional information is mailed to the provider.
- For all professional claims, if the requested information is not received within 30 days from the date the claim has been pended, a second notification letter is mailed to the provider.
- If the requested information is not received within 60 days from the claim-received date of the claim, the claim will be denied.
- For all inpatient and ancillary claims, if the requested information is not received within 60 days from the claim receipt date, the claim is denied.

If HealthTeam Advantage obtains the requested additional information within 60 days from the receipt of the claim and the information does not support payment or a favorable consideration, the claim is denied immediately. Providers can access the appropriate reconsideration process.

Providers should not initiate a new claim after receiving the notification letter requesting additional information. For reference, the notification letter includes the pended claim number that was previously submitted. Once HealthTeam Advantage receives the additional information requested, the original claim is processed.

All requested information must be received at the address indicated in the letter, which is:

HealthTeam Advantage Claim Department
P.O. Box 164579

Fort Worth, TX 76161

If payment is denied due to not complying with the clean claim requirements, the claim is treated as a non-reimbursable service and cannot be billed to the member; however, the provider can request a reconsideration.

Claims for HealthTeam Advantage members must comply with the clean claim requirements for fee-for-service Medicare (CFR 422.500).

The following information must be included on the claim:

- Provider identification (ID) number;
- Current Tax Identification Number (TIN);
- Current National Provider Identification Number (NPI);
- Member's name, address, telephone number, gender, and date of birth;
- HealthTeam Advantage member ID number;
- HealthTeam Advantage member group number;
- Current CPT code for each procedure performed and any applicable modifiers;
- CMS coding for place of service and type of service;
- Revenue codes for Departmental revenue, when applicable;
- Diagnosis code number (ICD-10). Indicate appropriate symptoms or diagnoses for tests performed and submit up to four diagnosis codes. Bill to highest level of specificity;
- ICD-10 procedure and DRG codes for all UB- 04 claims;
- Referral provider (indicate ordering provider on UB-04);
- Billing provider's name and remit address;
- Date of service;
- Current coordination of benefits (COB) information or other insurance information such as motor vehicle, workers' compensation or other third-party liability insurance information;
- If applicable: name and invoice of the chemotherapeutic agent and HCPCS code used for chemotherapy services.

HealthTeam Advantage network providers are required to submit claims for all covered services that are provided to HealthTeam Advantage members.

"60-Day" Claims

All other Medicare Advantage claims are to be paid or denied within 60 calendar days of the earliest date received.

Electronic Claims Submission

HealthTeam Advantage has contracted with Emdeon (WebMD) to provide claims clearinghouse services for HealthTeam Advantage electronic claim submission. HealthTeam Advantage

providers should file claims for HealthTeam Advantage members electronically whenever possible.

Providers can contact Change Healthcare Customer Service at 888-363-3361.

Payer Identification (ID) Number is: 37228

Advantages of submitting claims include:

- Reduction of costs associated with printing/mailing paper claims;
- Data integrity due to clearinghouse edits;
- Faster receipt of claims by HealthTeam Advantage, resulting in reduced processing time and faster payment;
- Confirmation of receipt of claims by the clearinghouse for your records;
- Availability of reports when electronic claims are rejected;
- Ability to track electronic claims, resulting in greater accountability.

EDI Reports

For successful EDI claim submission, participating providers must utilize the electronic reporting made available by their vendor or clearinghouse. There may be several levels of electronic reporting:

- Confirmation/rejection reports from EDI vendor;
- Confirmation/rejection reports from EDI clearinghouse;
- Confirmation/rejection reports from HealthTeam Advantage.

Providers are encouraged to contact their vendor/clearinghouse to see how these reports can be accessed/viewed or downloaded. All electronic claims that have been rejected must be corrected and resubmitted. Rejected claims may be resubmitted electronically.

For questions regarding electronic claims submission, contact HealthTeam Advantage Claims Customer Service at 844-806-8217.

Paper Claims Submission

When electronic filing of claims is not possible, professional paper claims must be submitted on an original red CMS 1500 claim form and must be filled out appropriately to fulfill of the requirements necessary in submitting a clean claim. Facility paper claims must be submitted on an original UB-04 claim form and must be filled out appropriately to fulfill the requirements for submitting a clean claim.

Copies of claim forms will not be accepted.

Paper claims can be mailed to:
HealthTeam Advantage Claims Department
P.O. Box 164579
Fort Worth, TX 76161

Corrected Claims

Corrected claims must be received by HealthTeam Advantage within 45 calendar days of the Explanation of Payment (EOP) issue date, unless otherwise stated in your contract or payment may be denied. If payment is denied, the claim is treated as a non-reimbursable service and cannot be billed to the member.

Corrected claims must be appropriately marked on top of the claim "Corrected Claim" and submitted to:

HealthTeam Advantage Claims Department
P.O. Box 164579
Fort Worth, TX 76161

When resubmitting a corrected claim electronically, you must enter the appropriate claim frequency code "Corrected Claims Process 2010"; Loop 2300; Segment CLM05-3; 7-replacement of prior claim; 8-void/cancel of prior claim.

Explanation of Payment (EOP)

HealthTeam Advantage's Explanation of Payment contains all the information about claims submissions, denial or messaging codes and cash receipts for overpayments, if applicable. The Explanation of Payment should be reviewed when you receive it and reconciled against billing records. The Explanation of Payment includes HealthTeam Advantage member names and dollar amounts paid for all claims processed during a week. Processing claims and adjustments results in one of the following remittance situations:

- Positive remittance - A remittance that totals to a positive amount and results in a payment to the provider. The total at the bottom of the Remittance agrees with the check or electronic payment the provider receives.

- Negative remittance - A remittance produced when the adjusted dollars exceed the total amount of payment on the remittance. The total at the bottom of the remittance is negative, and does not result in a check or electronic payment to the provider.

Explanation of Payments and checks are mailed weekly. If you have not received payment or an Explanation of Payments after 60 days, please call claims customer service at 844-806-8217 to verify the status of your claim.

Denials

Claim denials with member liability and provider denials must be issued and mailed within 60 calendar days of the earliest date received.

Refunds

Should an overpayment occur, HealthTeam Advantage will send a claim payment notification letter with detailed claim information about the payment error and request a return of the overpayment. If you do not dispute or return the requested payment within the specified period, the overpayment amount will be applied and subtracted from a future reimbursement as per the terms disclosed in the overpayment letter.

HealthTeam Advantage makes every attempt to identify claim overpayments and issue provider notices for overpayment refunds to be made within 30 days but in no case more than 12 months after the date of the original payment. If a provider receives an Overpayment Refund Request letter from HealthTeam Advantage, the provider should follow the instructions outlined in the letter for returning the overpayment or disputing the request. If a provider independently identifies an overpayment from HealthTeam Advantage, the following steps should be taken:

Return a check made payable to HealthTeam Advantage to:

HealthTeam Advantage Claims Department
P.O. Box 164579
Fort Worth, TX 76161

Include a copy of the Explanation of Payment that accompanied the overpayment to expedite HealthTeam Advantage's adjustment of the provider's account. If the Explanation of Payment is not available, the following information must be provided:

- HealthTeam Advantage member name and ID number;
- Date of service;
- Payment amount;
- Vendor or provider name and number;
- Provider Tax Id number; and,
- Reason for the overpayment refund.

If you are contacted by a third-party overpayment recovery vendor acting on behalf of HealthTeam Advantage, please follow the overpayment refund instructions provided by the vendor.

If you believe that you have received a HealthTeam Advantage check in error and have not cashed the check, return the check to:

HealthTeam Advantage Claims Department
P.O. Box 164579
Fort Worth, TX 76161

Please include the applicable EOP and a cover letter indicating why the check is being returned.

Coordination of Benefits

Providers should obtain all insurance information from their patients and verify the primary insurance. HealthTeam Advantage will also obtain all insurance information and load any other insurance other than HealthTeam Advantage for the member into the claims system.

Balance Billing

Balance billing is the practice of a contracted, network provider billing a member for the difference between the allowed amount and billed charges for covered services. When participating providers contract with HealthTeam Advantage, they agree to accept HealthTeam Advantage's contracted rate as payment in full. Balance billing members for any covered service is a violation of your Provider Agreement and CMS regulations. Contracted, network providers can only seek reimbursement from HealthTeam Advantage members for copayments, coinsurance, and non-covered services.

Coding

Three major publications, the American Medical Association's Current Procedural Terminology (CPT-4) code book, the CMS Healthcare Common Procedural Coding System (HCPCS) code book and the International Classification of Diseases (ICD-10-CM Effective October 1, 2015) represent the basic standard of service code documentation and reference material as required by HealthTeam Advantage. Current ICD-10-CM codes, CPT codes, HCPCS codes, and modifiers reflective of the date of service are required on all HealthTeam Advantage claims. These codes should be used in accordance with all applicable federal and state guidelines.

Valid ICD-10-CM diagnosis codes are required on all claims. The first diagnosis on the claim form is reserved for the prima code each diagnosis to the highest level of specificity (4th or 5th digit when available).

Valid AMA CPT-10 and Level II HCPCs procedure codes are required on all claims.
Procedure code modifiers are to be used only when the service meets the definition of the modifier and are to be linked only to procedure codes intended for their use.

All providers must bill claims according to CMS guidelines. Some services may be subject to reduction by the multiple procedure reduction rule.

Services and supplies that are covered but considered included in a related service will be denied or bundled into the payment for the related service. HealthTeam Advantage follows the

CMS bundled services policy with few exceptions.

HealthTeam Advantage considers other services that are not part of the CMS bundled services policy as always included in a more primary procedure.

HealthTeam Advantage does not require documentation at the time of claim submission. Note that in the event the claim is audited, documentation may be required.

Appeals & Grievances

HealthTeam Advantage follows the requirements as set forth by the Centers for Medicare and Medicaid (CMS) Medicare Advantage Appeals and Grievances. This information can be located in the Medicare Managed Care Manual, Chapter 13 on the CMS website at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html

HealthTeam Advantage is responsible for processing all Medicare Advantage member grievances and appeals as outlined in the Code of Federal Regulations (CFR) 422.562(a).

HealthTeam Advantage has an internal Appeals and Grievances Department, which is responsible for the processing of all appeals and grievances. This enables HealthTeam Advantage to receive, process, and resolve the issue(s) as expeditiously as the member's health requires and in accordance with the CMS timeliness requirements.

What is an Appeal (Reconsideration)?

As defined by CMS Managed Care Manual, Chapter 13, an appeal is:
Any of the procedures that deal with the review of adverse organization determinations on the health care services an enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service as defined in 42 CFR 422.566(b). These procedures include reconsideration by the Medicare health plan and if necessary, an independent review entity, hearings before Administrative Law Judges (ALJs), review by the Medicare Appeals Council (MAC), and judicial review.

When Can A Contracted Provider File an Appeal?

CMS states that Contracted Providers do not have appeal rights. Contracted Providers are not permitted to file appeals on claims. Those must be handled through the Provider Dispute process with the plan's third-party administrator (TPA).

Contracted Physicians are only permitted to file appeals on behalf of a member (member must be aware) for pre-service denials and certain types of discontinuation of service denials (SNF, HH, or CORF).

Standard appeal - A standard pre-service appeal request is processed by HealthTeam Advantage within a 30-calendar day time frame, from the date the Plan receives the request.

Expedited appeal - An expedited appeal request is a time sensitive service appeal request that is processed by HealthTeam Advantage within a 72-hour time frame, from the date and time

the Plan receives the request. For additional information on the criteria for an expedited review, see Chapter 13, Section 80 in the CMS Managed Care Manual.

How to Request an Appeal:

- All appeals must be requested within 60 calendar days of the denial
- Standard and Expedited appeal requests can be requested in writing via fax or postal mail.

Note: For all expedited appeal requests, please clearly state "expedite" on the written request.

- Standard requests must be in writing to:

HealthTeam Advantage
Attention: Appeals and Grievances Department
7800 McCloud Rd, Suite 100
Greensboro, NC 27409

Fax: 1-800-845-4104

- Expedited requests can be requested verbally through our Healthcare Concierge Department at 888-965- 1965 from 8:00 AM – 8:00 PM EST, 7 days a week between October 1 and February 14th and 8:00 AM – 8:00 PM EST, Monday thru Friday between February 15th and September 30th.

Due to the time frames CMS mandates for Medicare Advantage plans to process appeals, plan physicians and providers may receive requests for medical records to assist in the resolution of an appeal.

If all relevant medical records, office notes, etc. are submitted with the appeal request, additional information may not be needed, and this will help ensure a timely decision on the request.

Physicians and providers must forward any requested medical records to the HealthTeam Advantage's Appeals and Grievance department. When contacted for medical records or other case documentation, the requested information must be furnished within the parameters outlined on the request from HTA Appeals & Grievances. This ensures timeliness with CMS requirements.

What is a Grievance?

As defined in Chapter 13 of the CMS Managed Care Manual, a grievance is: any complaint or dispute, other than an organization determination, expressing dissatisfaction with the way a Medicare health plan or delegated entity provides health care services, regardless of whether any remedial action can be taken. An enrollee or their representative may make the complaint

or dispute, either orally or in writing, to a Medicare health plan, provider, or facility.

An expedited grievance may also include a complaint that a Medicare health plan refused to expedite an organization determination, or reconsideration, or invoked an extension to an organization determination or reconsideration time frame.

Member grievances pertain to issues such as:

- Office waiting times;
- Physician demeanor and behavior;
- Office staff demeanor and behavior;
- Adequacy of facilities;
- Quality of care;
- Billing inquiries

If applicable to the grievance, providers may be asked to provide medical records, notes or a provider statement. Providers must submit the requested information within the timeframe outlined in the request for information from HealthTeam Advantage.

Members or their authorized representative can file a grievance at any time in writing or by telephone.

- **Standard Grievances** - HealthTeam Advantage's Appeals and Grievances staff must provide a response within 30 calendar days of the date that the request is received by the plan, or as expeditiously as the member's health requires

- **Expedited Grievances** - Must meet the CMS criteria for an expedited grievance. HealthTeam Advantage's Appeals and Grievances staff must provide a response within 24 hours of the date and time that the request is received by the plan, or as expeditiously as the member's health requires

Members may send a written grievance request to:

HealthTeam Advantage
Attention: Appeals and Grievances Department
7800 McCloud Rd, Suite 100
Greensboro, NC 27409

Fax: 1-800-845-4104

Members make a verbal grievance request by contacting a HealthTeam Advantage Healthcare Concierge Representative at 888-965-1965.

Quality Improvement

HealthTeam Advantage promotes quality care and service excellence for its members. The organization's Quality Management (QM) program provides the framework and structure within which the health plan pursues this commitment. A framework in which the health plan consults with network physicians in selecting and prioritizing quality improvement projects, developing indicators, analyzing performance, identifying and proposing solutions to problems and aiding in communication of program activities with other providers.

The program promotes objective and systematic measurement, monitoring, and evaluation of services and implements quality management activities based upon findings. It is established at the direction of and approved by the Board of Directors, the governing body for HealthTeam Advantage.

The President is designated the authority and responsibility for the overall operation of the Program. The Medical Director, the senior clinical staff member, is responsible for all clinical aspects of the Program and works closely with the Vice President of Pharmacy Operations and Quality Programs to carry out those responsibilities. All senior and department leadership are responsible for implementing the Program throughout the organization. The Plan committee structure has an important role in implementing the Program and includes network providers in their membership.

The Program is designed to comply with regulatory requirements. It is evaluated and updated on an annual basis.

The overall goal of the Quality Management Program is to achieve quality care and services for members through the development, implementation and ongoing improvement of organizational systems.

Consistent with its emphasis on quality, HealthTeam Advantage maintains the Quality Management Program with goals to:

- Promote physical and mental health for HealthTeam Advantage members;
- Promote evidence-based medicine;
- Promote healthy lifestyles, risk identification, and early intervention;
- Promote active involvement by the member in health care planning and decision-making;
- Promote and coordinate efficient and effective resource utilization;
- Facilitate timely access and availability to care and services;
- Facilitate communication regarding performance improvement initiatives;
- Promote consumer safety.

Confidentiality

All records and proceedings of the Quality Management Program and the Quality Council as well as the subcommittees, related to member or practitioner specific information are confidential, and are subject to applicable laws regarding confidentiality of medical and peer review information. All member or provider information is maintained in confidential files. The health care providers hold all information in strictest confidence. Members of the Quality Improvement Committee and the subcommittees sign a "Confidentiality Agreement" annually. This agreement requires the members to maintain confidentiality of any and all information discussed during the meeting. The CEO, in accordance with applicable laws regarding confidentiality, issues Quality Management reports when required by law.

Due to the nature of routine Quality Management operations, HealthTeam Advantage has implemented policies and procedures to protect and ensure proper handling of confidential and privileged medical record information. Upon employment, all HealthTeam Advantage employees, including contracted professionals who have access to confidential or member information, sign a written statement delineating responsibility for maintaining confidentiality.

Conflict of Interest

HealthTeam Advantage maintains a Conflict of Interest policy to ensure potential conflicts are avoided by staff and members of committees. This policy precludes using proprietary or confidential HealthTeam Advantage information for personal gain or the gain or others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers, or members, except when it is determined that the financial interest does not create a conflict. No person may participate in the review, evaluation or final disposition of any case in which that person has been professionally involved of where judgment may be comprised.

Fiscal and clinical interests are separated. HealthTeam Advantage and its delegates do not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage, services or care.

There are no financial incentives for utilization management decision-makers that could encourage decisions that result in underutilization.

Quality Management Scope

The scope of the Quality Management program encompasses both clinical and non-clinical care and services conducted at HealthTeam Advantage and by its providers. Inherent in its structure is ongoing education to integrate the continuous quality management model across all HealthTeam Advantage functions and its delegated entities. Under the direction of the plan Medical Director, HealthTeam Advantage coordinates and facilitates ongoing monitoring and improvement of activities outlined in its Quality Management Program Description and Work Plan.

Health promotion and health management activities are integral part of the Quality Management program. Particular attention is given to high volume, high risk areas of care and services of the populations HealthTeam Advantage serves.

HealthTeam Advantage has integrated quality management activities into all health plan functional areas. These include, but are not limited to, the following functional areas and departments:

- Medical Health Services including: Complex Care Management, Disease Management, Care Coordination, and Care Transitions;
- Operations, including member and provider services;
- Network Management;
- Compliance;
- Member Services;
- Appeals and Grievances;
- Claims;
- Medicare;
- Delegation Oversight;
- Credentialing Oversight;
- Pharmacy;
- Utilization Management – as described in Utilization Program.

The Quality Management program description and evaluation are reviewed and approved not less than annually by the Quality Council.

Ultimate review and approval of the Quality Management program description, annual evaluation and work plan, rests with the Board of Directors.

Goals and Objectives

Quality Management's goal is to improve the health status of members through high quality, well-coordinated care;

- Deliver exceptional performance as demonstrated by internal measures and the Centers for Medicare and Medicaid Services (CMS) 5-star rating system;
- Promote use of evidence-based medicine by the health plan and by network providers;
- Facilitate early risk identification and interventions;
- Involve members in health care planning and decision-making, promote healthy lifestyles;
- Coordinate utilization of medical technology and other medical resources efficiently and effectively for member welfare;
- Facilitate effective organizational communication of performance improvement initiatives and priorities;
- Establish an environment responsive to member concerns and grievances;

- Facilitate timely access and availability to care; and
- Promote consumer safety.

Quality Management Activities

Integration is a vital component of successful quality management. Departments involved in quality management activities are integrated through coordinated referral processes and systems for quality/risk/utilization issues, care management, and member complaints/grievances. As the central area for receiving potential quality/risk management issues and coordination of Quality Management activity, the Quality department acts as a critical interface between HealthTeam Advantage departments, Centers for Medicare and Medicaid Services (CMS), and other regulatory agencies.

While HealthTeam Advantage does delegate Quality Improvement activities, the plan does collaborate with the network to ensure quality initiatives and goals are met.

The Quality Management program uses a variety of mechanisms to continuously measure, evaluate, and improve the care and services provided to members. HealthTeam Advantage has adopted a uniform approach to quality and the processes for addressing quality issues. Process steps include designing, measuring, assessing and improving processes utilizing the Plan-Do-Study-Act (PDSA) cycle to meet or exceed the minimum performance standards established by the organizations.

The following activities are included in the Quality Management program and reflect important aspects of care and service:

Clinical Practice and Preventative Health Guidelines:

Evidenced-based guidelines are used to monitor and improve the quality of care provided by participating practitioners. HealthTeam Advantage evaluates the most current medical evidence including but not limited to, the U.S. Preventative Services Task Force, the Centers for Disease Control and Preventative specialty organizations. HealthTeam Advantage measures population-based performance against preventative health and clinical guidelines annually, primarily through HEDIS measurement.

Disease Management

Disease Management services are available to HealthTeam Advantage members at no cost. Triad HealthCare Network, Care Management provides disease and care management activities for congestive heart failure (CHF), diabetes, chronic obstructive pulmonary disease (COPD), hypertension (HTN) and major depression for plan members and beneficiaries that meet the program's eligibility criteria. Disease Management is a program of coordinated health care interventions and communications for members with conditions in which patient self-care efforts are significant to outcomes.

The Disease Management Program Goals:

- Supports the physician or practitioner/patient relationship and plan of care;
- Emphasize prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies;
- Evaluates clinical, humanistic, and economic outcomes on an on-going basis with the goal of improving overall health.
- Enhance member self-management skills
- Reduce intensity and frequency of disease-related symptoms
- Enhance member quality of life, satisfaction, and functional status
- Improve member adherence to the Physician/Practitioner and health care
- Facilitate appropriate health care resource utilization
- Reduce avoidable hospitalizations, emergency room visits, and associated costs related to the disease; and medical claim costs.

Physicians can make referrals for Disease Management by sending a referral request or calling THN Care Management at 844-873-9947 .

Complex Case Management

Complex Case Management is available to members identified as high risk for adverse health outcomes. The goal of Complex Case Management is to facilitate appropriate care and services for plan members who have experienced a significant health event or illness.

Complex Case Management Program is a more intense case management approach and utilizes a multidisciplinary team of registered nurses, social workers, pharmacists, dieticians and physicians. Evidence-based guidelines for complex case management focused standard assessment and screening tools, condition- specific clinical guidelines and case management specific assessments targeted to at-risk populations. The goal is to help members achieve optimal health outcomes in balance with available resources.

Additionally, the complex case management community- based program facilitates access to community resources through social work support to patient and caregivers across the care continuum. Members are identified through various avenues including predictive modeling, discharge planning activities, and/or physician referrals. These services are offered to plan members at no cost; if applicable to their individual needs.

Referrals for complex case management can be made to via our delegated Care Management department, Triad Healthcare Network Care Management at 844-873-9947.

Medical Record Review (MRR)

The objectives of Medical Record Review activities are to:

- Evaluate compliance with medical record documentation requirements.
- Document the presence of information that conforms to accepted standards of

medical practice, which includes evidence of continuity and coordination of care.
- Evaluate compliance with medical record confidentiality policies.

HealthTeam Advantage's MRR for Primary Care Providers (PCPs) are conducted in accordance to state, CMS and quality requirements at least every three years by the Medical Management department. Overall results and opportunities for improvement are reported to the Delegation Oversight Review Committee (DORC).

Improvement action plans as recommended by the DORC, are implemented and monitored by the Medical Management department.

Member Satisfaction

Member satisfaction is assessed through annual member satisfaction surveys such as the Consumer Assessment of Health Providers and Systems (CAHPS), Health Outcomes Survey (HOS), as well as member complaint/grievance and disenrollment data. Member survey results are used to:

- Measure HealthTeam Advantage performance and identify opportunities for improvement.
- Measure the effectiveness of previously implemented improvement interventions.
- Establish benchmarks and monitor HealthTeam Advantage performance against national CAHPS performance data.
- Assess overall levels of satisfaction to determine if HealthTeam Advantage is meeting member expectations.

Action plans to address opportunities for improvement, based on member satisfaction results, are reviewed and approved by the Quality Council.

Monitoring of Performance Indicators

Ongoing monitoring of performance indicators is designed to reveal trends and improvement opportunities in targeted populations, National standard indicators, e.g. Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and systems (CAHPS), Health Outcomes Survey (HOS) are used to continuously measure HealthTeam Advantage performance.

Results are used to identify current gaps in care of service and are integrated in quality improvement projects for HealthTeam Advantage.

Practitioner Accessibility and Availability Monitoring

Practitioner accessibility and availability monitoring is conducted on an ongoing basis to ensure that established standards for reasonable geographic location of practitioners, number and type of practitioners, appointment availability, provision for emergency care, and after-hours service are measured. The cultural, ethnic, racial, linguistic needs of HealthTeam Advantage's

members are assessed on an ongoing basis and formally evaluated at least annually. Monitoring activities may include practitioner surveys, onsite visits, evaluation of member satisfaction, and evaluation of complaints/grievances, geo-access surveys, and when applicable, monitoring of closed primary physician panels. For more information regarding access and availability monitoring, please contact your assigned Provider Concierge Representative.

Specific deficiencies are addressed with a CAP, and follow-up activity is conducted to reassess compliance. Practitioner accessibility and availability activities are reported to an overseen by the Quality Management Committee.

Monitoring/Improvement of Quality Indicators

Selection of objective and measurable indicators for programs and interventions impacting effectiveness of care and services, are based on industry-wide specifications used to assess quality of care pertaining to functional status, access, satisfaction and outcomes (e.g. HEDIS, CAHPS, HOS).

Data is retrieved from the HealthTeam Advantage data tables, a central repository of all transaction systems, including but not limited to: member demographics, claims and encounters, pharmacy, and laboratory data. Supplemental data sources, such as medical records, case management, and member reported health assessment data, are used to support reporting, validation, and analyses, Quality Improvement Projects (QIPs) specifically address the unique characteristics and special needs of the HealthTeam Advantage population, hence they are stratified by plan type, age, disease categories, and risk status.

Care and services are evaluated in a variety of settings that include institutional and ambulatory. Also, evaluated is the coordination among contracted providers and with outside agencies. Inherent in the structure is ongoing, continuous education to integrate the quality management process model across all HealthTeam Advantage functions and delegated entities.

Outcomes are assessed by the annual HEDIS report, comprised of a comprehensive description and assessment of the HealthTeam Advantage transaction systems and internal audit processes (Roadmap), data integration and rate generation, collection and review of medical records, management and coordination of the HEDIS audit by outside certified audit agency, and a final report to CMS. The project involves an organization-wide effort to ensure data accuracy and completeness.

HOS and CAHPS results are reviewed to assess member health status and satisfaction with plan services and care received.

CMS issues the annual CAHPS and HOS baseline and associated reports. An analysis of HealthTeam Advantage's results is presented to the Quality Council as an attachment to the annual Quality Program Evaluation. The analysis includes recommendations for process improvements and quality initiatives.

HealthTeam Advantage collects, analyzes and reports Part C reporting data elements to CMS as defined by regulatory and technical specification outlines from CMS. The data are collected both internally and externally from our delegated entities.

Quality Improvement Projects (QIPs) and Chronic Care Improvement Program (CCIP)

The Centers for Medicare and Medicaid Services (CMS) mandates that each Medicare Advantage Plan has a Quality Improvement Project (QIP) and a Chronic Care Improvement Program (CCIP) a part of the plan's overall quality improvement plan. The focus area may be mandated by CMS, but HealthTeam Advantage must design the projects to include performance metrics, disease specific interventions and improvement strategies

Quality indicators for QIPs are objective, clearly defined, based on current clinical knowledge or health services research, and capable of measuring outcomes such as changes in health status, functional status, and member satisfaction.

The Chronic Care Improvement Program (CCIP) integrates both quality and chronic care management programs. These programs involve care coordination, interventions, and ongoing monitoring of progress. The goal of the CCIP program involves education and outreach to members and providers to promote health, manage symptoms, and assure timely access.

Interventions are evaluated and refined to achieve demonstrable improvement and effectiveness. HealthTeam Advantage relies on its delegated entities to provide data necessary for evaluating the effectiveness of each of the interventions. Results of evaluations and recommendations are reviewed and approved by the Utilization Management and Quality Assurance Committee.

Patient Safety

HealthTeam Advantage supports the prevention and elimination of healthcare errors by our commitment to the practice of Evidence-Based Medicine. This is accomplished through a variety of mechanisms, including but not limited to, processes to report identified adverse events, Medication Therapy Management Program (MTM), and potential quality of care referrals. In addition, HealthTeam Advantage provides education to members to promote patient awareness, encouraging health care advocacy, and facilitate decision-making through the HealthTeam Advantage newsletter and other program-specific materials.

Never Events Policy

HealthTeam Advantage has determined that if a healthcare service is deemed a "never event" or a "hospital acquired condition" as defined by CMS, that neither HealthTeam Advantage nor the member will be responsible for payments for said services. Healthcare facilities and providers are prohibited to collect and/or bill members for co-payments, coinsurance, deductible charges, or balance bill HealthTeam Advantage or its members for events which are

designated as ineligible for payment.

Examples of additional charges directly resulting from the occurrence of such a "never event" include:

- The event results in an increased length of stay, level of care or significant intervention.
- An additional procedure is required to correct an adverse event that occurred in the previous procedure or provision of a healthcare service.
- An unintended procedure is performed.
- Readmission is required because of an adverse event that occurred in the same facility.
- These guidelines do not apply to the entire episode of care, but only the care made necessary by the serious adverse event.

Pursuant to the above guidelines, a healthcare facility or provider will not seek payment for costs directly resulting from the occurrence of the following surgical events:

- Surgery performed on the wrong body part.
- Surgery performed on the wrong patient.
- Wrong surgical procedure on a patient.
- Retention of a foreign object in a patient after surgery or other procedure.
- Intraoperative or immediately post-operative death in an otherwise healthy patient (defined as a Class 1 patient for purposes of the American Society of Anesthesiologist patient safety initiative).
- Surgical Site infections following orthopedic, CABG, and bariatric procedures

Medication Therapy Management Program (MTMP)

HealthTeam Advantage participates in Medication Therapy Management Program (MTM). The program is based on CMS requirements/guidelines for MTM development. Members identified for the Medication Therapy Management Program (MTMP) program are believed to be at increased risk of experiencing morbidity and mortality due to the loss of the physiologic reserve.

HealthTeam Advantage works in conjunction with their Pharmacy Benefits Manager (PBM) to conduct the MTM program.

Potential Quality Issues

HealthTeam Advantage maintains a system of trended quality issues identified over time, using the Quality Management process.

Potential quality issues may be referred from a variety of internal and external sources. All quality issues identified by HealthTeam Advantage staff or providers will be investigated and assigned a quality determination through the reportable events policy and procedures.

The Quality Department's clinical staff conducts the preliminary review and investigation, with a subsequent review by a physician and/or referral for physician peer review. Cases are referred to the Quality Council if further review is needed.

Over-Utilization or Under-Utilization of Services

HealthTeam Advantage has established a methodology for monitoring over- and under-utilization of services. Using data submitted by the provider organizations, HealthTeam Advantage compares the utilization on several key indicators to specific performance standards. Key indicators may include, but are not limited to, Bed Days/1000; Average Length of Stay (LOS) for Acute, Skilled Nursing and Behavioral Health care; ER Visits/1000, and member appeals.

CMS Star Rating

HealthTeam Advantage has a comprehensive CMS 5 Star program aimed at increasing its star rating to 5. Strategies to achieve this goal include, but are not limited to:

- Obtain executive leadership buy-in and promotion of quality
- Educate all staff members on their impact on the CMS 5-star rating for HealthTeam Advantage
- Integrate quality initiatives across the organization
- Promote a culture that is integrated/cooperative, nimble, flexible and accountable.
- Data Collection and identification of opportunities for improvement (HEDIS, CAHPS, Provider Reporting)
- Develop unique initiatives aimed at both providers and members

Quality Management Outcome and Evaluation

The Quality Management Program description and the Work Plan govern the program structure and activities for a period of one year. No less than annually, the Quality Department in cooperation with key departments throughout HealthTeam Advantage complete a formal evaluation to include:

- Completed and ongoing activities that address quality and safety of clinical care and services.
- Trending of performance measures related to quality and safety of clinical care and service.
- Analysis of results, including barrier analysis and opportunities for improvement.
- Evaluation of overall effectiveness and progress towards network-wide safe clinical practices.

The Board of Directors approves the Quality Improvement Program annually.

Advanced Directives

Living Will Declaration and Advance Directives

The Omni Budget Reconciliation Act (OBRA) of 1990 included substantive new law that has come to be known as Patient Self-Determination Act and which largely became effective on December 1, 1991.

The Patient Self-Determination Act applies to hospitals, nursing facilities, and providers of home health care or personal care services, hospice programs and Medicare Advantage health plans (HealthTeam Advantage) that receive Medicare or Medicaid funds. The primary purpose of the act is to ensure that members of HealthTeam Advantage are made aware of advance directives and are given the opportunity to execute them if they so desire. This act also prevents discrimination in care if the member chooses not to execute advance directives.

What is a Health Care Advance Directive?

A health care advance directive is the primary legal tool for any health care decision made when you cannot speak for yourself. "Health Care Advance Directive" is the general term for any written statement you make while competent concerning your future health care wishes. Formal advance directives include the living will and the health care power of attorney.

What Does CMS Require of HealthTeam Advantage?

HealthTeam Advantage is required to include a description of our written policies on advance directives to our members including an explanation of the following:

- HealthTeam Advantage cannot refuse care or otherwise discriminate against an individual based on whether the individual has executed an advance directive;
- Each member has the right to file a complaint if the member believes HealthTeam Advantage is noncompliant with advance directive requirements, as well as the information of where to file the complaint;
- When applicable, HealthTeam Advantage requires that all providers document in a prominent part of the individual's current medical record whether the individual has executed an advance directive;
- HealthTeam Advantage is required to comply with North Carolina State law. Visit www.caringinfo.org for information regarding forms and terminology. You may also share this website with your HealthTeam Advantage members;
- HealthTeam Advantage must provide for community education regarding advance directives.

Delegated Activities

Medicare Advantage Organizations commonly contract with delegated entities to perform certain functions that otherwise would be the responsibility of the organization to perform, including management and provision of services.

The Medicare Advantage Organization, however, remains ultimately responsible for all services provided and otherwise fulfilling all terms and conditions of its contract with CMS regardless of any relationships that the organization may have with other entities.

Medicare Advantage Organizations must oversee and be accountable for any functions or responsibilities that are delegated to other entities. It is the sole responsibility of the Medicare Advantage Organization to ensure that the function is performed in accordance with all applicable standards.

HealthTeam Advantage has the sole discretion to allow the delegation of activities to providers or other entities. Delegated entities may not modify the delegated activities or the obligation to perform the delegated activities without prior written consent from HealthTeam Advantage.

Delegated entities are responsible for the performance of all delegated activities, including reporting requirements, in accordance with all applicable laws, this manual, and other administrative policies and procedures of HealthTeam Advantage as may be amended from time to time. HealthTeam Advantage will provide delegated entities with HealthTeam Advantage's standards and requirements applicable to the delegated activities and will notify delegated entities of any substantive changes to these standards and requirements.

Delegated entities may utilize their own policies and procedures for the delegated activities, provided that and only to the extent such policies and procedures are consistent with HealthTeam Advantage's delegation policies. If the delegated entity's policies and procedures are inconsistent with HealthTeam Advantage's delegation policies, HealthTeam Advantage's delegation policies will apply.

The contract between HealthTeam Advantage and the delegated entity specifies the activities that have been delegated, if any, and reporting responsibilities. Delegated entities should refer to their contract with HealthTeam Advantage for additional information.

Delegation Determinations and Monitoring/Auditing

Prior to the delegation of any activity, HealthTeam Advantage evaluates the entity's ability to perform the delegated activity and documents that it has approved the entity's policies and procedures with respect to the delegated activity. HealthTeam Advantage also verifies that the contractor has devoted sufficient resources and appropriately qualified staff to performing the function.

HealthTeam Advantage monitors the performance of the delegated entity on an ongoing basis and formally reviews the performance of the entity at least annually. HealthTeam Advantage has established a multi-disciplinary Delegation Oversight Review Committee that is ultimately responsible for maintaining a comprehensive oversight program for the routine monitoring of delegated activities performed on behalf of HealthTeam Advantage by delegated entities.

HealthTeam Advantage has written procedures for monitoring and review of delegated activities. HealthTeam Advantage uses Delegation Oversight Audit tools to conduct pre-delegation due-diligence as well as focused and annual audits of delegated entities.

The Delegation Oversight Audit includes, but is not limited to, a review of all applicable policies and procedures and the evidence demonstrating the implementation of the processes, a file review as applicable, a review of applicable committee minutes, and any additional documentation required to demonstrate the performance of the delegated activities.

A HealthTeam Advantage representative will work collaboratively with the delegated entity to schedule and perform the audit. HealthTeam Advantage may also, at its discretion, perform unscheduled audits as it deems necessary. Results of the audit and any requirements for corrective action will be returned to the delegated entity within 30 days of the date of HealthTeam Advantage's recommendation/determination. HealthTeam Advantage will also send a confirmation letter to the delegated entity designating the functions that have been delegated.

Depending on the results of a pre-delegation review or on-going auditing and monitoring, HealthTeam Advantage will assign one of the following delegation statuses to the entity:

- Full Delegation: The delegated entity is authorized to perform delegated activities with ongoing monitoring and, at a minimum, annual oversight audits performed by HealthTeam Advantage.
- Conditional Delegation with a Corrective Action Plan (CAP): If the delegated entity fails to meet standards required to maintain or be granted "Full Delegation" status, a CAP is required with Conditional Delegation status which may include more frequent and/or focused audits. All CAP activities and submissions are reviewed by the Delegation Oversight Review Committee for determination of delegated status.

Revocation and Resumption of Delegated Activities

Per CMS regulations, HealthTeam Advantage or CMS may revoke delegated activities and reporting requirements, or specify other remedies, in instances where CMS or HealthTeam Advantage determines that a delegated entity has not performed satisfactorily.

Delegated entities should refer to their contract with HealthTeam Advantage for specific details regarding how deficiencies and de-delegation will be handled.

Should an entity request to be considered for re-delegation of activities, the Delegation Oversight Review Committee will review any request for re-delegation.

Compliance Requirements

To meet CMS requirements, all delegated entities are also required to complete an annual Compliance Attestation Process. For more information about HealthTeam Advantage's commitment to compliance, integrity and ethical values, visit our website at https://healthteamadvantage.com/compliance-integrity/.

Credentialing

Prior to consideration for acceptance into the HealthTeam Advantage network, all providers must submit a completed application including a signed and dated attestation and meet the established criteria outlined in the credentialing policies and procedures. Once the credentialing staff receives the application, it is sent to the plan's delegated credentialing department.

The delegated credentialing department performs primary source verifications relating to the provider's credentials to include, but not limited to, education, licensure, board certification, malpractice claims history and site visit. If any issues or concerns are identified during the credentialing process, the delegated credentialing staff will present the information to the Credentialing Committee Chair for review.

All provider files will be presented to the delegated Credentialing Committee who will determine credentialing status. The delegated Credentialing Committee will be provided a list of "clean files" for approval. A "clean file" is defined as one which the provider has met all established criteria and has no issues. For files that do not meet the established criteria, the delegated Credentialing Committee will take the issue into consideration, as well as results of the primary source verification, malpractice history, sanction history, disciplinary actions, site visit or other information deemed relevant by HealthTeam Advantage.

Providers having any questions regarding credentialing may contact the Provider Concierge department at providerconcierge@healthteamadvantage.com.