WELCOME TO ALLWELL FROM ABSOLUTE TOTAL CARE

2021 PROVIDER ORIENTATION

Agenda

- Plan Overview
- Membership, Benefits, and Additional Services
- Providers and Authorizations
- Preventive Care and Screenings
- Model of Care (MOC) (Allwell Dual Medicare [D-SNP] Only)
- Medicare Star Ratings
- Web-Based Tools
- Network Partners
- Billing Overview
- Electronic Funds Transfer (EFT) and Electronic Medical Records (ERA)
- Advance Directives
- Fraud, Waste, and Abuse
- Centers for Medicare and Medicaid Services (CMS) Mandatory Trainings

PLAN OVERVIEW

Who We Are

- Allwell from Absolute Total Care is a Medicare Advantage plan .
- We provide quality healthcare you'd expect from a big company, but delivered on a local level.
- That means our members benefit from strategic care coordination and programs through the strong and collaborative relationships we build with healthcare providers and community organizations.
- Allwell is designed to give members:
    - Affordable healthcare coverage.
    - Benefits they need to take good care of themselves.
    - Access to doctors, nurses, and specialists who work together to help them feel their best.
    - Coverage for prescription drugs.
    - Extra benefits that aren’t covered by Medicare Part A or Part B (Original Medicare).

Who We Are

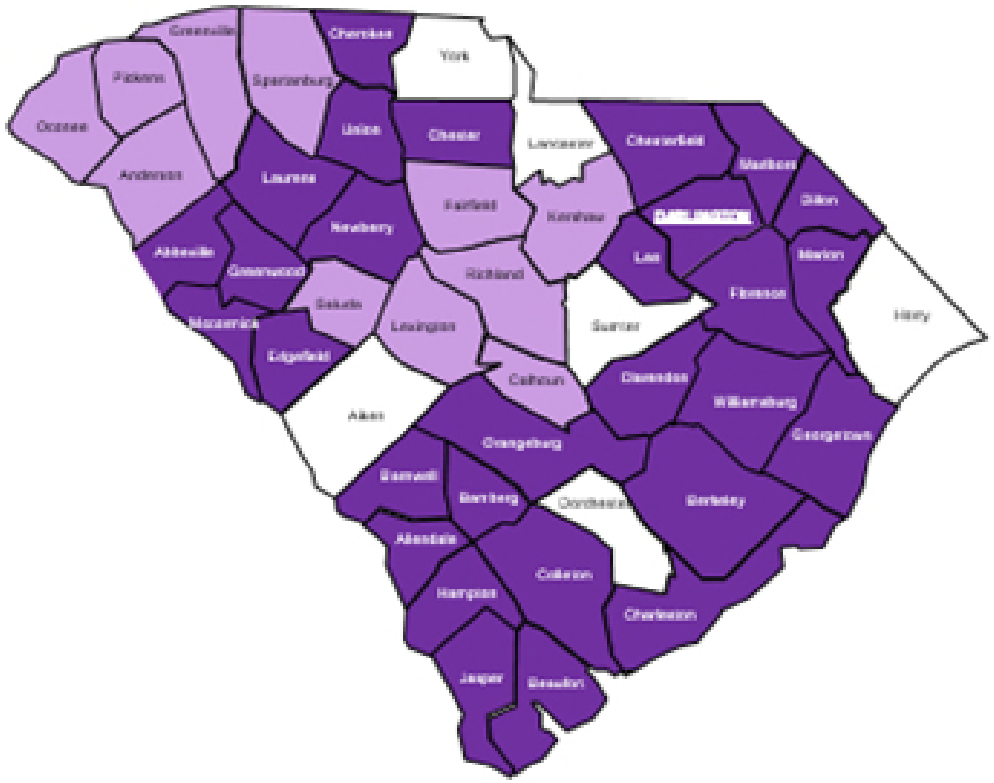
- Allwell from Absolute Total Care provides complete continuity of care to Medicare members.
- This includes:
  - Integrated coordination care.
  - Care management.
  - Co-location of behavioral health expertise.
  - Integration of pharmaceutical services with the Pharmacy Benefit Manager (PBM).
  - Additional services specific to the beneficiary needs.
- Our approach to care management facilitates the integration of community resources, health education, and disease management.
- Allwell promotes members' access to care through a multidisciplinary team, including registered nurses, social workers, pharmacy technicians, and behavioral health Case Managers, all are co-located in a single, locally-based unit.

MEMBERSHIP, BENEFITS, AND ADDITIONAL SERVICES

Membership

- Medicare beneficiaries have the option to stay in the original fee-for-service Medicare plan or choose a Medicare Advantage plan from Allwell from Absolute Total Care.
- Allwell from Absolute Total Care's Medicare Advantage Prescription Drug plans (Allwell Medicare [HMO] and Allwell Dual Medicare [HMO D-SNP]) are available in 40 counties.
- Allwell from Absolute Total Care members may change primary care providers (PCPs) at any time. Changes take effect on the first day of the month.
- Providers should verify eligibility before every visit by using one of the below options:
  - Website: allwell.absolutetotalcare.com.
  - 24/7 Interactive Voice Response (IVR) Line: 1-855-766-1497.
  - Provider Services: 1-855-766-1497.

2021 Allwell Medicare (HMO) and Allwell Dual Medicare (HMO D-SNP) Plans



40 counties, including one **new** county

H1436-002 – 29 counties
H1436-004 – 11 counties
H1436-005 – 40 counties

Allwell Medicare (HMO) ID Card

FRONT PANEL

allwell. FROM | absolute total care.

<Allwell Medicare>
<Plan Name>
CMS #: *‹H1436-XXXX›*
Effective Date: *‹MM/DD/YYYY›*

MEMBER INFORMATION
Name: *‹First MI Last›*
Member ID #: *‹XXXXXXXX-XXX›*
Issuer ID: *‹(80840)› ‹9151014609›*

PROVIDER INFORMATION
PCP Name: ‹ ›
PCP Phone: ‹ ›

PHARMACY INFORMATION
MedicareRx
Prescription Drug Coverage

Rx Claims Processor:
‹CVS Caremark®›
RXBIN: *‹004336›*
RXPCN: *‹MEDDADV›*
RXGRP: *‹RX8917›*

BACK PANEL

FOR MEMBERS
Member Services: *‹1-855-766-1497 (TTY: 711)›*
***Extra Benefits: *24-hr Nurse Advice/Dental/ Vision ‹1-855-766-1497 (TTY: 711)›*
allwell.absolutetotalcare.com

FOR EMERGENCIES
Dial 911 or go to the nearest emergency room (ER).

FOR PROVIDERS
For Medical/Dental/Vision Eligibility and Prior Auth/Referrals: *‹1-855-766-1497›*

Pharmacy Prior Auth: *‹1-800-867-6564›*
For Help (PHARMACY USE ONLY): ‹1-888-865-6567›

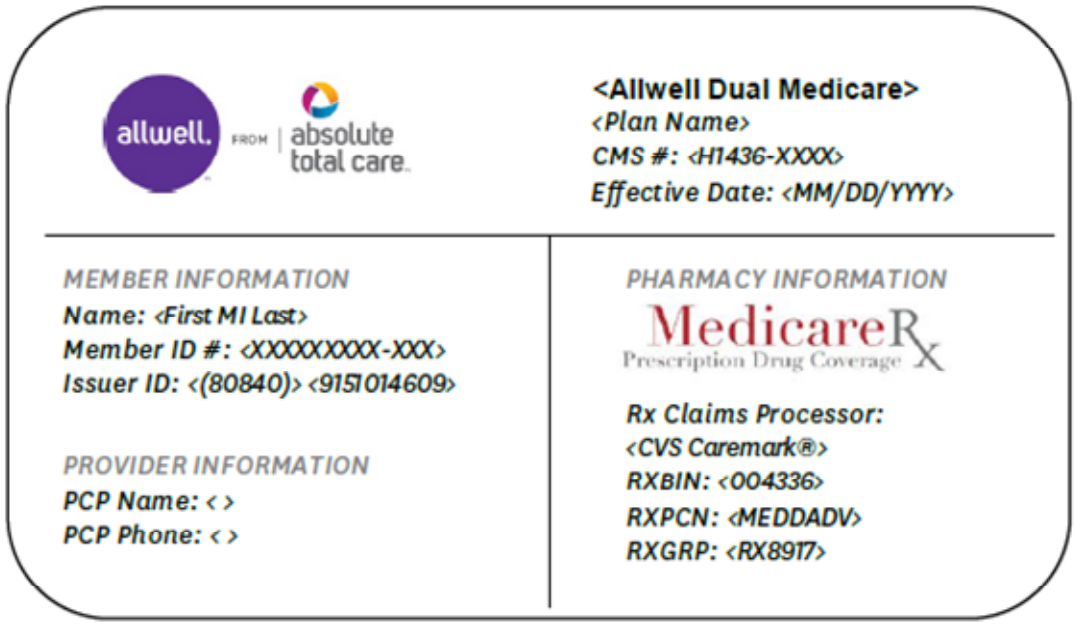
***please refer to your EOC for your extra covered benefits

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

MEDICAL CLAIMS
EDI Payor ID: ‹68069›
‹Allwell from Absolute Total Care›
‹Attn: Claims›
‹P.O. Box 3060 Farmington, MO 63640-3822›

Allwell Dual Medicare (HMO D-SNP) ID Card

FRONT PANEL



BACK PANEL

Plan Coverage

- Our Medicare Advantage plan covers:
  - All Medicare Part A and Part B benefits.
  - Part B drugs, such as chemotherapy drugs.
  - Part D drugs
    - No deductible at network retail pharmacies or mail order*.
  - Additional benefits and services such as:
    - Dental.
    - Vision.
    - Over-the-counter (OTC).
    - Hearing.
    - $0 PCP copay.
    - $0 generic prescription drugs.
    - And more!

**HMO D-SNP plan H1436-005 may have a deductible.*

Pharmacy List of Drugs (Formulary)

- The Formulary is available at allwell.absolutetotalcare.com.
- Please refer to the Formulary for specific types of exceptions.
- When requesting a Formulary exception, a Request For Medicare Prescription Drug Coverage Determination Form must be submitted.
- The completed form can be faxed to Envolve Pharmacy Solutions at 1-866-226-1093.

Covered Services

Hospital Inpatient and Outpatient	Medical Equipment and Supplies
Physician Services	Appropriate Cancer Screening Exams
Prescribed Medicines	Appropriate Clinical Screening Exams
Lab and X-ray	Initial Preventative Physical Exam – Welcome to Medicare
Home Health Services	Annual Wellness Visit
Screening Services	Annual Physical Exam
Dental Services	Therapy Services
Vision Services	Chiropractic Services
Hearing Services	Podiatric Services
Behavioral Health	Opioid Treatment Services
Acupuncture	Telehealth

Services may vary according to plan.

Additional Benefits: Hearing and Dental

Hearing Benefit
$0 copay for one routine hearing test every year.
$40 copay for hearing exam (Medicare-covered).
$0 copay for one hearing aid fitting evaluation.
$0 to $1,580 copay per hearing aid, maximum benefit two hearing aids.

Dental Benefit
Two oral exams per year with no copay.
Two cleanings per year with no copay.
HMO: $1,500 maximum benefit limit per year.
HMO D-SNP: $2,500 maximum benefit limit per year.

Note: Services may vary according to plan.
Members are responsible for any remaining balance over the maximum coverage limit.

Additional Benefits: Vision Services and Over-the-Counter (OTC) Items

Vision Benefit
$0 copay for one routine eye exam every year.
$0 copay for vision exam (Medicare-covered).
HMO: $150 allowance* for eyeglasses (frames and lenses) or contact lenses every year.
HMO D-SNP: $450 allowance* for eyeglasses (frames and lenses) or contact lenses every year.

OTC Benefit
HMO: $60-65 allowance per calendar quarter depending on plan.
HMO D-SNP: $345 allowance per calendar quarter.
Commonly used OTC items listing available at allwell.absolutetotalcare.com.
Conveniently shipped to member's home within five to 12 business days.

Note: Services may vary according to plan.
Members are responsible for any remaining balance over the maximum coverage limit.

Additional Benefits: Limited Duration Meals and Virtual Visits

Limited Duration Meals Benefit (HMO D-SNP Only)
$0 copay.
Requires medical necessity, care management coordination, and prior authorization.
Up to three home-delivered meals/day up to 28 days, to stabilize a chronic condition.
Annual maximum number of 42 days and 112 meals combined for both chronic care and discharge.
Virtual Visit (Telehealth) Benefit
$0 copay.
Virtual visit (medical or behavioral health) with Teladoc provider. Available 24 hours per day, 365 days per year.

Note: Services may vary according to plan.
Members are responsible for any remaining balance over the maximum coverage limit.

Additional Benefits

- Nurse advice line:
  - Free health information line staffed with registered nurses 24/7 to answer health questions.
- Fitness benefit:
  - Fitness center membership at participating gyms with no extra cost or up to two home fitness kits per year.
- Multi-language interpreter services:
  - Free interpreter services to answer questions about the medical or drug plan. To get an interpreter, call us at 1-855-766-1497.
- Additional medical nutrition therapy (MNT):
  - $0 copay per service.
  - Additional counseling above Medicare-covered MNT hours. Prior authorization required.

Additional Benefits

- Nutritional/dietary counseling:
  - $0 copay per visit.
  - Nutritional counseling services with a registered dietician or nutrition professional.
- Smoking cessation counseling:
  - $0 copay per session.
  - Up to five additional counseling visits covered through Teladoc each year.

PROVIDERS AND AUTHORIZATION

Primary Care Providers (PCPs)

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

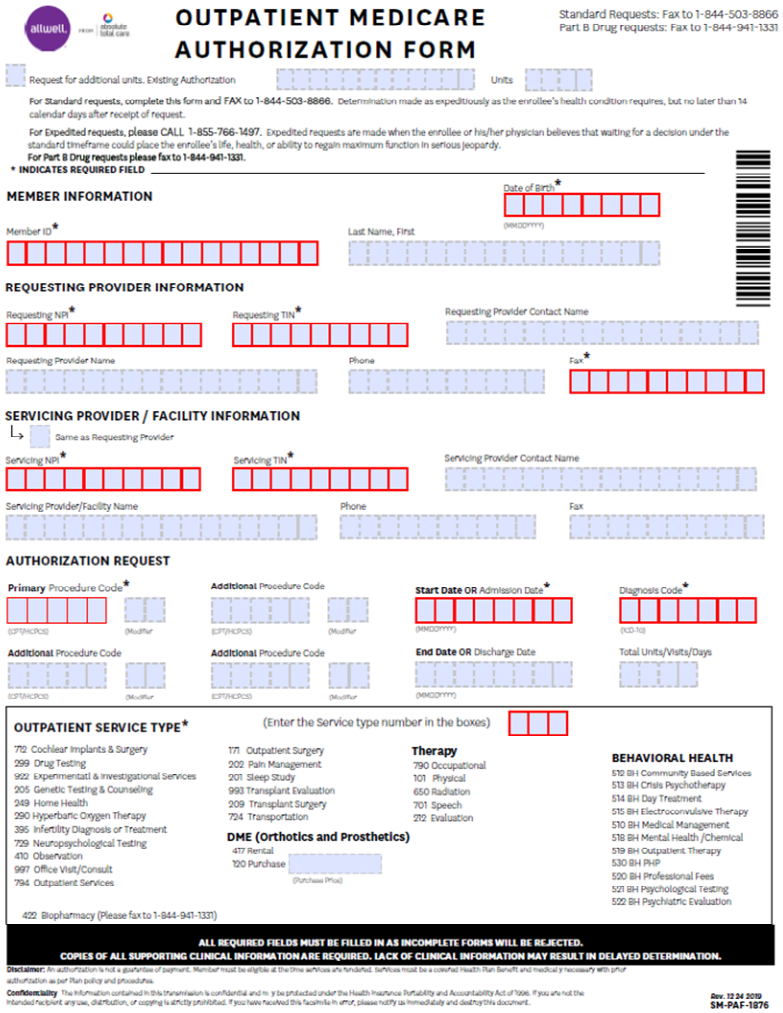
Utilization Management

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

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

Prior Authorization

- Prior authorization is required for:
  - Inpatient admissions, including observation.
  - Home health services.
  - Ancillary services.
  - Radiology (MRI, MRA, PET, CT).
  - Pain management programs.
  - Outpatient therapy and rehab (occupational therapy, physical therapy, speech therapy).
  - Transplants.
  - Surgeries.
  - DME.
  - Part B drugs.
  - Diabetic supplies and services.



OUTPATIENT MEDICARE AUTHORIZATION FORM

Standard Requests: Fax to 1-844-503-8866
Part B Drug requests: Fax to 1-844-941-1331

Request for additional units. Existing Authorization ____ Units ____

For Standard requests, complete this form and FAX to 1-844-503-8866. Determination made as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after receipt of request.

For Expedited requests, please CALL 1-855-766-1497. Expedited requests are made when the enrollee or his/her physician believes that waiting for a decision under the standard timeframe could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

For Part B Drug requests please fax to 1-844-941-1331.

* INDICATES REQUIRED FIELD

MEMBER INFORMATION

Member ID* | Last Name, First | Date of Birth* (MMDDYYYY)

REQUESTING PROVIDER INFORMATION

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

Requesting Provider Name | Phone | Fax*

SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider

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

Servicing Provider/Facility Name | Phone | Fax

AUTHORIZATION REQUEST

Primary Procedure Code* (CPT/HCPCS) (Modifier) | **Additional** Procedure Code (CPT/HCPCS) (Modifier) | **Start Date OR** Admission Date* (MMDDYYYY) | Diagnosis Code* (ICD-10)

Additional Procedure Code (CPT/HCPCS) (Modifier) | **Additional** Procedure Code (CPT/HCPCS) (Modifier) | **End Date OR** Discharge Date (MMDDYYYY) | Total Units/Visits/Days

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

712 Cochlear Implants & Surgery
299 Drug Testing
922 Experimental & Investigational Services
205 Genetic Testing & Counseling
249 Home Health
290 Hyperbaric Oxygen Therapy
395 Infertility Diagnosis or Treatment
729 Neuropsychological Testing
410 Observation
997 Office Visit/Consult
794 Outpatient Services

171 Outpatient Surgery
202 Pain Management
201 Sleep Study
993 Transplant Evaluation
209 Transplant Surgery
724 Transportation

DME (Orthotics and Prosthetics)
477 Rental
120 Purchase (Purchase Price)

Therapy
790 Occupational
101 Physical
650 Radiation
701 Speech
212 Evaluation

BEHAVIORAL HEALTH
512 BH Community Based Services
513 BH Crisis Psychotherapy
514 BH Day Treatment
515 BH Electroconvulsive Therapy
510 BH Medical Management
518 BH Mental Health /Chemical
519 BH Outpatient Therapy
530 BH PHP
520 BH Professional Fees
521 BH Psychological Testing
522 BH Psychiatric Evaluation

422 Biopharmacy (Please fax to 1-844-941-1331)

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

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

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

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Out-of-Network Coverage

- Plan authorization is required for out-of-network services, except:
  - Emergency care.
  - Urgently needed care when the network provider is not available (usually due to out-of-area).
  - Kidney dialysis at Medicare-certified dialysis center when temporarily out of the service area.

Medical Necessity Determination

- When medical necessity cannot be established, a peer-to-peer conversation is offered:
  - An Allwell from Absolute Total Care Medical Director will reach out to the requesting provider to initiate the peer-to-peer discussion.
  - Concurrent review turnaround time is 24 hours (one calendar day).
  - Standard prior authorization turnaround time is 14 calendar days.
- Denial letters will be sent to the member and provider.
- The clinical basis for the denial will be indicated.
- Member appeal rights will be fully explained.

PREVENTIVE CARE AND SCREENING TESTS

Preventive Care

- $0 copay for all preventive services covered under Original Medicare at zero cost-sharing.
- Initial Preventive Physical Exam - Welcome to Medicare:
  - Measurement of height, weight, body mass index (BMI), blood pressure, visual acuity screen, and other routine measurements. Also includes an electrocardiogram, education, and counseling. Does not include lab tests. Limited to one per lifetime.
- Annual Wellness Visit:
  - Available to members after the member has the one-time initial preventive physical exam (Welcome to Medicare physical).
- Annual Routine Physical Exam:
  - Comprehensive physical exam allowing a separate visit to discuss general health questions or issues without presentation of a specific chief complaint. Does not include lab or diagnostic testing and is in addition to initial and annual wellness visits.

Preventive and Screening Services

Abdominal Aortic Aneurysm Screening	Cervical and Vaginal Cancer Screenings	Medical Nutrition Therapy Services
Alcohol Misuse Counseling	Colonoscopy	Medication Review
Blood Pressure Screening	Colorectal Cancer Screenings	Obesity Screening and Counseling
BMI, Functional Status	Depression Screening	Pain Assessment
Bone mass measurement	Diabetes Screenings	Prostate Cancer Screenings (PSA)
Breast Cancer Screening (Mammogram)	Fecal Occult Blood Test	Sexually Transmitted Infections Screening and Counseling
Cardiovascular Disease (Behavioral Therapy)	Flexible Sigmoidoscopy	Tobacco Use Cessation Counseling (Counseling for People With no Sign of Tobacco-Related Disease)
Cardiovascular Screenings	HIV screening	Vaccines, Including Flu Shots, Hepatitis B Shots, Pneumococcal Shots

MODEL OF CARE (MOC)

(ALLWELL DUAL MEDICARE [HMO D-SNP] ONLY)

Model of Care (MOC)

- Allwell's MOC plan delivers our integrated care management program for members with special needs.
- Only applies to HMO D-SNP members.
- The goals of our MOC are:
  - Improve access to medical, mental health, and social services.
  - Improve access to affordable care.
  - Improve coordination of care through an identified point of contact.
  - Improve transitions of care across healthcare settings and providers.
  - Improve access to preventive health services.
  - Assure appropriate utilization of services.
  - Assure cost-effective service delivery.
  - Improve beneficiary health outcomes.

Model of Care (MOC) Elements

- Description of the HMO D-SNP population.
- Care coordination and care transitions protocol.
- Provider network.
- Quality measurement.

Model of Care (MOC) Process

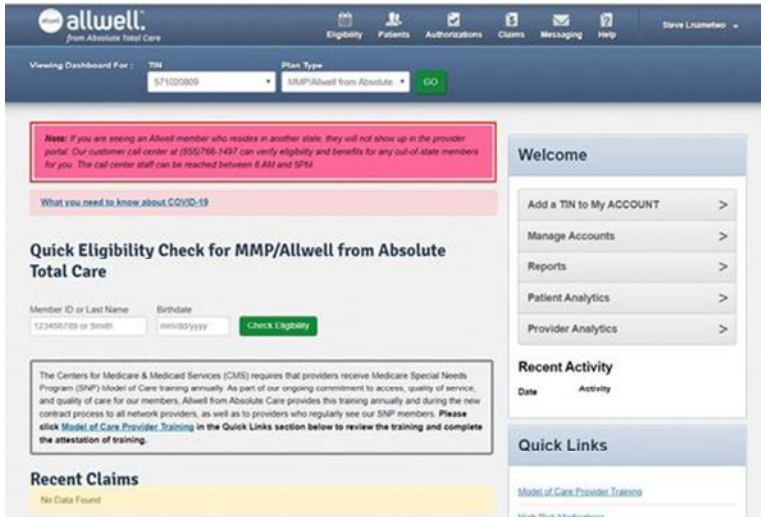
- Every HMO D-SNP member is evaluated using a comprehensive Health Risk Assessment (HRA) within 90 days of enrollment, and at minimum annually, or more frequently with any significant change in condition or transition of care.
- The HRA collects information about the member's medical, psychosocial, cognitive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

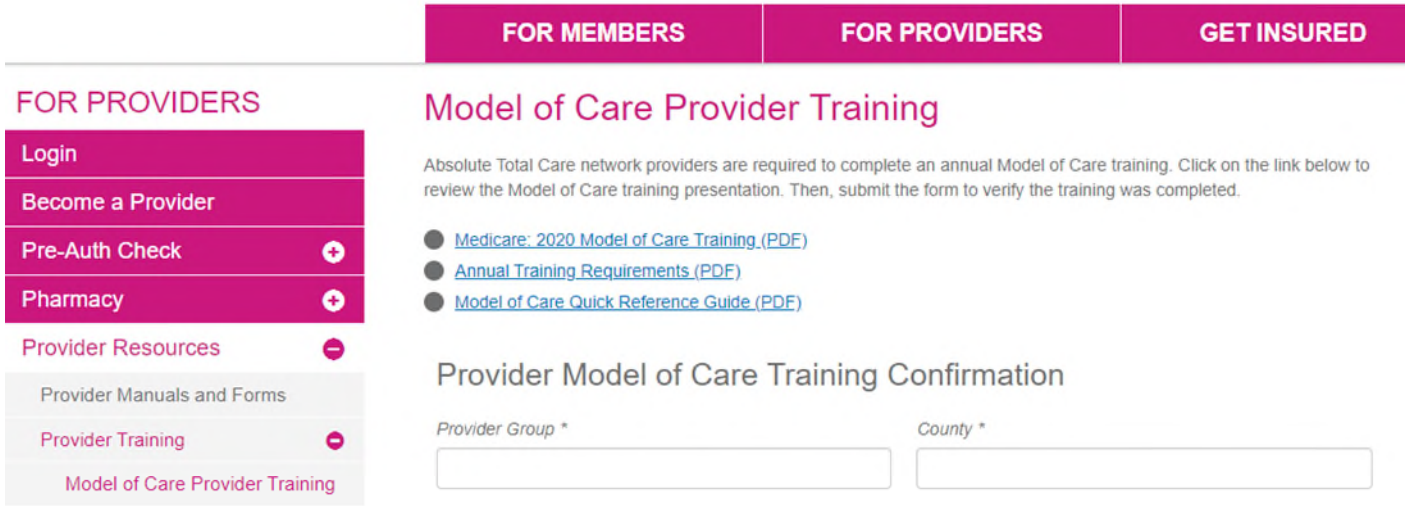
Model of Care (MOC) Process

- Allwell from Absolute Total Care values our partnership with our physicians and providers.
- The MOC requires all of us to work together to benefit our members through:
  - Enhanced communication between members, physicians, providers, and Allwell from Absolute Total Care.
  - Interdisciplinary approach to the member’s special needs.
  - Comprehensive coordination with all care partners.
  - Support for the member's preferences in the MOC.
  - Reinforcement of the member’s connection with their medical home.

Model of Care (MOC) Information

- MOC information is available in the Secure Provider Portal as well as the Provider Training webpage at allwell.absolutetotalcare.com.





MEDICARE STAR RATINGS

Medicare Star Ratings

- What are the CMS Star Ratings?
  - CMS uses a five-star quality rating system to measure Medicare beneficiaries' experience with their health plans and the healthcare system.
  - This rating system applies to Medicare Advantage plans that cover both health services and prescription drugs (MAPD).
  - The ratings are posted on the CMS consumer website, www.medicare.gov, to give beneficiaries help in choosing an Medicare Advantage and MAPD plan offered in their area.
  - The Star Rating system is designed to promote improvement in quality and recognize PCPs for demonstrating an increase in performance measures over a defined period of time.

Medicare Star Ratings

- CMS' Star Ratings system is based on measures in nine different domains.

Part C:

- Staying healthy: screenings, tests, and vaccines.
- Managing chronic (long-term) conditions.
- Member experience with the health plan.
- Member complaints, problems getting services, and improvement in the health plan's performance.
- Health plan Customer Service.

Part D:

- Drug plan Customer Service.
- Member complaints and changes in the drug plan's performance.
- Member experience with the drug plan.
- Drug safety and accuracy of drug pricing.

How Can Providers Improve Star Ratings?

- Continue to encourage patients to obtain preventive screenings annually or when recommended.
- Management of chronic conditions such as hypertension and diabetes including medication adherence.
- Continue to talk to your patients and document interventions regarding topics such as fall prevention, bladder control and the importance of physical activity and emotional health and wellbeing (HOS).
- Create office practices to identify noncompliant patients at the time of their appointment.
- Follow up with patients regarding their test results (CAHPS).
- Submit complete and correct encounters/claims with appropriate codes and properly document medical chart for all members, including availability of medical record for chart abstractions.

How Can Providers Improve Star Ratings?

- Review the gap in care files, which list members with open gaps, available on our Secure Provider Portal.
- Review medication and follow up with members within 14 days post-hospitalization.
- Identify opportunities for you or your staff to have an impact on your patient's health and well-being.
- Make appointments available to patients and reduce wait times (CAHPS).

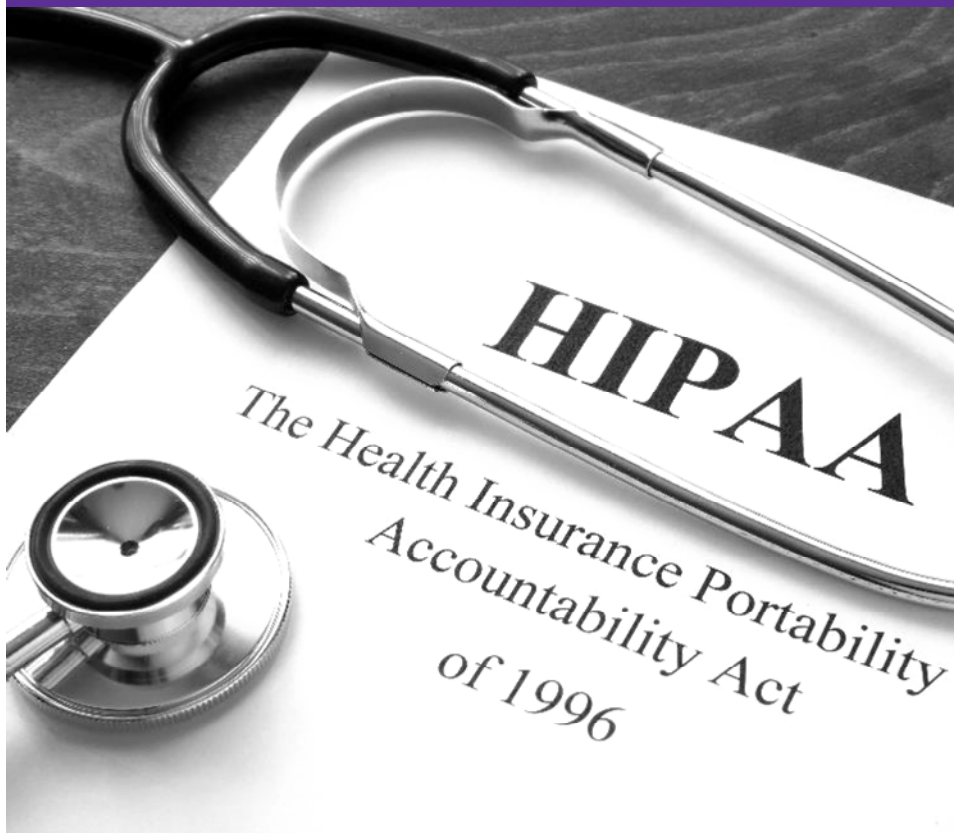
WEB-BASED TOOLS

Public Provider Website

- Website: allwell.absolutetotalcare.com.
- Through the website, providers can access:
  - Provider Manual.
  - Forms.
  - Healthcare Effectiveness Data and Information Set (HEDIS) Tips and Quick Reference Guides.
  - Provider News.
  - Pre-Auth Check Tool.
  - Provider Resources.

Secure Provider Portal

- Easily access the data and tools you need via our Secure Provider Portal:
  - Authorizations.
  - Claims:
    - Download payments history.
    - Processing status.
    - Adjustments (corrections/resubmissions).
    - Reconsiderations.
    - Clear Claim Connection (claim auditing software).
  - Health records:
    - Care gaps*.
  - Patient listings* and member eligibility.
  - Monthly PCP Cost Reports*.



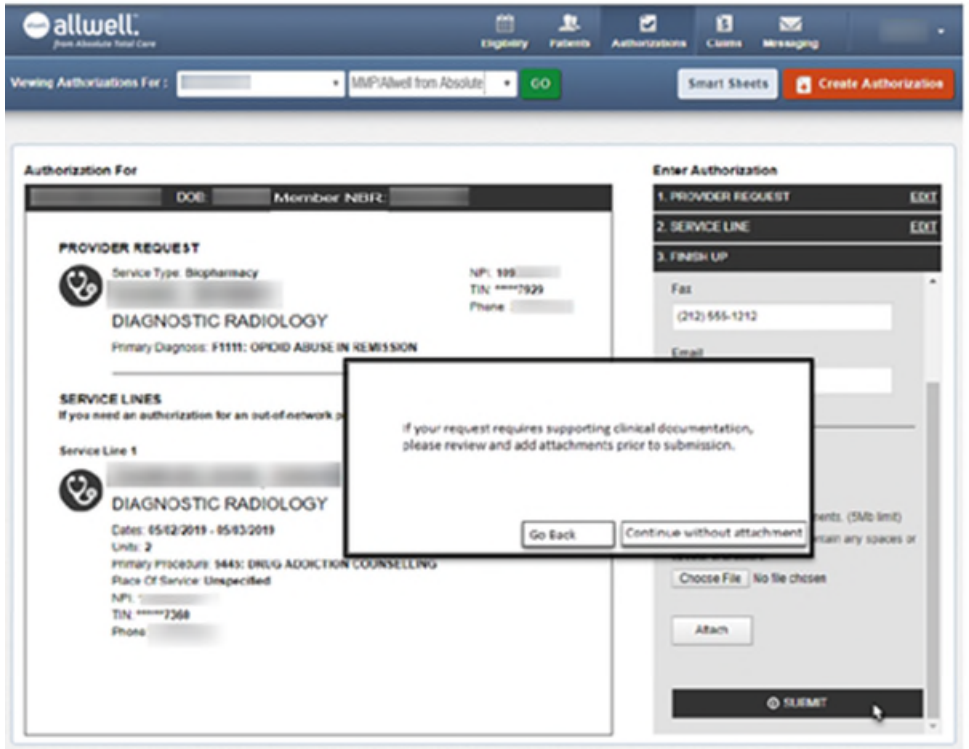
*Available for PCPs only

Secure Provider Portal: Updating Your Data

- Providers can improve member access to care by ensuring that their data is current in our Provider Directory.
- To update your provider data:
  - Log in to the Secure Provider Portal at allwell.absolutetotalcare.com.
  - From the main tool bar, select “Account Details”.
  - Select the provider whose data you want to update.
  - Choose the appropriate service location.
  - Make appropriate edits and click “Save”.

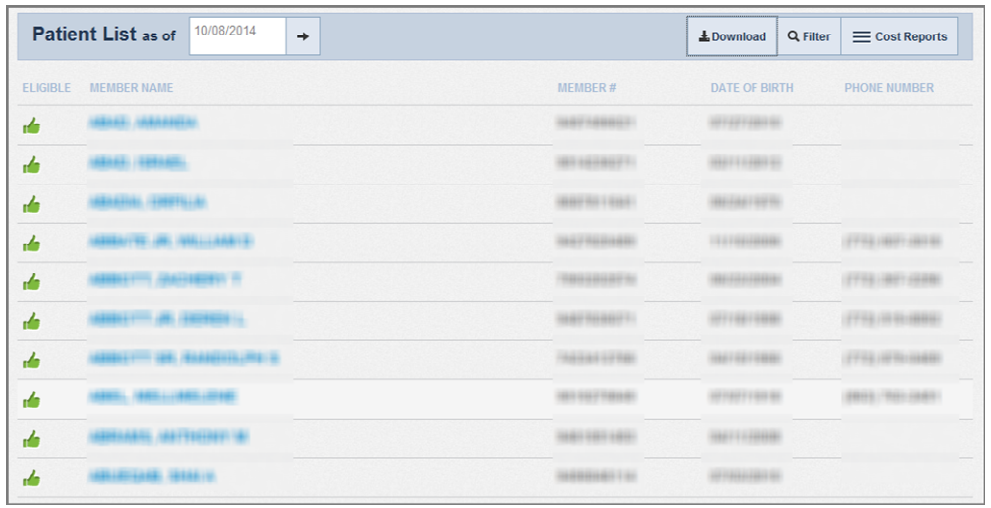
Secure Provider Portal: Authorization Enhancement

- Prior Authorization Request Documentation Alert:
  - Pop-up window appears if clinical documentation has not been attached.
  - Provider can add helpful documentation for an efficient clinical review.



Primary Care Provider (PCP) Reports

- Patient List:
  - Located on the Secure Provider Portal at allwell.absolutetotalcare.com.
  - Includes member's name, ID number, date of birth, and telephone number.
  - Available to download to Excel or PDF formats and includes additional information such as member's effective date, termination date, product, gender, and address.



NETWORK PARTNERS

Partners and Vendors

Partner/Vendor	Type of Business	Phone	Fax	Website
Envolve Pharmacy Solutions (EPS)	Pharmacy Benefit Manager	1-800-867-6564	1-866-226-1093 (Prior Authorization Requests)	
Envolve Vision Benefits	Routine Eye Care			www.visionbenefits.envolvevision.com
LIBERTY Dental	Preventive and Comprehensive Dental Services	1-888-700-1246		www.libertydentalplan.com
National Imaging Associates (NIA)	Non-Emergent, Outpatient, High-Tech Imaging, Authorizations for: • CT, PET, or MRI • Outpatient Physical, Occupational, and Speech Therapy Services	1-877-807-2363		www.RadMD.com
Hearing Care Solutions (HCS)	Hearing Services, Hearing Aids	1-877-583-2842		www.hearingcaresolutions.com

Partners and Vendors

Partner/Vendor	Type of Business	Phone	Fax	Website
American Specialty Health (ASH)	Fitness Benefit	1-855-769-6829		www.silverandfit.com
Teladoc	Telehealth (Virtual Provider) Visits	1-800-835-2362		www.teladoc.com
Critical Signals Technologies (CST)	Personal Emergency Response System (PERS), 24/7 Monitoring	1-888-557-4462		www.CSTLTL.com
GA Foods*	Meals	1-866-575-2772		www.sunmeadow.com
TurningPoint	Authorizations for Orthopedic and Spinal Surgical Procedures	• Provider Relations: 1-866-422-0800 • Prior Authorization: 1-844-245-6513	1-854-999-4018	www.myturningpoint-healthcare.com

**HMO D-SNP plan only.*

Durable Medical Equipment (DME) and Lab Partners

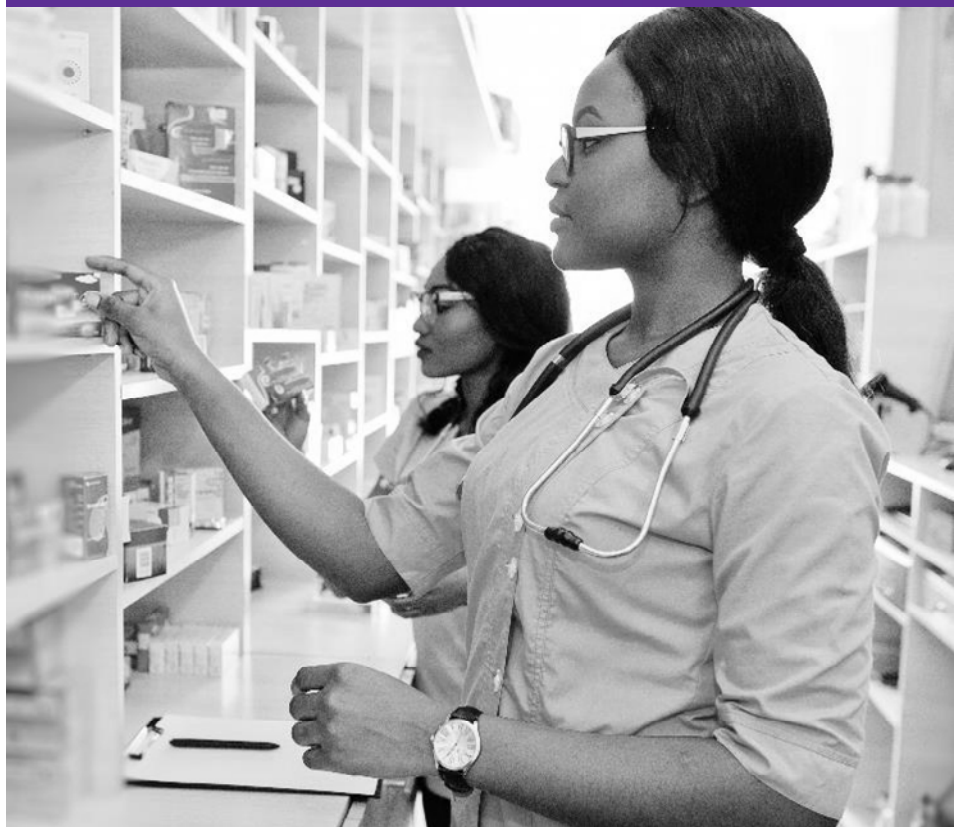
DME	
180 Medical	Hanger Prosthetics and Orthotics
ABC Medical	J&B Medical Supply
American Home Patient	KCI
APRIA Health Care	Lincare
Breg	National Seating & Mobility
CCS Medical	Numotion
Critical Signal Technologies	Shield Healthcare
DJO	St. Louis Medical Supply
EBI Biomet	Tactile Medical
Edge Park	Zoll

Lab*	
Ambry Genetics Corp.	MD Labs
Bio Reference Labs	Myriad Genetic Laboratories
Clinical Pathology Labs	Natera, Inc.
Diatherix Laboratories, LLC	Quest Diagnostics
Eurofins NTD, LTD	Sequenom Center for Molecular Medicine
Lab Corp	

**Select list of lab tests may be rendered at the provider's office. All other lab tests should be sourced to an in-network lab listed here. Please refer to the Payment Policy CC.PP.055, "Physician's Office Lab Testing," found on our website, allwell.absolutetotalcare.com, for the complete list of lab tests which may be conducted in the provider's office.*

AcariaHealth: Specialty Pharmacy

- AcariaHealth is a national comprehensive specialty pharmacy providing services in all specialty disease states including:
  - Cystic Fibrisis.
  - Hemophilia.
  - Hepatitis C.
  - Multiple Sclerosis.
  - Oncology.
  - Rheumatoid Arthritis.
- Most biopharmaceuticals and injectables require prior authorization at customercare@acariahealth.com.



BILLING OVERVIEW

Electronic Claims Transmission

- When possible, we recommend utilizing Electronic Data Interchange (EDI) to submit claims and attachments for payment.
- EDI allows for a faster processing turn around time than paper submission.
- Allwell partners with six clearinghouses for submission:
    - Emdeon: Payer ID 68069.
    - Gateway.
    - Availity/THIN.
    - SSI.
    - Medavant.
    - Smart Data Solution.

Electronic Data Interchange (EDI) Support

- Companion guides for EDI billing requirements plus loop segments can be found on our website, allwell.absolutetotalcare.com.
- For more information, contact:

Allwell from Absolute Total Care
c/o Centene EDI Department
1-800-225-2573 ext. 6075525
EDIBA@centene.com

Claims Submission Timelines

- Medicare Advantage claims are to be mailed to the following :

  Allwell from Absolute Total Care
  P.O. Box 3060
  Farmington, MO 63640-3822

- Participating providers have 365 calendar days from the date of service to submit a timely claim.
- All claim adjustments (corrections/resubmissions), reconsideration requests, or claim disputes must be received within the required time frames from the original date of notification of payment or denial:
  - Claim adjustments (corrections/resubmissions): Within 90 calendar days.
  - Claim reconsiderations: Within 90 calendar days.
  - Claim disputes: Within 60 calendar days.

Claims Payment

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

Claim Reconsiderations and Disputes

- A request for reconsideration is to be submitted when a provider disagrees with how a clean or adjusted claim was processed. Reconsiderations may be submitted via the Secure Provider Portal or mailed to the address below.
  - Examples include but are not limited to:
    - Denials related to code edit or authorization. Requests related to code edit or authorization denial require medical records and must accompany the request for reconsideration/
    - Payment amount which does not align with expected payment/
- A claim dispute is to be used only when a provider has received an unsatisfactory response to a previous reconsideration request/
- Submit reconsiderations or disputes along with a completed Provider Reconsideration/Dispute Form to:

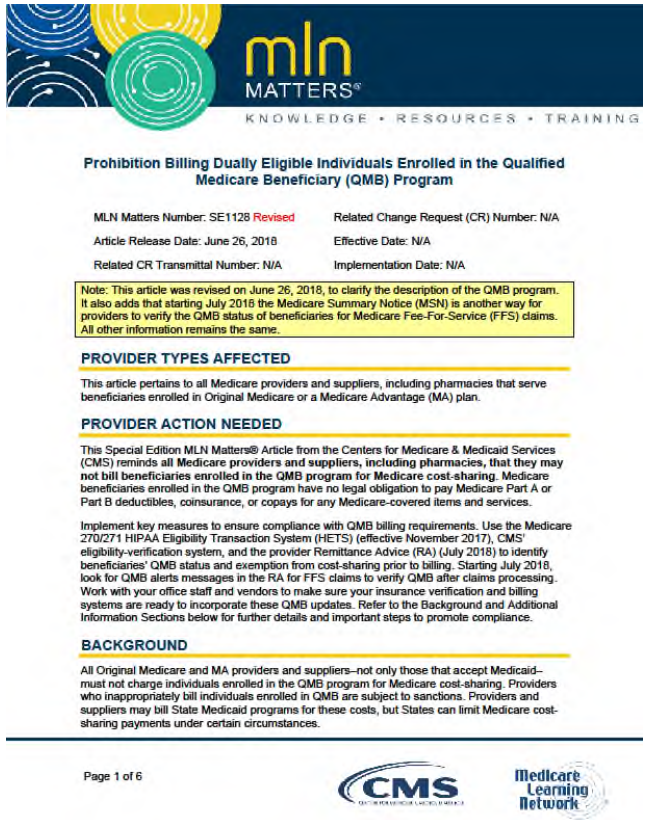
Allwell from Absolute Total Care

P.O. Box 3060

Farmington, MO 63640-3822

Allwell Dual Medicare (HMO D-SNP) Member Billing

- An HMO D-SNP member is a Qualified Medicare Beneficiary (QMB) and cannot be billed for Medicare deductibles, coinsurance, or copays.
- Provider reimbursement from a Medicare Advantage plan and Medicaid constitutes payment in full regardless of the type of service.
- A nominal copay can apply to DME, home health care, and dental care.
- Balance billing is a federal regulation and prohibited by law. Please refer to CMS' Prohibition Billing Dually Eligible Individuals Enrolled in the QMB Program document posted on our website at allwell.absolutetotlacare.com
- Improper billing is also a violation of the Medicare provider agreement. Improper billing is:
  - Billing for Medicare deductibles, coinsurance, or copays for covered medical services. This includes services or items furnished by out-of-network providers, including emergency and urgent care services.
  - Billing for Medicaid-covered medical services or items with the exception of allowable copays/cost-sharing.



mln MATTERS®

KNOWLEDGE • RESOURCES • TRAINING

Prohibition Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program

MLN Matters Number: SE1128 Revised | Related Change Request (CR) Number: N/A

Article Release Date: June 26, 2018 | Effective Date: N/A

Related CR Transmittal Number: N/A | Implementation Date: N/A

Note: This article was revised on June 26, 2018, to clarify the description of the QMB program. It also adds that starting July 2018 the Medicare Summary Notice (MSN) is another way for providers to verify the QMB status of beneficiaries for Medicare Fee-For-Service (FFS) claims. All other information remains the same.

PROVIDER TYPES AFFECTED

This article pertains to all Medicare providers and suppliers, including pharmacies that serve beneficiaries enrolled in Original Medicare or a Medicare Advantage (MA) plan.

PROVIDER ACTION NEEDED

This Special Edition MLN Matters® Article from the Centers for Medicare & Medicaid Services (CMS) reminds **all Medicare providers and suppliers, including pharmacies, that they may not bill beneficiaries enrolled in the QMB program for Medicare cost-sharing.** Medicare beneficiaries enrolled in the QMB program have no legal obligation to pay Medicare Part A or Part B deductibles, coinsurance, or copays for any Medicare-covered items and services.

Implement key measures to ensure compliance with QMB billing requirements. Use the Medicare 270/271 HIPAA Eligibility Transaction System (HETS) (effective November 2017), CMS' eligibility-verification system, and the provider Remittance Advice (RA) (July 2018) to identify beneficiaries' QMB status and exemption from cost-sharing prior to billing. Starting July 2018, look for QMB alerts messages in the RA for FFS claims to verify QMB after claims processing. Work with your office staff and vendors to make sure your insurance verification and billing systems are ready to incorporate these QMB updates. Refer to the Background and Additional Information Sections below for further details and important steps to promote compliance.

BACKGROUND

All Original Medicare and MA providers and suppliers–not only those that accept Medicaid–must not charge individuals enrolled in the QMB program for Medicare cost-sharing. Providers who inappropriately bill individuals enrolled in QMB are subject to sanctions. Providers and suppliers may bill State Medicaid programs for these costs, but States can limit Medicare cost-sharing payments under certain circumstances.

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CMS | Medicare Learning Network

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

- Electronic payments can mean faster payments, leading to improvements in cash flow.
- Eliminate re-keying of remittance data.
- Match payments to statements quickly .
- Providers can quickly connect with any payers that are using PaySpan Health to settle claims.
- Free service for network providers: www.payspanhealth.com

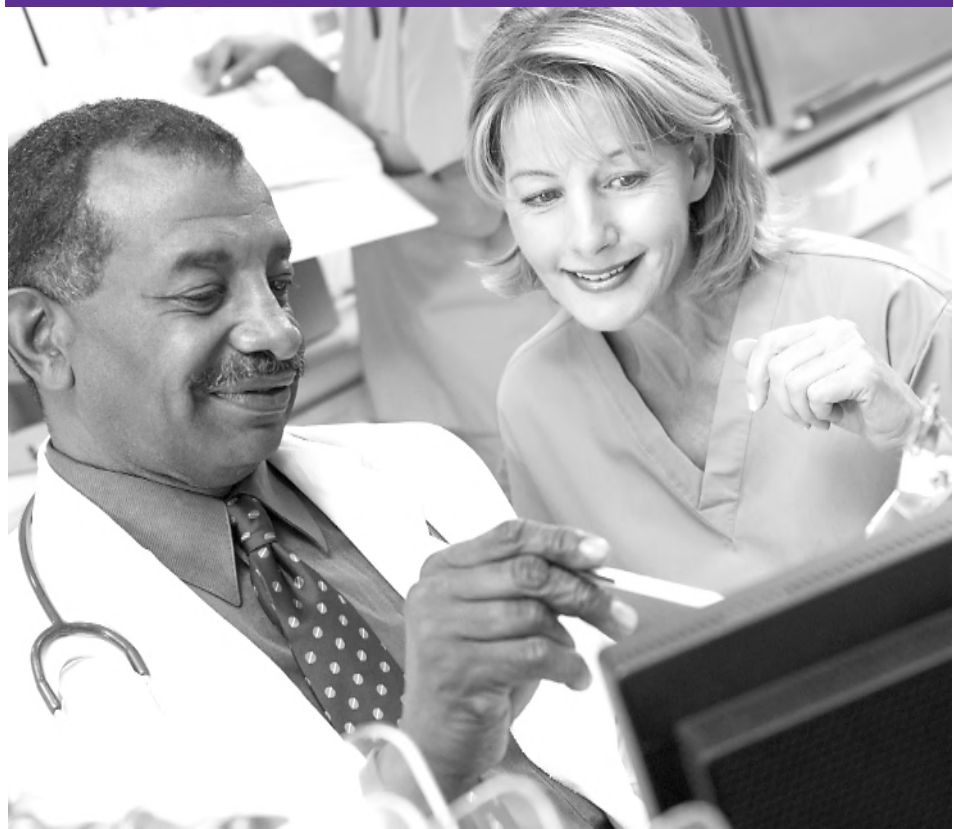
Code Auditing and Editing

- Allwell from Absolute Total Care uses code editing software based on a variety of edits:
  - American Medical Association (AMA).
  - Specialty society guidance.
  - Clinical consultants.
  - CMS.
  - National Correct Coding Initiative (NCCI).
- Software audits for coding inaccuracies such as:
  - Unbundling.
  - Upcoding.
  - Invalid codes.

MEANINGFUL USE: ELECTRONIC MEDICAL RECORDS

Meaningful Use

- The exchange of patient data between healthcare providers, insurers, and patients themselves is critical to advancing patient care, data security, and the healthcare industry as a whole.
- Electronic Health Records (EHR)/Electronic Medical Records (EMR) allow healthcare professionals to provide patient information electronically instead of using paper records.
- EHR/EMR can provide many benefits, including:
  - Complete and accurate information.
  - Better access to information.
  - Patient empowerment.
- Incentive programs may be available.



ADVANCE DIRECTIVES

Advance Medical Directives

- An advance directive will help the PCP understand the member's wishes about their healthcare in the event they become unable to make decisions on their own behalf. Examples include:
  - Living Will.
  - Healthcare Power of Attorney.
  - "Do Not Resuscitate" orders.
- Execution of an advance directive must be documented on the member's medical records.
- Providers must educate staff on issues concerning advance directives and maintain written policies that address a member's right to make decisions about their own medical care.

REGULATORY INFORMATION

Medicare Outpatient Observation Notice (MOON)

- Contracted hospitals and critical access hospitals must deliver the MOON to any member who receives observation services as an outpatient for more than 24 hours.
- The MOON is a standardized notice to a member informing them they are an outpatient receiving observation services and not an inpatient of the hospital or critical access hospital and the implications of such status.
- The MOON must be delivered no later than 36 hours after observation services are initiated, or if sooner upon release.
- The Office of Management and Budget (OMB) approved Medicare Outpatient Observation Notice and accompanying form instructions can be found at www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html.

FRAUD, WASTE, AND ABUSE

Fraud, Waste, and Abuse

- Allwell from Absolute Total Care follows the four parallel strategies of the Medicare and Medicaid programs to prevent, detect, report and correct fraud, waste, and abuse:
  - Preventing fraud through effective enrollment and education of physicians, providers, suppliers, and beneficiaries.
  - Detection through data analytics and medical records review.
  - Reporting any identified or investigated violations to the appropriate partners, including contractors, the NBI-MEDIC and federal and state law enforcement agencies, such as the Office of Inspector General (OIG), Federal Bureau of Investigation (FBI), Department of Justice (DOJ), and Medicaid Fraud Control Unit (MFCU).
  - Correcting fraud, waste, or abuse by applying fair and firm enforcement policies, such as pre-payment review, retrospective review, and corrective action plan.

Fraud, Waste, and Abuse

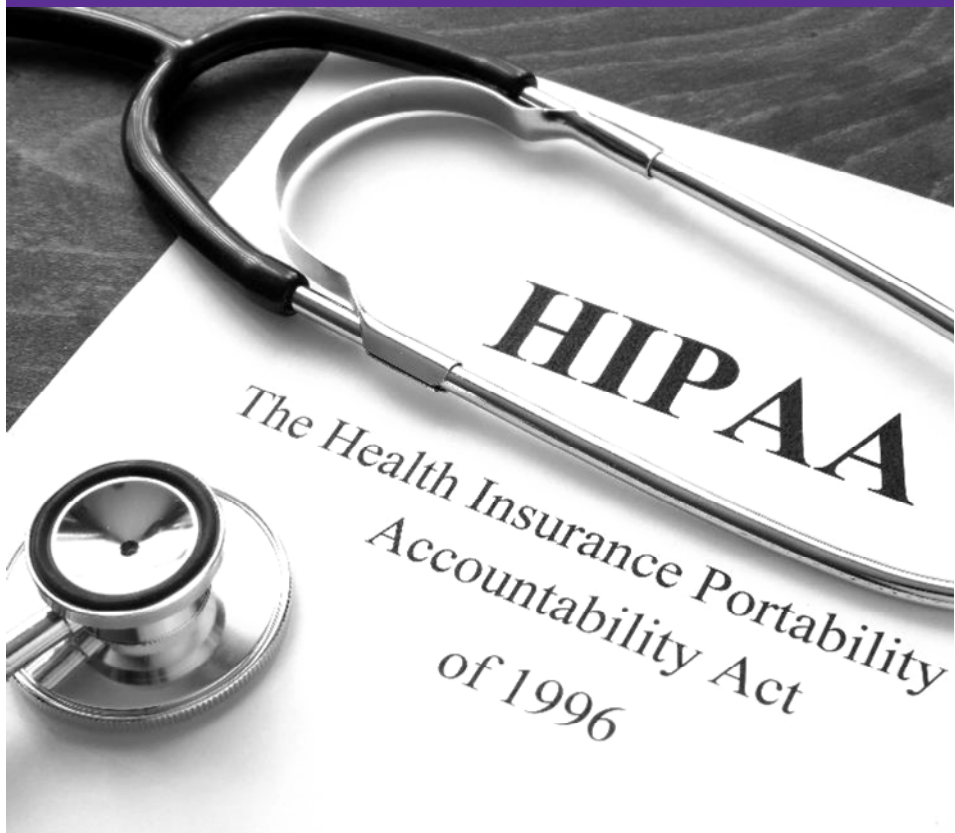
- Allwell from Absolute Total Care performs front- and back-end audits to ensure compliance with billing regulations. Most common errors include:
  - Use of incorrect billing code.
  - Not following the service authorization.
  - Procedure code not being consistent with provided service.
  - Excessive use of units not authorized by the Care Manager.
  - Lending of insurance card.
- Benefits of stopping fraud, waste, and abuse:
  - Improves patient care.
  - Helps save dollars and identify recoupments.
  - Decreases wasteful medical expenses.

Fraud, Waste, and Abuse

- Allwell from Absolute Total Care expects all its providers, contractors, and subcontractors to comply with applicable laws and regulations including, but not limited to, the following:
  - Federal and State False Claims Act.
  - Qui Tam Provision (Whistleblower).
  - Anti-Kickback Statute.
  - Physician Self-Referral Law (Stark Law).
  - Health Insurance Portability and Accountability Act (HIPAA).
  - Social Security Act (SSI).
  - U.S. Criminal Codes.

Medicare Reporting

- Potential fraud, waste, or abuse reporting may be called to our anonymous and confidential hotline at 1-866-685-8664 or by contacting the Compliance Officer at 1-855-766-1497. You can also email ATC.Compliance@centene.com.
- To report suspected fraud, waste, or abuse in the Medicare program, providers may also use one of the following avenues:
  - Office of Inspector General (HHS-OIG):
    - Phone: 1-800-447-8477 (TTY: 1-800-377-4950).
    - Fax: 1-800-223-8164.
    - Website: www.OIG.HHS.gov/fraud.
    - Email: HHSTips@oig.hhs.gov.
    - Mail: U.S. Department of Health and Human Services
      Office of Inspector General
      Attn: OIG HOTLINE OPERATIONS
      P.O. Box 23489
      Washington, DC 20026
  - NBI-MEDIC: 1-877-7SafeRx (1-877-772-3379).



CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) MANDATORY TRAININGS

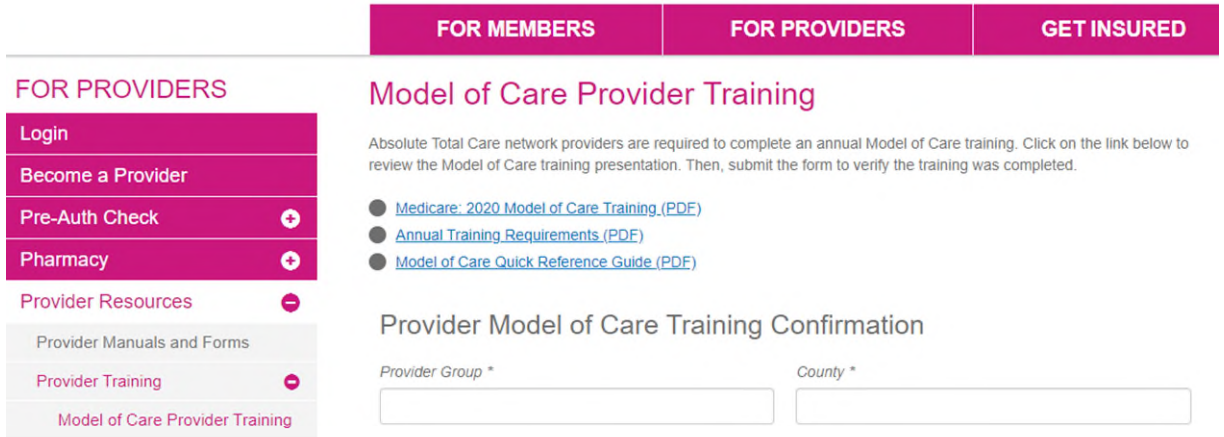
Centers for Medicare and Medicaid Services (CMS) Mandatory Trainings

- Allwell contracted providers, contractors and subcontractors are required to complete three required trainings:
  - MOC:
    - Within 30 days of joining Allwell from Absolute Total Care and annually thereafter (HMO D-SNP only).
  - General Compliance (Compliance):
    - Within 90 days of joining Allwell from Absolute Total Care and annually thereafter.
  - Fraud, Waste, and Abuse:
    - Within 90 days of joining Allwell from Absolute Total Care and annually thereafter.

CMS.gov
Centers for Medicare & Medicaid Services

Model of Care (MOC) Training Requirements*

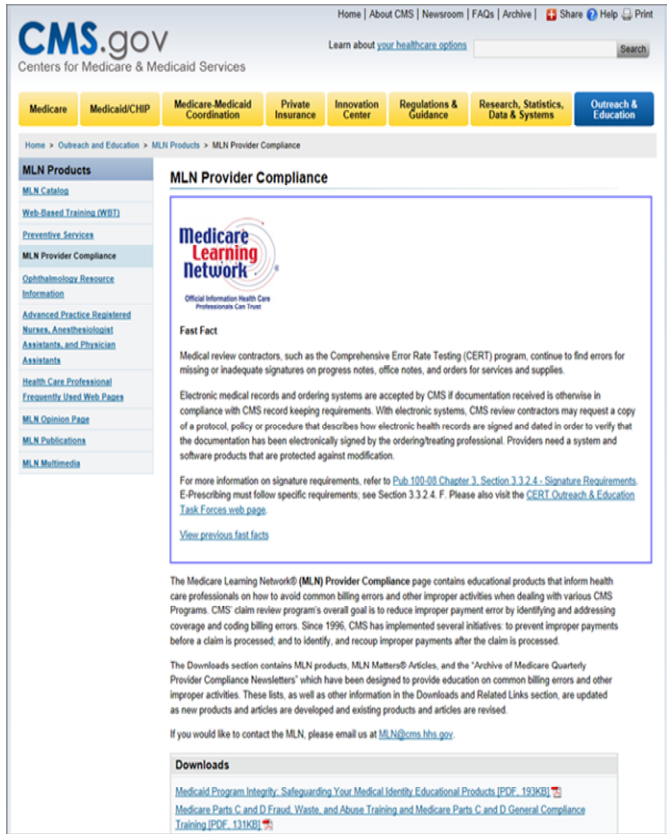
- MOC training is a CMS requirement for newly contracted Medicare providers within 30 days of execution of contract.
- MOC training must be completed annually by each participating provider.
- MOC information is available in the Secure Provider Portal as well as the Provider Training webpage at allwell.absolutetotalcare.com.



*Required for HMO D-SNP only.

General Compliance and Medicare Fraud, Waste, and Abuse Training

- Providers are required to complete training via the Medicare Learning Network (MLN) website.
- Must be completed by each individual provider/practitioner within the group rather than one person representing the group collectively.
- Training must be completed within 90 days of contracting and annually thereafter.
- Complete the certificate(s) of completion or attestation through the CMS MLN and provide a copy to Allwell from Absolute Total Care.



General Compliance and Medicare Fraud, Waste, and Abuse Training

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

Q&A