HealthSmart®
COMPLETE

Provider Manual

www.healthsmart.com

Table of Contents

About HealthSmart Complete

(a Centene Company)

Welcome

About HealthSmart Complete

HealthSmart Complete is the premier provider of customizable and scalable health plan solutions for self- funded employers. We deliver solutions that reduce costs and improve outcomes, all while treating Covered Persons with dignity and respect. But that's just the beginning of our story.

We're a company of innovators

Our HealthSmart Complete Network Solution offers national, comprehensive provider networks to ensure full access to healthcare products and services.

HealthSmart Complete delivers benefit plans and solutions to provide worry-free administration, quality coverage, and innovative care.

HealthSmart Care Management Solutions provides a full array of care management services that changes lives and helps employers and Covered Persons take control of healthcare costs.

HealthSmartRx Solutions delivers extremely attractive full-service pharmacy benefit management, coupled with an Rx discount program.

We offer business intelligence and web-based reporting.

We also offer a variety of health and wellness initiatives including onsite and remote employer-based clinics.

Vision and Mission

Our Vision. To be the premier administrator for self-funded plans that offers smart alternatives for smart consumers. We want our Covered Persons to be educated on their choices for a healthy lifestyle and positive financial outcomes.

Our Brand Promise. We partner to provide every service that plan sponsors need to reduce healthcare costs and manage members with dignity and respect

Our Values.

+ **Earned trust –** We use actions, not words, to earn the trust of our clients and members, and we deliver on what we say to keep that trust.
+ **Respect always –** In our daily jobs, we do things that demonstrate respect for the members we serve, our clients and each other.
+ **Do the right thing –** We don't take shortcuts, we don't let things fall through the cracks and when things don't go as planned, we make things right.
+ **Get better every day –** As good as our solutions, processes and workflows are today, we continually search for ways to improve.
+ **Innovation –** We think of new ways to solve problems, old and new, and deliver unique services that protect members and the client from unnecessary health care expense.
+ **Accountability –** We take responsibility for ourselves to own the quality of the jobs we perform, and hold each other to the same standards.
+ **Clients First –** We listen, clarify and confirm to understand our clients and respond with best-in-class service, support, and intelligence.
+ **Handle with Care –** We will treat every member with dignity and respect, whether assisting with claims, providing compassionate and effective care management, or answering questions.

HealthSmart Complete Network

Generally referred to as the HealthSmart Complete Network, this is a nationwide preferred provider organization (PPO) formed to meet the ever-changing and growing need for effective management of cost and quality in the healthcare delivery system. Covered Person(s) may receive medical care from any participating provider. Covered Person(s) will not be required to select primary care physician (PCP) and referrals are not required. With a strong focus on customer service, HealthSmart Complete creates a productive and effective business environment to meet the various needs of the health care delivery system for providers, employers, payors, and third-party administrators.

HealthSmart Complete Provider Network Management

Join Our Network

Providers can join the Network as an:

+ Individual Provider
+ Group of Providers
+ Hospital Based Group
+ Ancillary / Facility

To join the HealthSmart Complete Network, providers need to:

1. **Be registered with CAQH**
   (Council for Affordable Quality Healthcare Inc.).
   a. If not registered with CAQH, please go to https://proview.caqh.org/
      i. The CAQH application can be faxed to CAQH at (866) 293-0414
   b. If registered with CAQH, verify that information is accurate and up to date with CAQH Proview Login
   c. For more information on CAQH Proview, refer to User Guide
2. Call our contracting team at (833) 933-2272 or fill out our online Join Our Network form
3. Once obtained, execute the Participating Provider Agreement
4. Complete the appropriate credentialing documents
5. Return all materials to us using one of the following methods:
   a. Scan and Email to Contracting@HealthSmartComplete.com
   b. Fax to (833) 955-2484
   c. Mail by postal service to the following address:

      HealthSmart Complete
      Commercial Contracting Team
      7700 Forsyth Blvd.
      St Louis, Mo 63105

Provider Nominations

Members can nominate a provider by completing the online Nominate a Provider form.

Upon completion of the form, the HealthSmart Provider Relations team will review the nomination to ensure the provider satisfies our business needs and requirements, including, but not limited to the HealthSmart credentialing and contracting requirements.

Credentialing

The credentialing and recredentialing process exists to verify that participating providers meet the criteria established by HealthSmart Complete, as well as applicable government regulations and standards of accrediting agencies.

If a provider already participates with Centene Corporation, the provider will NOT be separately credentialed for the HealthSmart Complete product.

Notice: In order to maintain a current provider profile, providers are required to notify HealthSmart Complete of any relevant changes to their credentialing information in a timely manner but in no event later than 10 days from the date of the change.

Whether a standardized credentialing form is utilized or a provider has registered their credentialing information on the Council for Affordable Quality Health (CAQH) website, the following information must be on file:

+ Signed attestation as to correctness and completeness, history of license, clinical privileges, disciplinary actions, and felony convictions, lack of current illegal substance use and alcohol abuse, mental and physical competence, and ability to perform essential functions with or without accommodation
+ Current malpractice insurance policy face sheet, which includes insured dates and the amounts of coverage
+ Current controlled substance registration certificate, if applicable
+ Current drug enforcement administration (DEA) registration certificate for each state in which the providers will see HealthSmart Complete Persons
+ Completed and signed W-9 form (initial credentialing only)
+ Current educational commission for foreign medical graduates (ECFMG) certificate, if applicable
+ Curriculum vitae listing, at minimum, a five year work history if work history is not completed on the application with no unexplained gaps of employment over six months for initial applicants
+ Signed and dated release of information form not older than 120 days
+ Current clinical laboratory improvement amendments (CLIA) certificate, if applicable

HealthSmart Complete will primary source verify the following information submitted for credentialing and recredentialing:

+ License through appropriate licensing agency;
+ Board certification, or residency training, or professional education, where applicable;
+ Malpractice claims and license agency actions through the National Practitioner Data Bank (NPDB);
+ Federal sanction activity, including Medicare/Medicaid services (OIG-Office of Inspector General).

For providers (hospitals and ancillary facilities), a completed Organizational Provider Credentialing Application and all supporting documentation as identified in the application must be received with the signed, completed application.

Once the complete and clean application is received, the Credentialing Committee will usually render a decision on acceptance following its next regularly scheduled meeting in accordance to state and federal regulations.

Eligible Providers

All eligible providers are required to complete the credentialing process. All eligible providers must be recredentialed every 36 months. Including, but not limited to the following provider types:

+ Professional providers: MD, DO, PsyD, PHD, AUD, BCBA, OD, DC, CNM, DPM, PA, APN, APRN ANP and CNP, CNS, RD, LAC and DN
+ Institutional providers: Hospitals and Ancillary

Non-Registered CAQH Providers

Primary care providers cannot accept covered person assignments until they are fully credentialed.

Providers are required to self-register with CAQH ProView at https://proview.caqh.org. The CAQH will email the provider a Welcome kit with registration instructions. Providers receive a personal CAQH Provider ID, allowing them to register on the CAQH website at proview.caqh.org and obtain immediate access to the ProView database via the Internet.

Once obtaining authenticating key information, providers will have the opportunity to create their own unique user name as well as password to begin utilizing the system at any time.

Credentialing Committee

The HealthSmart Complete Credentialing Committee, including the Medical Director or their physician designee, has the responsibility to establish and adopt necessary criteria for participation, termination, and direction of the credentialing procedures. Committee meetings are typically held at least monthly and more often as deemed necessary. Failure of an applicant to adequately respond to a request for missing or expired information may result in termination of the application process prior to committee decision.

Recredentialing

HealthSmart Complete conducts provider recredentialing at least every 36 months from the date of the initial credentialing decision or most recent recredentialing decision. The purpose of this process is to identify any changes in the provider's licensure, sanctions, certification, competence, or health status which may affect the provider's ability to perform services under the contract. This process includes all providers, facilities, and ancillary providers previously credentialed and currently participating in the network.

In between credentialing cycles, HealthSmart Complete conducts provider performance monitoring activities on all network providers. HealthSmart Complete reviews monthly reports released by both Federal and State entities to identify any network providers who have been newly sanctioned or excluded from participation in Medicare or Medicaid. HealthSmart Complete also reviews Covered Persons' complaints/grievances against providers on an ongoing basis.

A provider's agreement may be terminated if at any time it is determined by the HealthSmart Complete Credentialing Committee that credentialing requirements or standards are no longer being met.

Participating Providers Right to Review and Correct Information

All providers participating within the network have the right to review information obtained by HealthSmart Complete to evaluate their credentialing and/or recredentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank, CAQH, malpractice insurance carriers, and state licensing agencies. This does not allow a provider to review references, personal recommendations, or other information that is peer review protected.

Participating providers have the right to correct any erroneous information submitted by another party (other than references, personal recommendations, or other information that is peer review protected) in the event the provider believes any of the information used in the credentialing or recredentialing process to be incorrect or should any information gathered as part of the primary source verification process differ from that submitted by the provider. HealthSmart Complete will inform participating providers in cases where information obtained from primary sources varies from information provided by the providers. To request release of such information, a written request must be submitted to your Provider Relations Representative. Upon receipt of this information, the providers will have 30 days from the initial notification to provide a written explanation detailing the error or the difference in information to the Credentialing Committee.

The HealthSmart Complete Credentialing Committee will then include this information as part of the credentialing or recredentialing process.

Providers Right to Be Informed of Application Status

All providers who have submitted an application to join have the right to be informed of the status of their application upon request. To obtain application status, the providers should contact their Provider Relations Representative.

Providers Right to Appeal or Reconsideration of Adverse Credentialing Decisions

Applicants who are existing providers and who are declined continued participation due to adverse credentialing determinations (for reasons such as appropriateness of care or liability claims issues) have the right to request an appeal of the decision. Requests for an appeal must be made in writing within 30 days of the date of the notice.

All written requests should include additional supporting documentation in favor of the applicant's appeal or reconsideration for participation in the network. Reconsiderations will be reviewed by the Credentialing Committee at the next regularly scheduled meeting and in accordance with state and federal regulations.

Written requests to appeal or for reconsideration of adverse credentialing decisions should be sent to the attention of the Credentialing Manager listed on the denial letter.

Provider Data Updates and Validation

HealthSmart Complete believes that providing easy access to care for our Covered Persons is extremely important. When information (for instance address, office hours, specialties, phone number, hospital affiliations, etc.) about your practice, your locations, or your provider changes, it is your responsibility to provide timely updates to HealthSmart Complete. HealthSmart Complete will ensure that our systems are updated quickly to provide the most current information to our Covered Persons.

Additionally, HealthSmart Complete, and our contracted vendors, perform regular audits of our provider directories. This may be done through outreach to confirm your practice information. Access to care is critical to ensuring the health and well-being of our Covered Persons, and in order to provide reliable access to care, it is important to respond to the outreach. Without a response, we are unable to accurately make your information available to patients and you may be at risk of being removed from the HealthSmart Complete Provider Directory.

We need your support and participation in these efforts. Please be sure to notify your office staff so that they may route these inquiries appropriately.

Provider Termination

Obligations of Participating Provider following Termination

Participating Providers are responsible for all contractual obligations for all services and transactions that occurred prior to the termination date.

After termination, Participating Providers remain responsible for maintaining confidentiality of and access to medical records, proprietary information, continuation of services, and indemnification, and any other provisions explicitly stated in the Provider Agreement that survive the termination.

Coordination of Care Following Termination of HealthSmart Complete Participation

If the network participation ends, HealthSmart Complete Covered Persons must be transitioned timely and for appropriate care. If a Covered Person is receiving ongoing care, continued services may be required for a reasonable time at the in-network contracted rate. Customer Service is available to assist you and our Covered Persons with this transition.

Provider Lookup

Participating Providers will be added to the HealthSmart Complete Provider Lookup. Covered Persons can access the HealthSmart Complete Provider Lookup from the www.HealthSmart Complete.com Member Center at https://HealthSmart Complete.com/Service-Centers/Member-Center.

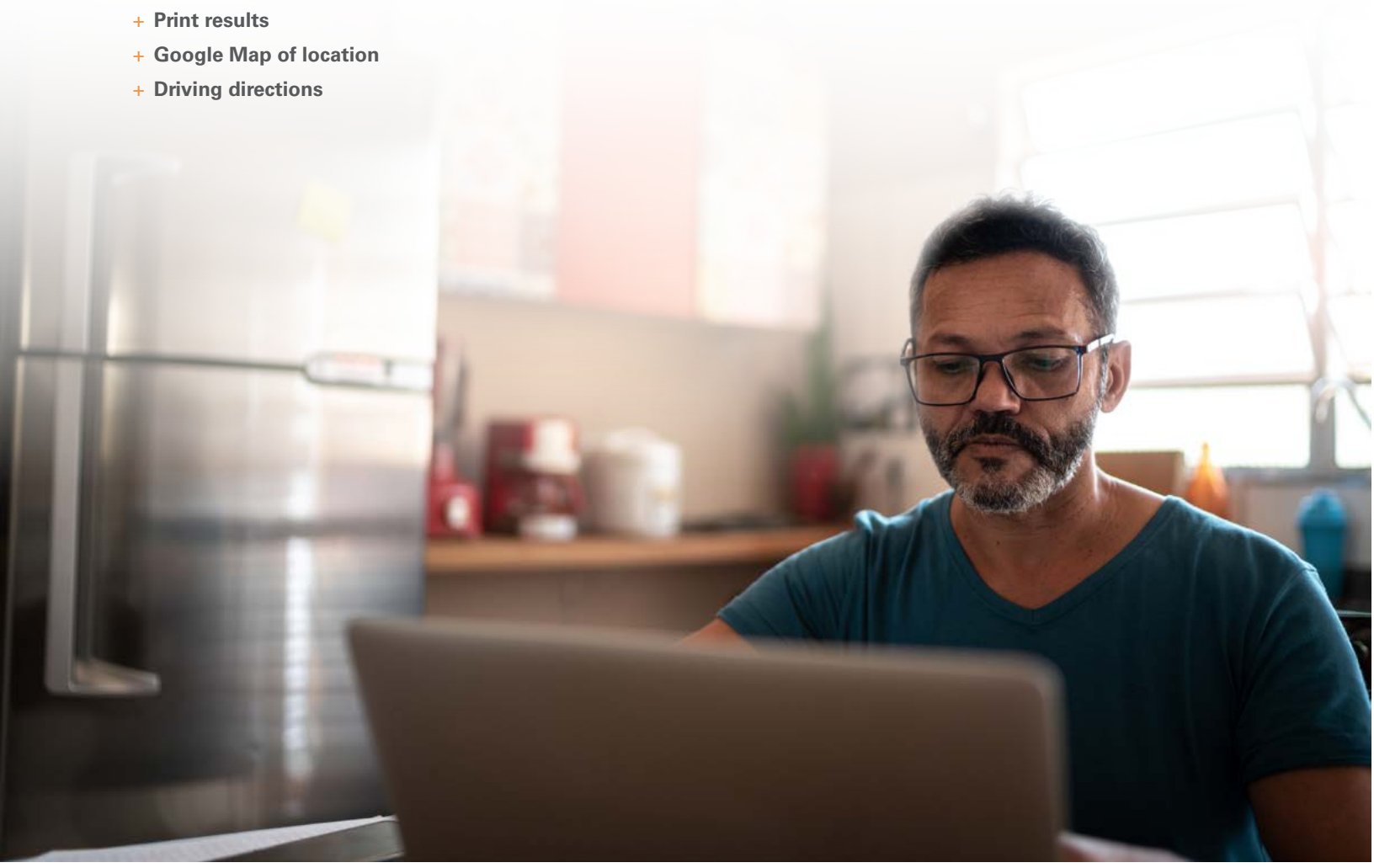
The HealthSmart Complete Provider Lookup allows the Cover Person(s) to search by:

1. **Network**
2. **Location**
3. **Specialty Type, Facility Type and/or Provider Name**

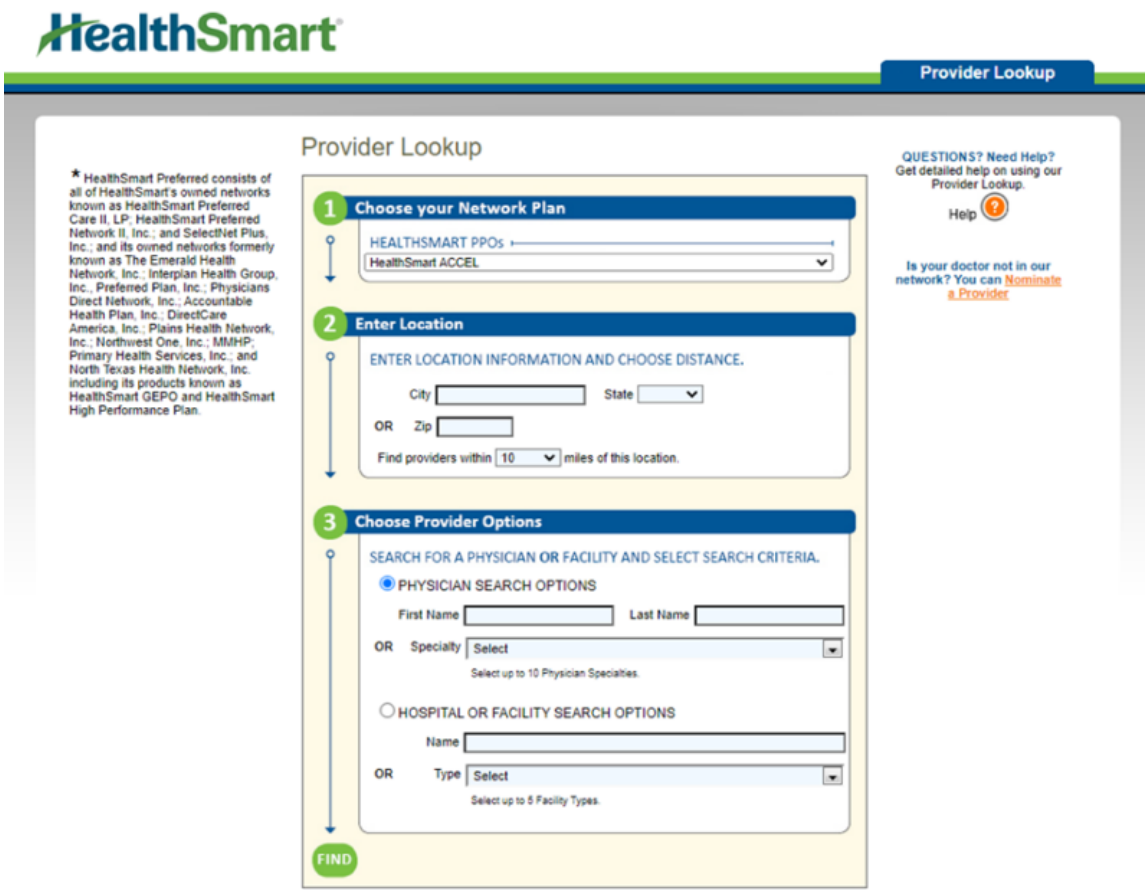
Provider Lookup search results will provide a listing of all Participating Providers that meet the search criteria. From the search results, Covered Persons can click on any provider name to see details.

The Provider Lookup also has the following features:

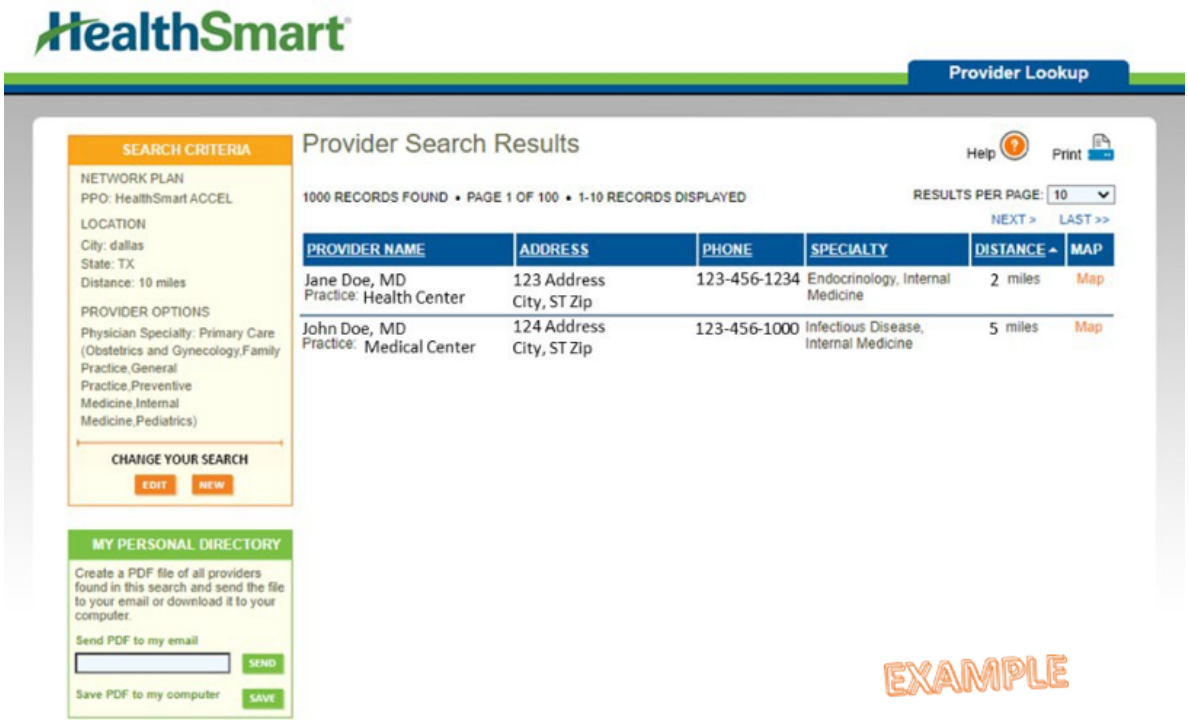
+ **My Personal Directory Email results –** Create PDF file of all providers found in the search and send the file to email or download to the computer.
+ **Electronic Business Card (vCard) -** Create an Electronic Business Card of a specific provider in vCard format for use in email programs and send the file to email or download to the computer.
+ **Print results**
+ **Google Map of location**
+ **Driving directions**



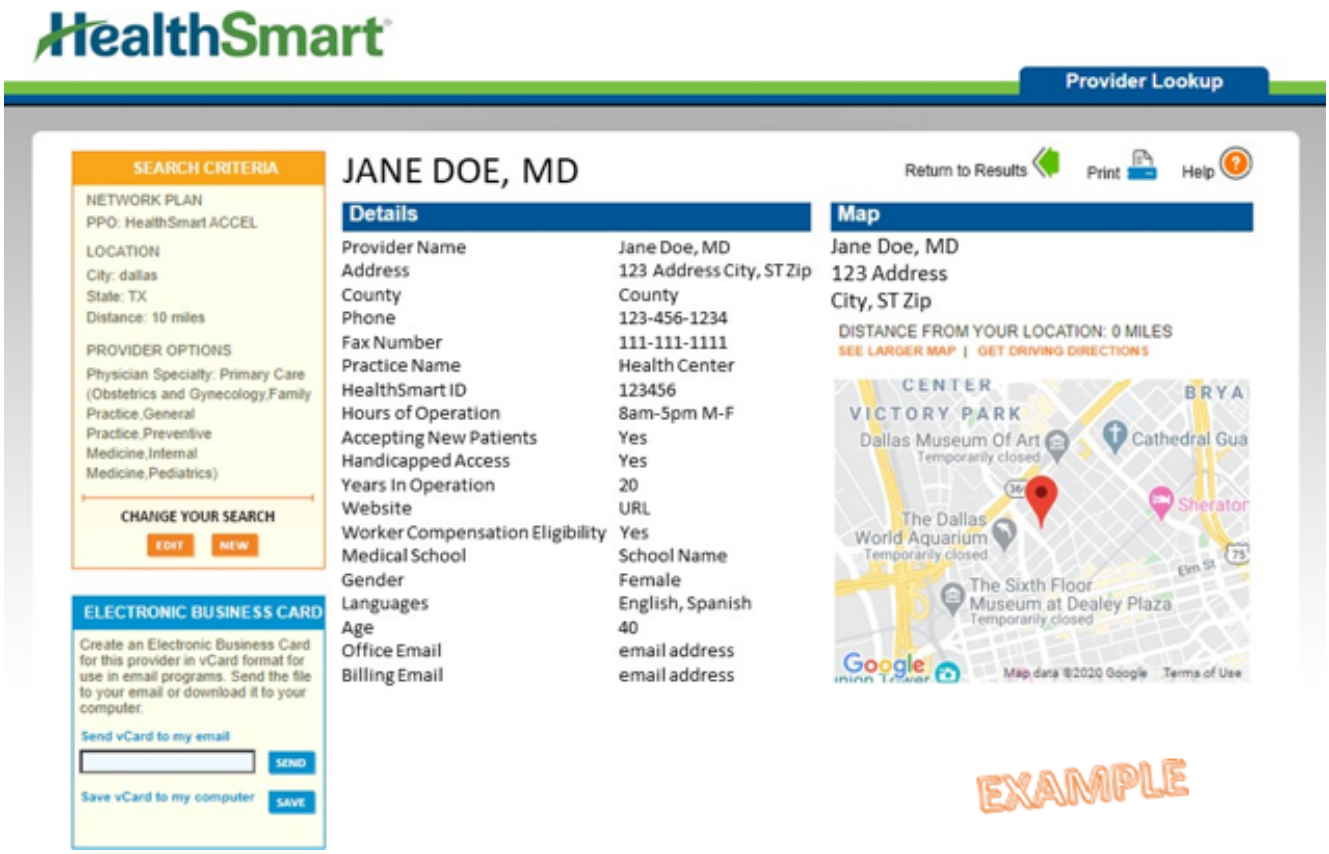
HealthSmart Complete Provider Lookup



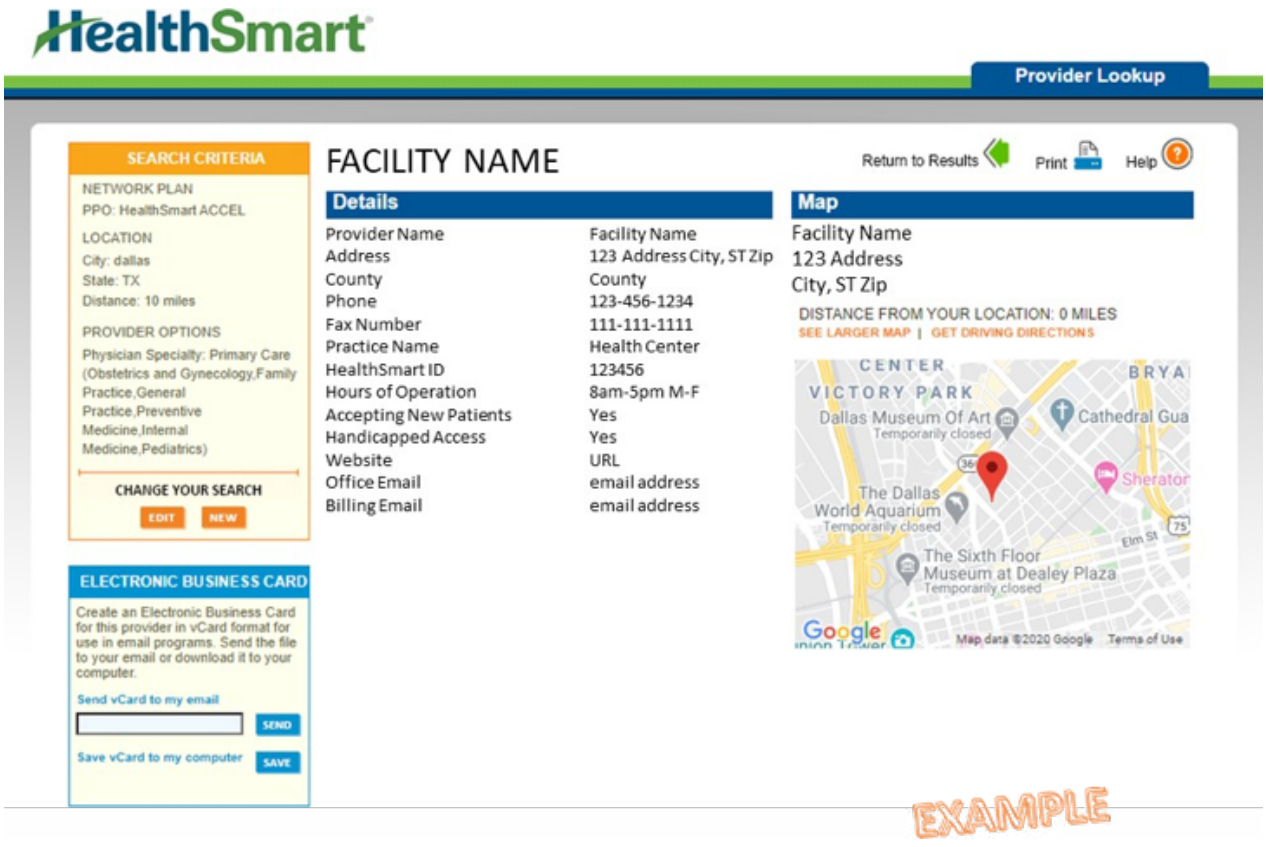
HealthSmart Complete Provider Lookup – Search Results List



HealthSmart Complete Provider Lookup – Provider Detail Page



HealthSmart Complete Provider Lookup – Hospital/Facility Detail Page



Utilization Management

Participating Providers are required to participate in and observe the protocols of the Utilization Management, Case Management and Quality Improvement Programs adopted by the payor to ensure that the covered services rendered by a Participating Provider meet the requirements of care, treatment and medical necessity consistent with industry standards. Failure to comply with the applicable Utilization Management Program may result in reduction of benefits to the Covered Person as well as payment adjustments or denials.

HealthSmart Complete's Utilization Management program adheres to all URAC Accreditation guidelines. Specifically requiring all Covered Persons, providers and employees making UM decisions to affirm that UM decisions are based only on appropriateness of care and service. Company does not offer or issue rewards for denial of coverage nor does it offer financial incentives to UM decision makers that result in underutilization.

Participating Providers should call the applicable phone number on the Covered Persons' identification card to request a prior authorization or seek guidance on the plan requirements. For procedures on how to request Prior Authorization, please refer to ***Prior Authorization section*** of manual.

If you or a Covered Person do not agree with a determination to not approve or certify a health care service made under the Utilization Management program, you or the Covered Person have the right to appeal the determination in accordance with Utilization Management program's appeal process. The appeals process may vary by the health plan's or payor's Utilization Management program and/or as mandated by state or federal law. Contact the number on the Covered Persons' identification card to request an appeal. For more information go to the ***Disputes, Appeals & Grievances section*** of the manual.

Concurrent Review

After the admission, the Utilization Management Department will monitor services on a concurrent basis. If the Covered Person is not discharged within the number of days initially approved, the Utilization Review personnel will contact the attending physician for additional medical information. Both care and services for each case are monitored. Further certification will depend upon the establishment of medical necessity.

Discharge Planning

Discharge Planning is the process which assesses a Covered Persons' need for treatment after hospitalization to help arrange for the necessary services and resources to affect an appropriate and timely discharge from the hospital. Discharge planning is also designed to identify those Covered Persons who will need care after discharge from the hospital. This care may include home health services, extended care facilities or home I.V. therapy. Early identification will ensure timely discharge thus providing less expensive yet quality care.

Emergency Admissions

Notification of Emergency Admission must take place within 48 hours of the admission by contacting the number on the Covered Persons' identification card.

Maternity Admissions

The Covered Person should contact HealthSmart Complete Care Management Solutions or the company providing Utilization Management Services on behalf of the plan early in the pregnancy with the expected date of delivery. The Utilization Review personnel will work closely with the physician to monitor the pregnancy for potential high risk. If the pregnancy is determined to be high risk, the case should be referred to a Case Management Nurse for potential intervention. The Utilization Management Department should be notified when the Covered Person is admitted for labor and delivery. Any other admissions prior to delivery, such as complications of pregnancy, require separate notification. The Utilization Management Department should also be notified if the baby is not going to be discharged with the mother.

Medical Criteria

A system used by Utilization Management Department personnel that utilizes clearly established, nationally recognized criteria for determining the appropriateness of medical services provided or to be provided. The criteria are reviewed at least annually and revised as indicated. The criteria may contain length of stay parameters based upon expected outcomes of care as specified in Milliman Care Guidelines.

Case Management

Case Management identifies Covered Persons that can benefit from close review and management due to length, severity, complexity and/or cost of healthcare. Case Managers locate and assess medically appropriate settings for the Covered Person, arrange for ancillary care and coordinate care of complex health care services so the Covered Persons' health care benefits can be managed as efficiently as possible.

Preventable Errors

In rendering covered services, Participating Provider shall not be entitled to compensation from payor or Covered Person(s) if such services or treatment were medically necessary as a result of Participating Provider's preventable error(s), including but not limited to, error(s) arising from surgery, use of medical devices or products, inadequate patient protection, inadequate care management, or unclean or unsafe environmental conditions.

Retrospective Review

The company providing Utilization Management recognizes that there will be Covered Persons who will not have precertification and concurrent review performed. These cases will be reviewed retrospectively focusing on day of admission and continued hospital stay. The Utilization Management Department personnel will contact the hospital or attending physician to obtain all necessary information. Using established medical criteria, the Utilization Management Department personnel will determine the medical necessity of the authorization. If the criteria are met, the service or product will be certified. If the medical criteria are not met, the denial and appeal procedures for precertification and concurrent review will be followed.

Review Guidelines

Review Guidelines will be conducted in accordance with the following National Database: Healthcare Screening Criteria for Utilization Management, Geographic Annualized Volume - Milliman Care Guidelines.

Disputes, Appeals & Grievances

Claim Appeals

The claim appeal and resolution process is available to any Participating Provider that wishes to initiate the process. The appeals process may vary by the client, so it is best practice for you to contact the payor on the patient's ID card.

The appeal will be reviewed by HealthSmart and/or the appropriate party. Once a disposition and finding is reached, a HealthSmart or payor representative will notify the requestor. If a secondary review is required, the initial appeal and review findings may be submitted for next level review. When a final disposition has been reached, notification is sent to the requestor of the appeal/complaint. If the review resulted in a change to the reimbursement of the claim(s), notification of the resolution is submitted to the payor to reprocess the claim in accordance with the findings of the appeal.

For questions regarding a provider credentialing status, termination or correction action notification, please contact the issuing party on the Notice or our Provider Relations Team.

Region	State in which provider practices	Provider Relations Team
Central	IA, IL, IN, KS, MO, MN, ND, NE, SD, WI	pr.central@healthsmart.com Fax: 214-574-2368
East	CT, DE, KY, MA, MD, ME, MI, NH, NY, OH, PA, TN, VA, VT, WV, RI, NJ	pr.east@healthsmart.com Fax: 214-574-2368
South	AL, AR, FL, GA, LA, MS, NC, NM, OK, SC, TX	pr.south@healthsmart.com Fax: 214-574-2368
West	AZ, CA, CO, ID, MT, NV, OR, UT, WA, WY, HI, AK	pr.west@healthsmart.com Fax: 214-574-2368

Clinical or Medical Necessity Appeals

An appeal is a request to the health insurer or plan by either a Covered Person or Participating Provider to review an adverse benefit determination.

The appeal process is available to any provider that wishes to initiate the process. The appeals process may vary by the client or payor's Utilization Management program and/or as mandated by state or federal law. If you or an Covered Person do not agree with a determination to not approve or certify a health care service made under the Utilization Management program, you or the Covered Person have the right to appeal the determination in accordance with Utilization Management program's appeal process. Please contact the appropriate Utilization Management vendor on the Covered Persons' ID card. Failure to observe the protocols of the Utilization Management program may result in a reduction of benefits to the Covered Person.

Disputes, Appeals & Grievances of any nature can be mailed to:

HealthSmart Complete
Attn: Client Service – Provider Appeals
222 W. Las Colinas Blvd., Suite 500 N
Irving, TX 75039

Please provide the following information when submitting a grievance:

+ Contact information (name, phone number, fax number and email address of the submitter)
+ Description of the issue and appeal/complaint with relevant and supporting documentation
+ An EOB and/or a copy of the claim(s) in question

Participating Provider Requirements

Participating Provider Rights & Responsibilities

Provider Rights

+ To be treated by HealthSmart Complete, its Covered Person(s) and Payor clients with dignity and respect.
+ To receive accurate and complete information and medical histories from Covered Person(s).
+ To have HealthSmart Complete Covered Person furnish their ID cards and requested medical information as requested.
+ To have access to information about HealthSmart Complete' s quality improvement programs including program goals, processes, and outcomes that relate to a Covered Persons' care and services.
+ To expect other HealthSmart Complete Participating Providers to act as partners in Covered Persons' treatment plans.
+ To expect Covered Person to follow their health care instructions and directions, such as taking the right among of medication at the right times.
+ To make a complaint or file an appeal against HealthSmart Complete, Payor and/or a Covered Person.
+ To file a grievance on behalf of a Person, with the Covered Persons' consent.
+ To contact HealthSmart Complete Provider Services and or Customer Service with any questions, comments, or problems.
+ To collaborate with other health care professionals who are involved in the care of Covered Person.
+ To collect copays, coinsurance, and deductibles from Covered Person at the time of service.

Provider Responsibilities

+ Participating Provider shall provide health care services to patients within the scope of its licensure or accreditation.
+ Participating Provider acknowledges and agrees to participate in the products and plans for which they are contracted and render covered services to Covered Person(s).
+ Participating Provider shall make available and provide medically necessary covered services within the scope of Participating Provider's license in accordance with generally accepted medical practices and standards prevailing in the medical community.
+ Participating Provider shall comply with all applicable laws, including but not limited to, the Americans with Disabilities Act.
+ Participating Provider shall provide covered services to Covered Person(s) in the same time and manner as customarily and regularly provided by Participating Provider to other patients who are not Covered Person(s) and shall not discriminate against, any Covered Person on basis of race, color age, religion, sex, national origin, ancestry, marital status, source of payment, disability, health status, utilization of medical or mental health services or supplies, sexual preference or orientation, veteran's status, or any other unlawful basis including, without limitation, the filing of a complaint, grievance or legal action against Participating Provider.
+ Participating Provider shall verify the eligibility of Covered Person(s) to receive covered services and obtain preauthorization from payor prior to rendering covered services, as may be required and in accordance with payor's policies and procedures and/or the plan.

+ Participating Provider shall cooperate with, participate in, and observe the protocols of the Utilization Management Program Guidelines, Quality Management Programs, and Provider Manual, and shall provide Covered Services to Covered Person in accordance with the applicable Utilization Management Program, as well as any other policies, procedures, standards, rules or guidelines adopted by Payor.

+ Participating Providers that are a hospital, clinic, outpatient center, laboratory or other health care facility, are accredited, and have and maintain all licenses, permits and certifications required by law for operation of its facility, parts thereof and/or equipment.

+ Participating Providers that are a physician, doctor of osteopathy, or allied health professional, are duly licensed to practice medicine, osteopathy or its applicable specialty and to provide covered services under the terms of this Agreement and shall maintain such licensure at all times it provides services to Covered Person.

+ Participating Provider is in compliance with all applicable local, state, and federal laws relating to the provision of services, and renders services in accordance with all applicable licensing requirements as well as all area standards of professional ethics and practice.

+ Participating Provider abides and will abide by recognized standards of coding and not engage in any unbundling, upcoding or other similar activities.

+ Participating Provider currently complies with and shall continue to meet and remain in compliance with, the HealthSmart Complete participation and credentialing criteria.

+ Participating Provider shall submit provider rosters, demographic, and tax identification changes to HealthSmart Complete on a monthly basis, or thirty (30) days prior to the effective date of such change, as applicable.

+ Participating Provider agrees that, when medically appropriate, Participating Provider shall refer Covered Persons to HealthSmart Complete Network Participating Providers for covered services which are not available from Participating Provider.

+ Participating Provider will not bill balance bill Covered Person(s) for any amounts over and above the contractual or imposed reimbursement amounts.

+ Participating Provider shall bill or collect from Covered Person(s)) deductibles, coinsurance or copayments required by the plan; and/or fees or charges for services that are not covered services; fees which exceed a specific benefit limitation.

+ Participating Provider shall submit clean claims electronically or on paper on a UB-04, CMS-1500 or successor form(s) with an itemized bill when applicable or requested in accordance with applicable law and within the time constraints outlined in their provider agreement.

+ Participating Provider shall maintain medical records in accordance with good professional standards, to the extent necessary for continuity of care, for all other necessary purposes, and in compliance with all applicable laws.

+ Participating Provider shall provide any accounting, administrative, and medical records maintained and pertaining to Covered Person and/or to Participating Provider's performance to the Center for Medicare and Medicaid Services (CMS), any Peer Review Organization (PRO) with which HealthSmart Complete and/or Payor contracts as required by CMS, the US Comptroller General, their designees and any other governmental officials entitled to such access by law (collectively, "Governmental Officials") as required by law and as may be necessary for compliance by HealthSmart Complete and/or Payor with the provisions of all state and federal laws.

+ Participating Provider will transfer the medical records of the Covered Person(s) to such other Participating Provider acquiring applicable disclosure and following confidentiality laws.

+ Participating Provider shall cooperate with accreditation and credentialing surveys, and compliance monitoring.

+ Participating Provider will maintain policies of comprehensive general and professional liability insurance in amounts reasonably satisfactory to HealthSmart Complete and in accordance with standard industry practice.

+ Participating Provider shall give prompt written notice to HealthSmart Complete whenever they become aware of any claims, suits or disciplinary actions have been taken against them.

Non-Discrimination

HealthSmart Complete complies with the guidance set forth in the final rule for Section 1557 of the Affordable Care Act, which includes notification of nondiscrimination and instructions for accessing language services in all significant materials and physical locations that serve all Covered Persons.

All providers who join the HealthSmart Complete Provider Network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR).

HealthSmart Complete requires providers to deliver services to Covered Persons without regard to race, color, national origin, age, disability or sex. Providers must not discriminate against Covered Persons based on their payment status and cannot refuse to serve based on varying policy and practices and other criteria for the collecting of financial responsibility from HealthSmart Complete Covered Persons.

Facility Management

When providing services to HealthSmart Complete Covered Persons:

+ Verify the Covered Persons' eligibility and benefits before rendering services which can be done by contacting the number on the Covered Persons' ID card.
+ Prior authorize services when required. Contact the number on the Covered Persons' ID card.
+ Failure to verify eligibility and obtain prior authorization may result in claim denial or reduction of benefits.

Office Hours

Participating Providers are expected to provide the same office hours of operation to HealthSmart Complete Covered Persons as those offered to PPO and commercial Covered Persons. There are a range of primary, specialty, facility and ancillary services available and accessible to HealthSmart Complete Covered Persons in their service area.

After Hours Care

Life-threatening situations require the immediate services of an emergency department. Urgent care can provide quick after-hours treatment and is appropriate for infections, fever, and symptoms of cold or flu. Participating Providers that cannot provide services after hours should refer Covered Persons to an urgent care center when appropriate. Providers or a licensed professional must be available for after-hours calls.

Wait Times for Covered Persons

The following expected wait times for HealthSmart Complete Covered Persons to schedule an appointment with a HealthSmart Complete Participating Provider should not exceed the following:

+ Twenty-four (24) to forty-eight (48) hours for urgent appointments
+ Four (4) weeks for specialty care appointments
+ Six (6) weeks for routine appointments

Timeliness Standards for Notifying Covered Person of Test Results

After receiving results, notify Covered Persons within:

+ **Urgent:** 24 hours
+ **Non-urgent:** 10 business days

Data Management

Medical Records

Participating Providers shall maintain complete and professionally adequate medical records for all patients, in accordance with good professional standards, to the extent necessary for continuity of care, for all other necessary purposes, and in compliance with all applicable laws.

HealthSmart Complete may request and has the right to inspect any accounting, administrative, and medical records maintained by Participating Provider pertaining to Covered Persons and/or to Participating Provider's performance.

Participating Provider shall provide such information to the Center for Medicare and Medicaid Services (CMS), any Peer Review Organization (PRO) with which HealthSmart Complete and/or Payor contracts as required by CMS, the US Comptroller General, their designees and any other governmental officials entitled to such access by law (collectively, "Governmental Officials") as required by law and for compliance by HealthSmart Complete and/or Payor with the provisions of all state and federal laws.

HealthSmart Complete, Payor, and Government Officials shall have access to, and copies of, the medical records, books, charts, and papers relating to Participating Provider's provision of health care services to Covered Persons, and payment received by Participating Provider from Covered Persons (or from others on their behalf).

These records are required to be maintained for least six (6) years after the end of each contract year, or longer period if required by law. Participating Provider shall make readily available to HealthSmart Complete, Payor and/or governmental agencies with regulatory authority, all medical and related administrative and financial records of Covered Person(s) who receive Covered Services. Payor (or its designee) may request, and Participating Provider shall not unreasonably withhold or delay, additional records as may be requested in order to verify that Participating Provider's charges are reasonable and in line with prevailing community standards, to the extent not prohibited by applicable law.

Participating Provider shall, upon request of Covered Person(s) or other Participating Provider, and subject to applicable disclosure and confidentiality laws, transfer the medical records of the Covered Person(s) to such other Participating Provider at no charge to the Covered Person(s). This obligation shall survive any termination or expiration of Participating Provider's agreement with HealthSmart Complete.

Confidentiality – HIPAA/ PHI

HealthSmart Complete Participating Providers agree that all Protected Health Information, including that related to patient conditions, medical utilization and pharmacy utilization, available by any means, will be used exclusively for patient care, medical records, claims submissions, and all other related purposes as permitted by the HIPAA Privacy Rule.

Confidential or Proprietary Information

Participating Provider may, from time to time, receive confidential or proprietary information from HealthSmart Complete, including business plans, customers, customer lists, operations, programs, relationships, targets, compensation terms and arrangements described within the HealthSmart Complete Provider Agreement. Participating Provider agrees that such information shall be kept confidential and, unless otherwise required by law (in which case Participating Provider will provide prompt written notice to HealthSmart Complete prior to such required disclosure) shall not be disclosed to any person except as authorized in writing by HealthSmart Complete.

Regulatory Requirements

Incorporation of Other Legal Requirements

Any provisions now or hereafter required to be included in this manual by applicable federal and/or state laws and regulations or by CMS shall be binding upon and enforceable against Participating Providers and be deemed incorporated herein, irrespective of whether or not such provisions are expressly set forth in this manual or elsewhere in Participating Provider's agreement.

Administrative, Medical and Reimbursement Policy Changes

From time to time, HealthSmart Complete may amend its policies to comply with applicable federal, state or local laws and regulations. HealthSmart Complete will communicate changes to the Provider Manual as technology, procedures, policies and programs change. These may be communicated through a variety of methods including but not limited to:

+ Periodic Provider Manual updates
+ Letter
+ Facsimile
+ Email
+ Website updates

Providers are responsible for periodically checking the HealthSmart Complete website for policy updates in the Provider Manual and complying with these changes upon receipt of these notices or otherwise becoming aware or informed of such changes.

Covered Persons Rights & Responsibilities

Participating Providers must comply with the rights of Covered Person as set forth below:

Covered Person(s) Rights:

+ To receive accurate information about HealthSmart Complete services, HealthSmart Complete Participating Providers, the rights of Covered Persons and Participating Providers, and how to contact HealthSmart Complete with any questions or concerns.
+ To be treated with respect and dignity.
+ To privacy of their personal health information, consistent with state and federal laws, and HealthSmart Complete policies.
+ To communicate with their providers about the medically necessary care and treatments for their condition, regardless of cost or benefit coverage. Covered Persons have a right to know about and understand any costs they will need to pay.
+ To register complaints about HealthSmart Complete services or the care provided by a HealthSmart Complete Participating Provider. This includes the right to have their complaints addressed in a timely and appropriate manner.
+ To choose the healthcare provider in the HealthSmart Complete network consistent with the terms of their benefit plan and applicable state and federal law.
+ To adequate access to qualified medical providers and treatment or services regardless of age, race, creed, sex, sexual orientation, national origin, or religion. Sex discrimination includes, but is not limited to, discrimination on the basis of pregnancy, gender identity and sex stereotyping.
+ To access medically necessary urgent and emergency services 24 hours a day and seven days a week.

Covered Persons Responsibilities:

+ To read and understand, to the best of their ability, all materials concerning their health benefits or to ask for assistance if they need it.
+ To treat all health care professionals and staff with courtesy and respect.
+ To give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about their health. Covered Persons should make it known whether they clearly understand their care and what is expected of them. The person needs to ask questions of their provider, so they understand the care they are receiving
+ To show their I.D. card and keep scheduled appointments with their provider and call the provider's office during office hours whenever possible if the Person has a delay or cancellation.
+ To follow all health benefit plan guidelines, provisions, policies, and procedures.
+ To give all information about any other medical coverage they have at the time service.
+ To pay all deductible amounts, copayment amounts, or cost-sharing percentages at the time of service.

Verification of Eligibility

Eligibility

Participating Provider shall verify the eligibility of Covered Person(s) to receive Covered Services and obtain preauthorization from Payor prior to rendering Covered Services. It is within the sole discretion of Payor to determine the eligibility of any Covered Person(s) and whether a service is a Covered Service under the Plan.

HealthSmart recommends you contact the HealthSmart payor located on the Covered Persons' ID card and if possible, prior to rendering services. Plan design may vary, and restrictions may apply specific to a payor and/ or plan. At the time of service, obtain an estimate of patient's coinsurance, deductible, plan design and copay information to determine Covered Persons' payment responsibility.

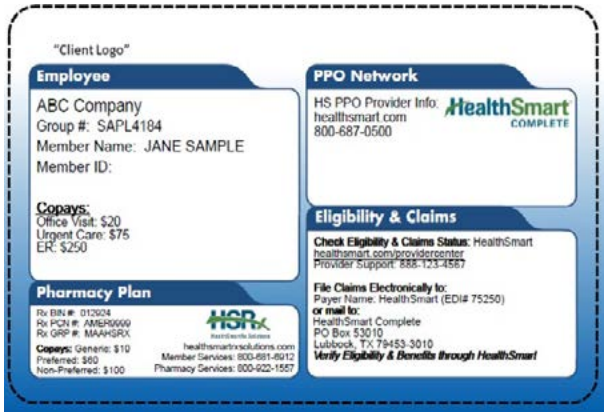
To achieve maximum reimbursement for a Covered Person, proposed medical care may need to be certified by the payor's Utilization Management (UM) service. This UM process can be a combination of telephone, written, fax or online communication. Depending on the urgency of the medical care, notification requirements will vary. Contact the UM vendor number on the Covered Persons' ID card.

Certifying treatment does not guarantee payment for services rendered to any Covered Person. When a determination is made not to approve or certify a health care service, written notification is sent to the attending physician, hospital, Covered Person and payor and an appeal may be initiated by the provider and/or the Covered Person to the payor. Instructions how to appeal are available in the explanation of benefits or EOB.

ID Cards

HealthSmart Complete Covered Persons are issued an identification card by the payor. Although each card will differ depending on the HealthSmart Complete payor, in most cases, the HealthSmart Complete logo or name should be visible. As indicated in the Participating Provider Agreement and this Provider Manual, certain networks/products may not require a logo on the patient identification card. Please note that presentation of a Covered Person ID card is not a guarantee of eligibility.

Below are examples of the HealthSmart Complete Covered Person ID card. ID cards may vary based upon the product, plan and payor.



Prior Authorization

Services that Require Prior Authorization

To verify if a service requires prior authorization, please contact the number on the Covered Persons' identification card. It is the responsibility of the facility in coordination with the rendering provider to ensure that an authorization has been obtained for all inpatient and selected outpatient services. All inpatient admissions require prior authorization. Providers, such as surgeons, performing a procedure on outpatient basis are encouraged to verify the prior authorization requirements since certain procedures performed in the office or outpatient facility setting may need pre-authorized. Anesthesiology, pathology, radiology, or hospitalist services related to a procedure or hospital stay requiring a prior authorization will be considered downstream and will not require a separate prior authorization. Services related to an authorization denial will result in a denial of all associated claims.

Procedure for Requesting Prior Authorizations from HealthSmart Complete Care Management

Please note, the contact information below is specific to the HealthSmart Complete owned Care Management Department. Clients may utilize different vendors and it is important to contact the number on the Covered Persons' ID card to avoid any misdirected requests that could result in a delay.

Prior authorizations through HealthSmart Complete Care Management can be requested by phone, secure email for fax.

Phone: The HealthSmart Complete Care Management Department is available Monday through Friday from 7:00 AM to 6:00 PM Central Standard Time (CST) at 877-202-6379

Fax: Fax prior authorization requests utilizing a completed HealthSmart Complete Prior Authorization Request Form along with supplemental clinical information to 214-574-2355. The form can be found in the Provider Manual Appendix.

Please note: *Faxes will not be monitored after hours and will be responded to the next business day.*

Email: Prior authorization requests can be sent by secure email utilizing a completed HealthSmart Complete Prior Authorization Request Form along with supplemental clinical information to hsprecert@HealthSmartComplete.com. The form can be found in the Provider Manual Appendix.

Please note: Emails will not be monitored after hours and will be responded to the next business day.

Referrals

To prevent a potential reduction in health benefits, please make best efforts to refer Covered Persons to HealthSmart Complete Participating Providers. In addition, Participating Providers shall admit Covered Persons to participating facilities within the HealthSmart Complete Network except in the case of an emergency. For assistance in finding other HealthSmart Complete Participating Providers for referral purposes, contact HealthSmart Complete Provider Customer Service at 800-687-0500 or through the Provider Lookup online at www.HealthSmart Complete.com.

In the event the Participating Provider does not have hospital privileges with a participating network facility and a Covered Person requires hospitalization, Participating Provider must make best efforts to refer the Covered Person to another Participating Provider with hospital privileges at a facility within the same network. Inform the Covered Person whenever a referral is made to an out-of-network provider.

Coordination of Benefits

Covered Persons are sometimes covered by more than one insurance policy. Always obtain complete benefit information from each payor when verifying a Covered Persons' health plan benefit and precertification requirements.

Billing & Payments

Reimbursement

Participating Provider should bill for services for a Covered Person at their normal retail rate. Participating Provider shall accept the applicable reimbursement amount from the payor as specified in their contract with HealthSmart Complete as payment in full for services rendered. Payments are less applicable copayments, deductibles or coinsurance amounts payable by the Covered Person. Payor's plan may exclude or reduce benefits for some types of medical care. Therefore, Participating Provider should verify a Covered Persons' plan coverage requirements by calling for eligibility and benefits using the toll-free number on the Covered Persons' identification card.

Participating Provider may not charge a Covered Person for covered services beyond copayments, coinsurance or deductibles, as described in the applicable benefit plan.

Covered Persons should be billed directly for services which are not covered by the Covered Persons' health benefits plan.

If applicable, Participating Provider shall be reimbursed by the payor upon application of benefits. Prompt claim processing by the payor is contingent upon Participating Provider submitting a clean claim (as defined by the provider agreement), including completing each claim form accurately and completely. HealthSmart Complete must also have all the necessary patient and insured information in order to reprice the claim timely.

Electronic Fund Transfer (EFT) & Electronic Remittance Advice (ERA)

Electronic payment and remittance options saves time and simplifies reconciliation. HealthSmart Complete utilizes an ePayment vendor, Zelis Payments, for payment and remittance transactions, as well as compliance with PPACA Section 1104. Through HealthSmart Complete's ePayment vendor partnership with Zelis, HealthSmart Complete provides simpler, more efficient payment solutions, plus uniform remittances which are available to help you maximize revenue and profit, reduce costs and errors and increase payment efficiency.

+ **Zelis offers payments by:** ACH, Virtual Payment Card or Check
+ **Zelis offers Remittance Advice by**: 835, Excel or PDF

Electronic Funds Transfer (EFT) Enrollment

Providers who have received a payment from Zelis Payments:

+ Register online at zelispayments.com by choosing **"Get Started"** and following the steps as a "**Verified User"**

Providers who have not received a payment from Zelis Payments:

+ Submit a registration request online at zelispayments.com by choosing **"Get Started"** and follow the steps to **"Request User Registration".**

Helpful Hints for a Seamless EFT Enrollment:

1. Be sure to have the TIN (Tax I.D. Number) associated with the account you are registering
2. Ensure that you are an authorized representative of the designated provider
3. Have your contact, organization and financial account information available
4. Review all terms, pricing and authorization forms prior to submitting them to Zelis Payments

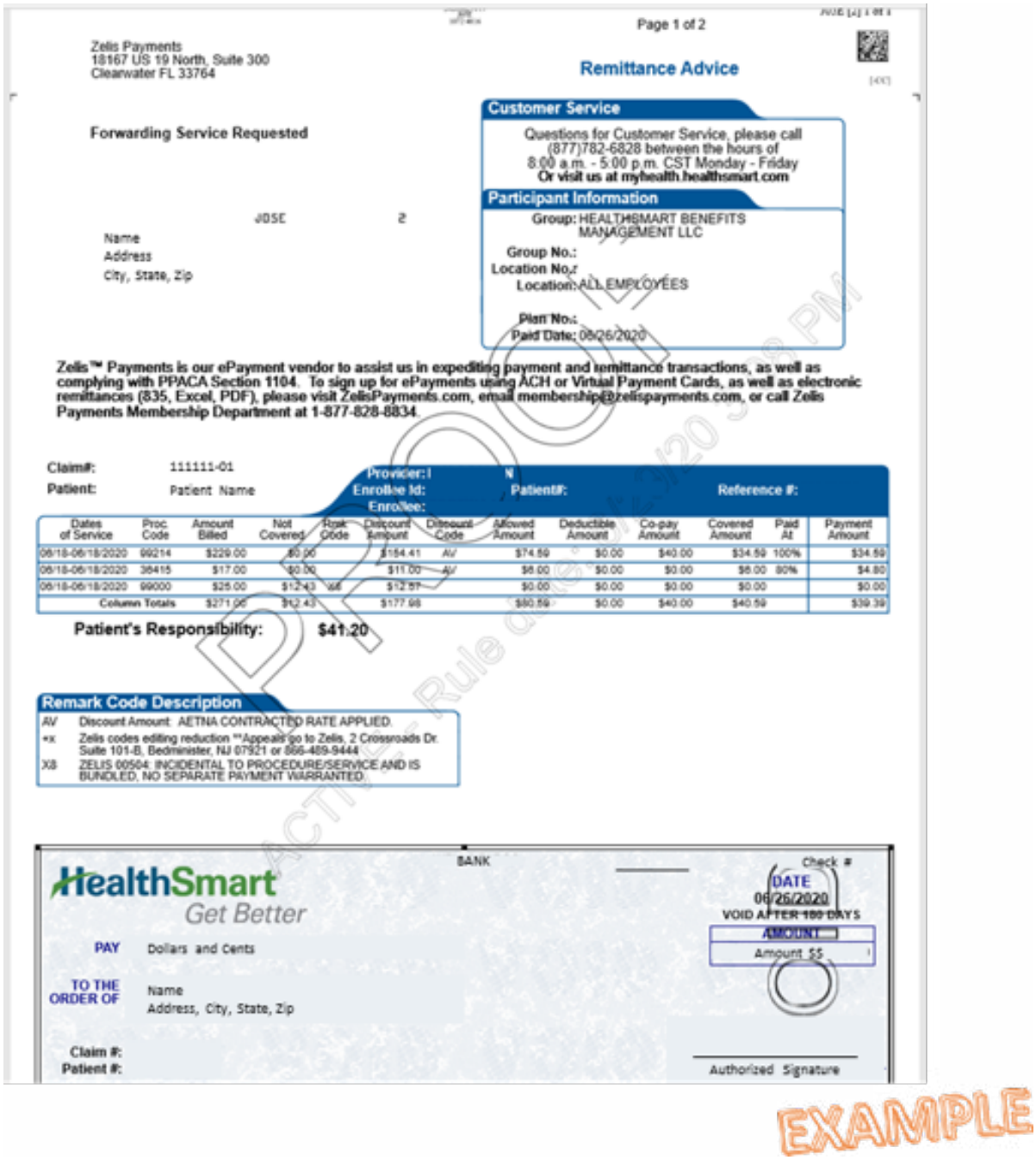
For more information on Zelis Payments:

+ Visit zelispayments.com
+ Email membership@zelispayments.com
+ Call 1-877-828-8834

Explanation of Payment / Remittance Advice

The Explanation of Payment (EOP) / Remittance Advice (RA) is generated by the payor and details how the Covered Persons' claim was processed. It identifies the date(s) and services provided, billed charges, the contract allowable, the Covered Persons' out of pocket responsibility and the payor's bundling rules, modifiers and/or edits. If you believe an error has been made in the adjudication of a Covered Persons' benefits, please contact the appropriate HealthSmart Complete Payor listed on the Covered Persons' ID card or Explanation of Payment (EOP).

HealthSmart Complete Benefit Solutions, Inc. – Provider's Remittance Advice



Page 1 of 2

Zelis Payments
18167 US 19 North, Suite 300
Clearwater FL 33764

Remittance Advice

Forwarding Service Requested

Name
Address
City, State, Zip

Customer Service

Questions for Customer Service, please call (877)782-6828 between the hours of 8:00 a.m. - 5:00 p.m. CST Monday - Friday
Or visit us at myhealth.healthsmart.com

Participant Information

Group: HEALTHSMART BENEFITS MANAGEMENT LLC
Group No.:
Location No.:
Location: ALL EMPLOYEES
Plan No.:
Paid Date: 06/26/2020

Zelis™ Payments is our ePayment vendor to assist us in expediting payment and remittance transactions, as well as complying with PPACA Section 1104. To sign up for ePayments using ACH or Virtual Payment Cards, as well as electronic remittances (835, Excel, PDF), please visit ZelisPayments.com, email membership@zelispayments.com, or call Zelis Payments Membership Department at 1-877-828-8834.

Claim#: 111111-01
Patient: Patient Name
Provider: I N
Enrollee Id:
Enrollee:
Patient#:
Reference #:

Dates of Service	Proc. Code	Amount Billed	Not Covered	Rmk Code	Discount Amount	Dtlmount Code	Allowed Amount	Deductible Amount	Co-pay Amount	Covered Amount	Paid At	Payment Amount
06/18-06/18/2020	99214	$229.00	$0.00		$154.41	AV	$74.59	$0.00	$40.00	$34.59	100%	$34.59
06/18-06/18/2020	36415	$17.00	$0.00		$11.00	AV	$6.00	$0.00	$0.00	$6.00	80%	$4.80
06/18-06/18/2020	99000	$25.00	$12.43	66	$12.57		$0.00	$0.00	$0.00	$0.00		$0.00
Column Totals		$271.00	$12.43		$177.98		$80.59	$0.00	$40.00	$40.59		$39.39

Patient's Responsibility: $41.20

Remark Code Description

AV	Discount Amount: AETNA CONTRACTED RATE APPLIED.
**	Zelis codes editing reduction **Appeals go to Zelis, 2 Crossroads Dr. Suite 101-B, Bedminister, NJ 07921 or 866-489-9444
X8	ZELIS 00504: INCIDENTAL TO PROCEDURE/SERVICE AND IS BUNDLED, NO SEPARATE PAYMENT WARRANTED.

BANK

HealthSmart
Get Better

Check #
DATE
06/26/2020
VOID AFTER 180 DAYS
AMOUNT
Amount $$

PAY Dollars and Cents

TO THE ORDER OF
Name
Address, City, State, Zip

Claim #:
Patient #:

Authorized Signature

EXAMPLE

Clean Claim Definition

A Clean Claim means a claim that is submitted for payment of covered services that are submitted electronically on a UB-04, CMS-1500 or successor form(s) (i.e. 837i and 837p), or paper claims using a UB-04, CMS-1500 or successor form(s). Participating Provider agrees to submit all claims timely, in accordance with applicable law, and at Participating Provider's normal retail rate. Participating Provider shall submit claims for payment within ninety- five (95) days of the date healthcare services were provided or as otherwise required by state or federal law and within the covered person(s) plan. Claims received after this time period may risk denial of payment. Company and/or payor reserve the right to request and require an itemized bill.

Claims

Claim Submission

Claims should be sent by following the instructions outlined on the Covered Persons' identification card. As a Participating Provider, you agree to submit claims for payment timely as defined in your Participating Provider Agreement (or as otherwise required by state or federal law). Incomplete claims or claims received late may be denied for payment by client or payor. Participating Providers shall not bill client, payor, HealthSmart or Covered Person(s) for such denied claims. All claims should be submitted using Participating Providers normal billed charges and the appropriate procedure code per American Medical Association (AMA) and Center for Medicare and Medicaid Services (CMS) standards.

Participating Providers are required to:

+ Submit clean claims in a timely manner, for services rendered to Covered Persons.
+ Submit claims using normal billed charges and the appropriate procedure codes per American Medical Association (AMA) and Center for Medicare and Medicaid Services (CMS) standards.
+ Submit HealthSmart clean claims electronically or on a UB-04, CMS-1500 or successor form(s).
+ Submit all claims in accordance with applicable law, and at Participating Provider's normal rate.
+ Submit claims for payment within ninety-five (95) days of the date healthcare services were provided (or as otherwise required by state or federal law, your Participating Provider Agreement or within the Covered Person(s) plan). Claims received after this time period may be denied for payment, and Participating Providers shall not bill the Covered Person(s).

Prompt repricing and routing of your claims is contingent upon a Participating Provider completing each claim form accurately and completely.

Submitting Claims Electronically

Submission of claims electronically is the recommended method for Participating Providers as it is faster and more accurate than paper claims submission. CMS-1500 and UB-04's may be submitted electronically through transaction networks and clearinghouses in a process known as Electronic Data Interchange (EDI). The EDI payor routing number on the Covered Persons ID card should be used for claim submission.

HealthSmart Complete EDI payor routing number:

+ 37283 (Change Healthcare)

Submitting Claims by Mail

If, despite best efforts, Participating Provider cannot submit claims electronically, Participating Provider shall submit paper claims using a UB-04, CMS-1500 or successor form(s).

Claims must be submitted to the physical address on the Covered Persons ID card.

Reason for Returned or Rejected Claims

In order to process the claim, the information filed must be complete and accurate. Some examples for returned or rejected claims are listed below:

+ Unable to identify employer group listed on the claim
+ Employer group is not effective for the date of service
+ Employer group terminated prior to this date of service
+ Patient no longer has access to the HealthSmart network
+ Patient/ insured not valid for this date of service for this group
+ Payor has requested that claims be submitted directly to them
+ Missing claim elements

HealthSmart Complete Repricing & Coding Guidelines

Anesthesia Payment Guidelines

All anesthesia services shall be repriced using ASA Guidelines, units, and modifiers inclusive of A, P and Q modifiers. In the event an appropriate ASA code is not available, Participating Provider shall use appropriate CPT-4 coding and/or modifiers.

AWP

All drugs and biological (HCPCS) codes shall have rates set utilizing Red Book AWP pricing. This pricing shall be maintained with updates no more than quarterly (Jan., April, July, and Oct) or as per effective dates indicated by the state of Texas for state supplied vaccines as appropriate.

Coding Guidelines

HealthSmart Complete shall recognize standard DRG, APC, ADA, NCCI, CPT-4, ASA, ICD-9, ICD-10 Medicare guidelines to re-price claims.

CPT Modifiers

HealthSmart Complete shall recognize standard insurance HCPCS, CPT-4, ADA, and ASA modifiers in accordance with Medicare standards.

Coding Methodologies

HealthSmart Complete shall recognize the following coding methodologies in accordance with published coding manuals and guidelines described in the Participating Provider's Agreement. HealthSmart Complete recognizes these publications will change from time to time. Therefore, HealthSmart Complete shall utilize current year at the time of service as a guide for re-pricing claims. Additional information on such coding methodology may be found at the following website locations:

+ **CPT-4** www.ama-assn.org/go/cpt
+ **ASA** www.asahq.org
+ **HCPCS** www.cms.hhs.gov/medicare/hcpcs
+ **ICD-9** www.cms.hhs.gov/medlearn/icd9code.asp
+ **ICD-10** www.cms.hhs.gov/ICD10IC
+ **DRG** www.cms.hhs.gov
+ **Revenue Codes** www.cms.hhs.gov

Medicare reimbursement amounts are updated by HealthSmart Complete annually to reflect new information regarding RVU's, GPCI's, conversion factor, gap fill RVU's, and the addition of new codes and services. The GPCI used for this Agreement is based on the Provider's primary location. HealthSmart Complete applies the site of service differential when re-pricing claims.

Down Coding and Rebundling

HealthSmart Complete does not currently apply down coding or rebundling methodologies in its re-pricing of claims. These guidelines are in no way intended to represent subsequent payor claims processing procedures, guarantee of payment or imply covered benefits. For payor claims processing procedures and covered benefit information please contact the payor directly.

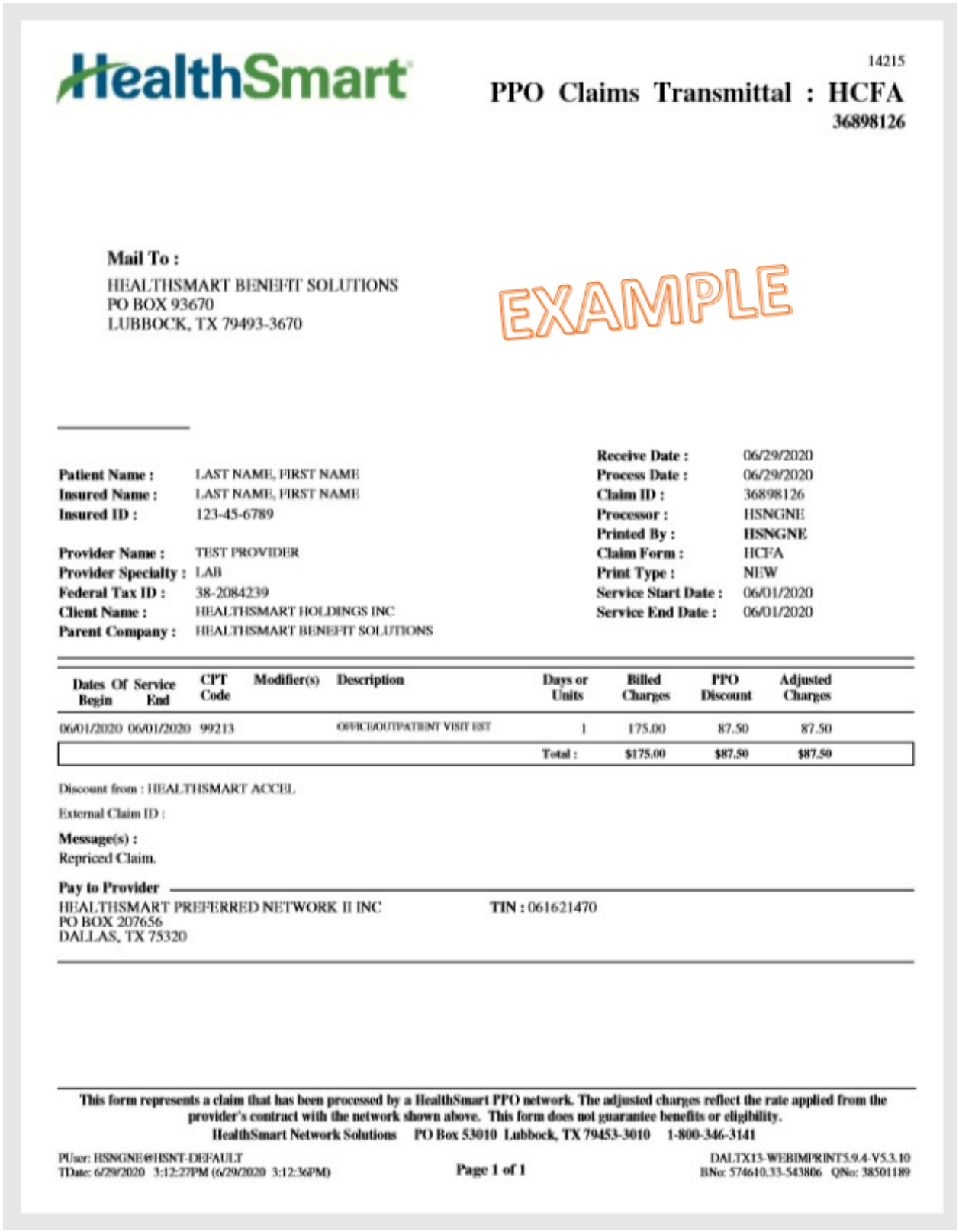
Multiple Surgeries

If more than one surgical procedure is performed during a single surgical episode, the claim will be priced in accordance with the Provider Agreement and claims logic applied by the payor.

Repricing Guidelines

The above represented claims re-pricing procedures reflect those of HealthSmart Complete only and are subject to change from time to time. Such procedures shall remain consistent with and in accordance with the Agreement, and applicable State and Federal law. These guidelines are in no way intended to represent subsequent payor claims processing procedures, guarantee of payment or imply Covered Services. For payor claims processing procedures and Covered Benefit information please contact the payor directly. For a complete list of HealthSmart Complete Payors, please visit www.HealthSmart Complete.com.

HealthSmart Complete Repricing Sheet



HealthSmart

14215

PPO Claims Transmittal : HCFA

36898126

Mail To :

HEALTHSMART BENEFIT SOLUTIONS
PO BOX 93670
LUBBOCK, TX 79493-3670

EXAMPLE

Patient Name :	LAST NAME, FIRST NAME	**Receive Date :**	06/29/2020
Insured Name :	LAST NAME, FIRST NAME	**Process Date :**	06/29/2020
Insured ID :	123-45-6789	**Claim ID :**	36898126
		Processor :	HSNGNE
Provider Name :	TEST PROVIDER	**Printed By :**	HSNGNE
Provider Specialty :	LAB	**Claim Form :**	HCFA
Federal Tax ID :	38-2084239	**Print Type :**	NEW
Client Name :	HEALTHSMART HOLDINGS INC	**Service Start Date :**	06/01/2020
Parent Company :	HEALTHSMART BENEFIT SOLUTIONS	**Service End Date :**	06/01/2020

Dates Of Service Begin	End	CPT Code	Modifier(s)	Description	Days or Units	Billed Charges	PPO Discount	Adjusted Charges
06/01/2020	06/01/2020	99213		OFFICE/OUTPATIENT VISIT EST	1	175.00	87.50	87.50
					Total :	**$175.00**	**$87.50**	**$87.50**

Discount from : HEALTHSMART ACCEL

External Claim ID :

Message(s) :
Repriced Claim.

Pay to Provider

HEALTHSMART PREFERRED NETWORK II INC
PO BOX 207656
DALLAS, TX 75320

TIN : 061621470

This form represents a claim that has been processed by a HealthSmart PPO network. The adjusted charges reflect the rate applied from the provider's contract with the network shown above. This form does not guarantee benefits or eligibility.

HealthSmart Network Solutions PO Box 53010 Lubbock, TX 79453-3010 1-800-346-3141

PUser: HSNGNE@HSNT-DEFAULT
TDate: 6/29/2020 3:12:27PM (6/29/2020 3:12:36PM)

Page 1 of 1

DALTX13-WEBIMPRINT5.9.4-V5.3.10
BNo: 574610.33-543806 QNo: 38501189

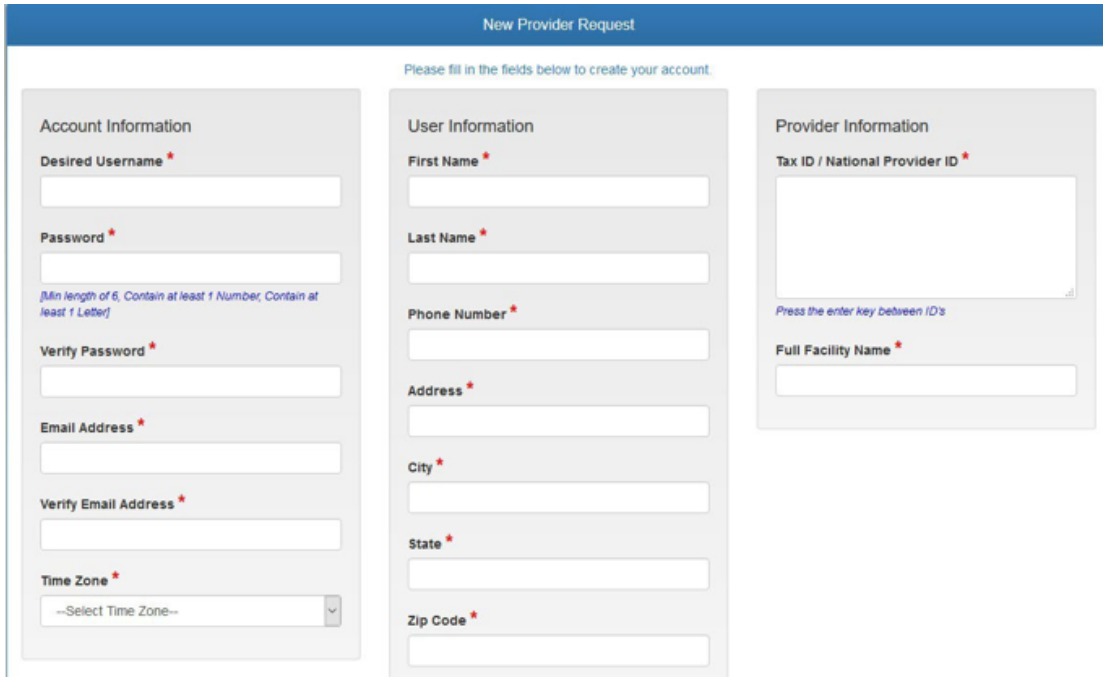
Web Exchange Provider Center

The HealthSmart Web eXchange system is custom developed to provide the best possible online experience for providers. Web eXchange is designed for all screen sizes and device types, and is tablet and mobile friendly. Within Web eXchange, providers can explore coverage information, claims, accumulators, explanation of benefits, ID cards, plan documents, ask questions, and much more. As always, HealthSmart keeps security and privacy at the forefront. Web eXchange utilizes high level encryption technology to keep all information safe and secure

This document will provide a glimpse into a few of the primary features contained in the Web eXchange Provider Center. Begin a search by first going to https://webexchange.healthsmart.com/WebExchange/.

Account Creation

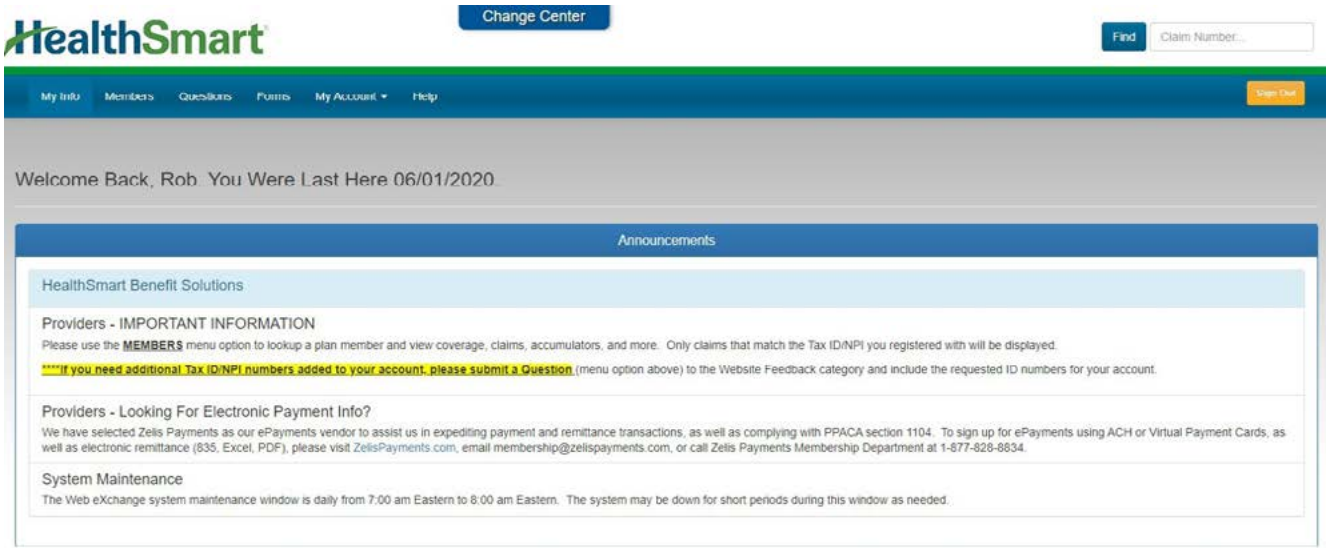
Select the **Create Account** drop down and choose **"Provider".**



Fill out the form and include all required fields as noted and click **Request Account**.

+ If Multiple Tax ID or NPI numbers are being requested, please press the ENTER key between each number entered.
+ Once submitted, the request will be reviewed by HealthSmart for validation. Account requests are typically reviewed in 1-2 business days.

The My Info Page



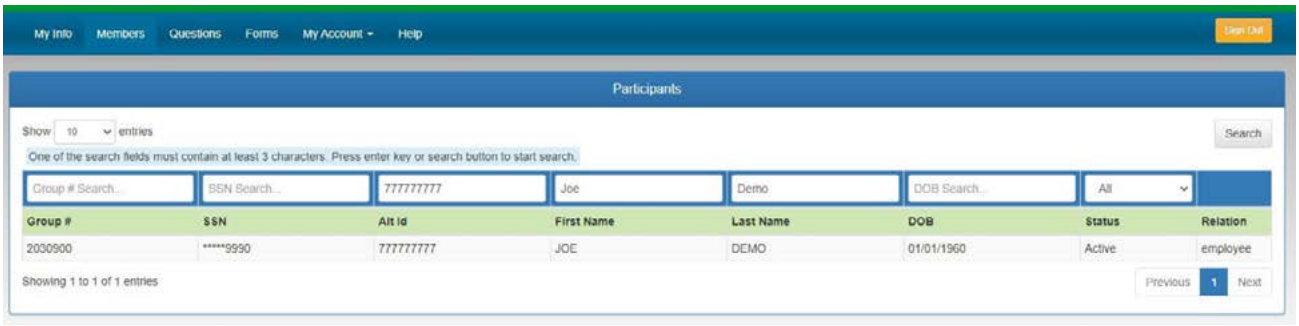
Once logged in, the My Info page is displayed. This is the main hub of Web eXchange, and provides easy access to Announcements, Member Information (Coverage/Eligibility, Claims, EOBS and Accumulators, Questions, Forms and Account Settings.

+ **The Top Menu Bar:** This menu is the primary navigation vehicle in Web eXchange. Use it to easily access everything Web eXchange has to offer. Simply click an option on the menu, and that area of the system will be displayed.

+ **Announcements:** In this area, HealthSmart can provide announcements to the providers. Announcements can be related to specific events or even new features available in Web eXchange.

+ **Find Claim Number:** This quick access lookup box allows you to go directly to a claim detail view if you have an existing claim number in hand.

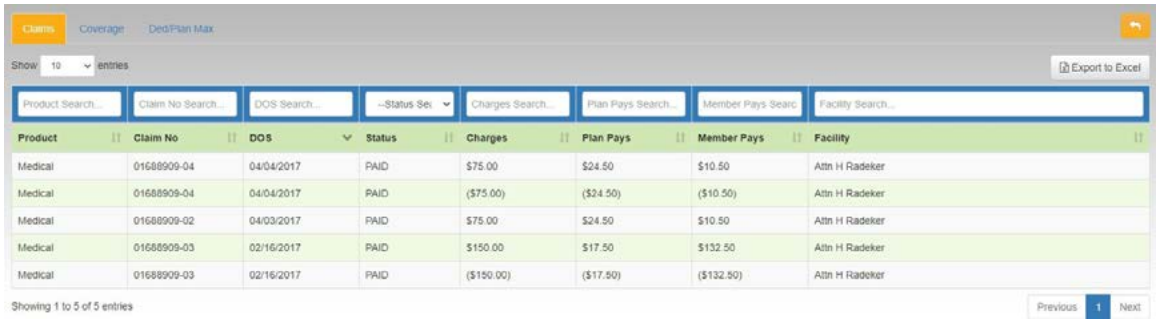
Members



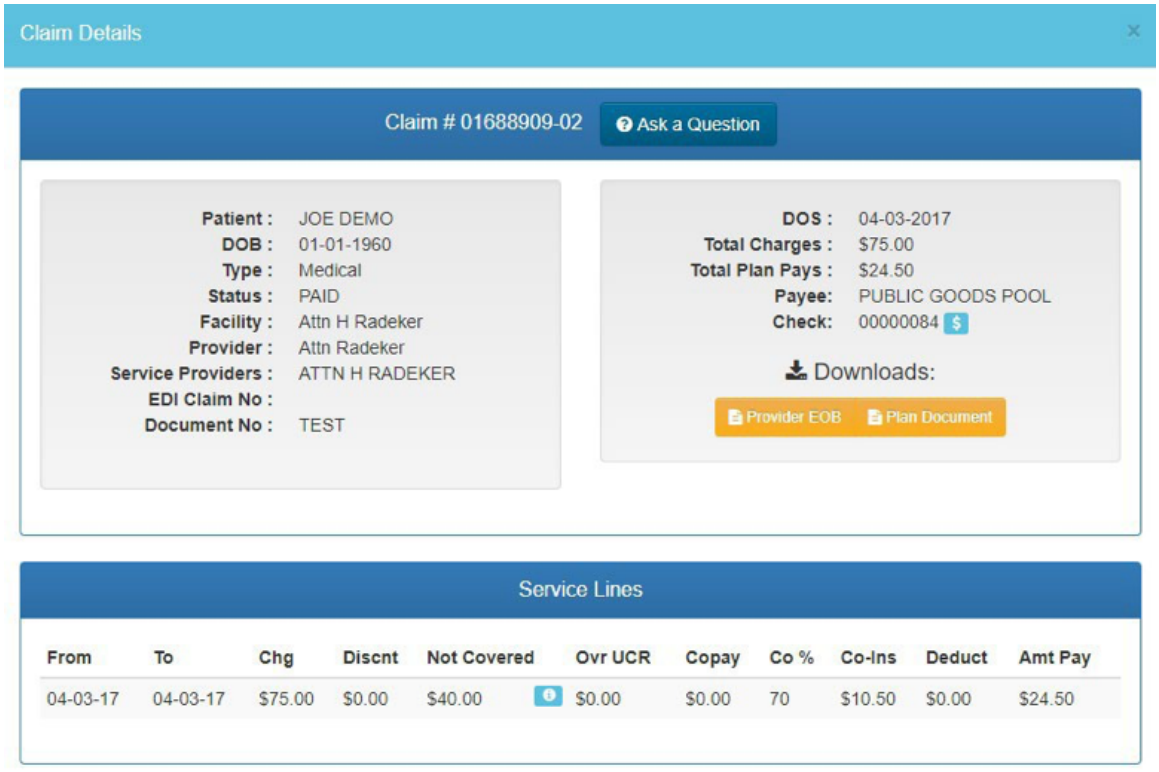
Selecting the **Members** option on the top menu will display the member search grid. Use the filter boxes (in any combination) at the top of each column to find the requested member. **Please use more than a single field like Last Name when searching.

Adding at least a SSN or ALT ID number from the member's ID card will significantly reduce the time it takes the system to produce the results. Once found, click the row that contains that member, and the details will be displayed. This will include Claims, Coverage and Ded/Plan Max information.

Claims



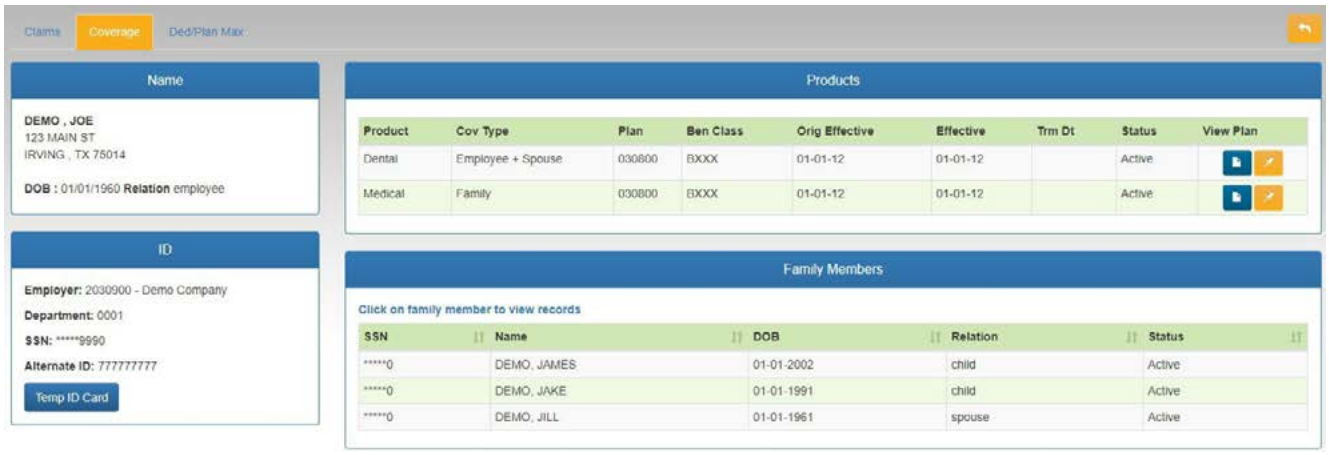
+ Claims can be sorted by any column by clicking the column name (Claim No, DOS, Status, etc.)
+ Use the filter boxes at the top of each column to reduce the number of claims displayed. Only claims that match the information entered in the filter boxes will be displayed.
+ The **Export to Excel** option can be used to send all listed claims to an Excel spreadsheet for offline viewing.
+ To see details on any claim, simply select it from the list.
+ **Ded/Plan Max** (Deductible, Out of Pocket, and Plan Maximums for some plans) can be displayed by selecting the Ded/Plan Max tab at the top of the display.



The **Claim Details** window will display all available information for the selected claim. Select the OK button to return to the claim list.

+ **Ask A Question:** This option at the top of the window allows a question to be asked about this claim. The question will be sent directly to HealthSmart. The response, once available, will be displayed on the Web eXchange system.
+ **EOB and Plan Document:** Use these buttons to display a copy of the EOB (Explanation of Benefits), or the plan document associated with this claim.

Coverage



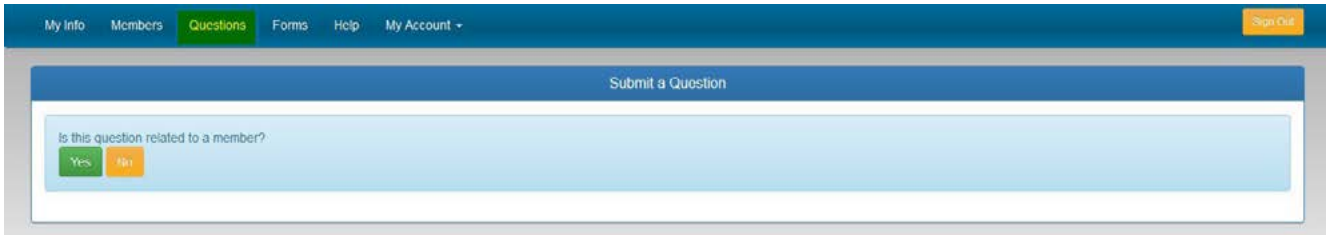
The **Coverage** area displays all available demographic and coverage related information for the member and dependents. **This document shows sample products (Medical, Dental, Prescription, etc.) and coding. These will vary depending on the coverages and plans available to the member.*

+ Select any **Product** row to see the coverage history for that product.

+ Select the **View Plan** icon to see the related plan document(s).

+ Select any **Covered Dependent** to see detailed product and coverage history information for that dependent.

+ If available, a **Temp ID Card** icon will display in the ID section. Selecting this icon will display a copy of the member ID card that can be printed or saved.



Questions

Select the **Questions** top menu item to submit a question to HealthSmart. Choose a category, enter details about the question, and select the **Ask** button. The appropriate HealthSmart department will research, and respond to the question on Web eXchange. Previously submitted transactions can be viewed and tracked under the **My Account** top menu item, and then the **My Transactions** option.

Forms

In the **Forms** area, providers can fill out and submit **Web Forms** (if available) directly on the secure Web eXchange system and use the **Form Downloads** section to save offline forms for submission via mail, fax, or secure email.

**The forms shown in this document are for example only.*

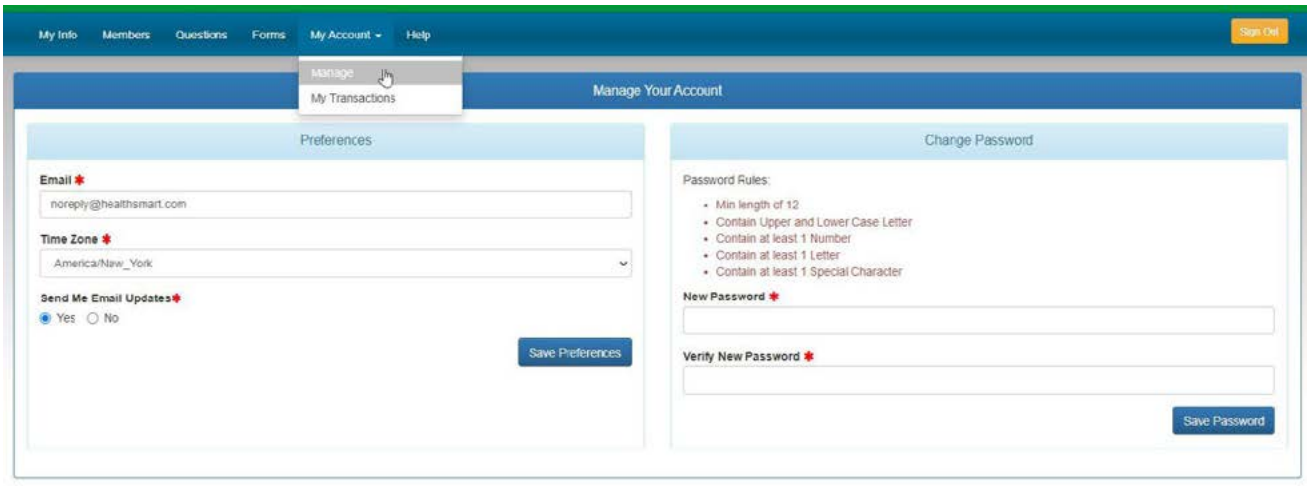
Web Forms (if available)

+ Select the desired form link, fill out the form data, and select the **Save** button at the bottom of the form. The form will then be submitted to HealthSmart for processing.

Form Downloads

+ Select the desired form link, save the form document to the local computer. Depending on the type of form, it can be filled out and resaved to the local computer, or printed to be filled out offline.

My Account



Under the **My Account** top menu, and then the **Manage** option, several standard user account settings can be maintained.

+ Email address

+ Time Zone

+ Password

+ Send Me Email Updates – Turn on/off email notifications regarding transactions on Web eXchange

Help

Select the Help top menu option to view the comprehensive Web eXchange help system. Select the **"Provider Center"** help area from the main help menu.

Sign Out

Use the **Sign Out** top menu option to log out of your account. This is always recommended when you are finished using Web eXchange to protect your personal information.

HealthSmart Complete's Network Clients

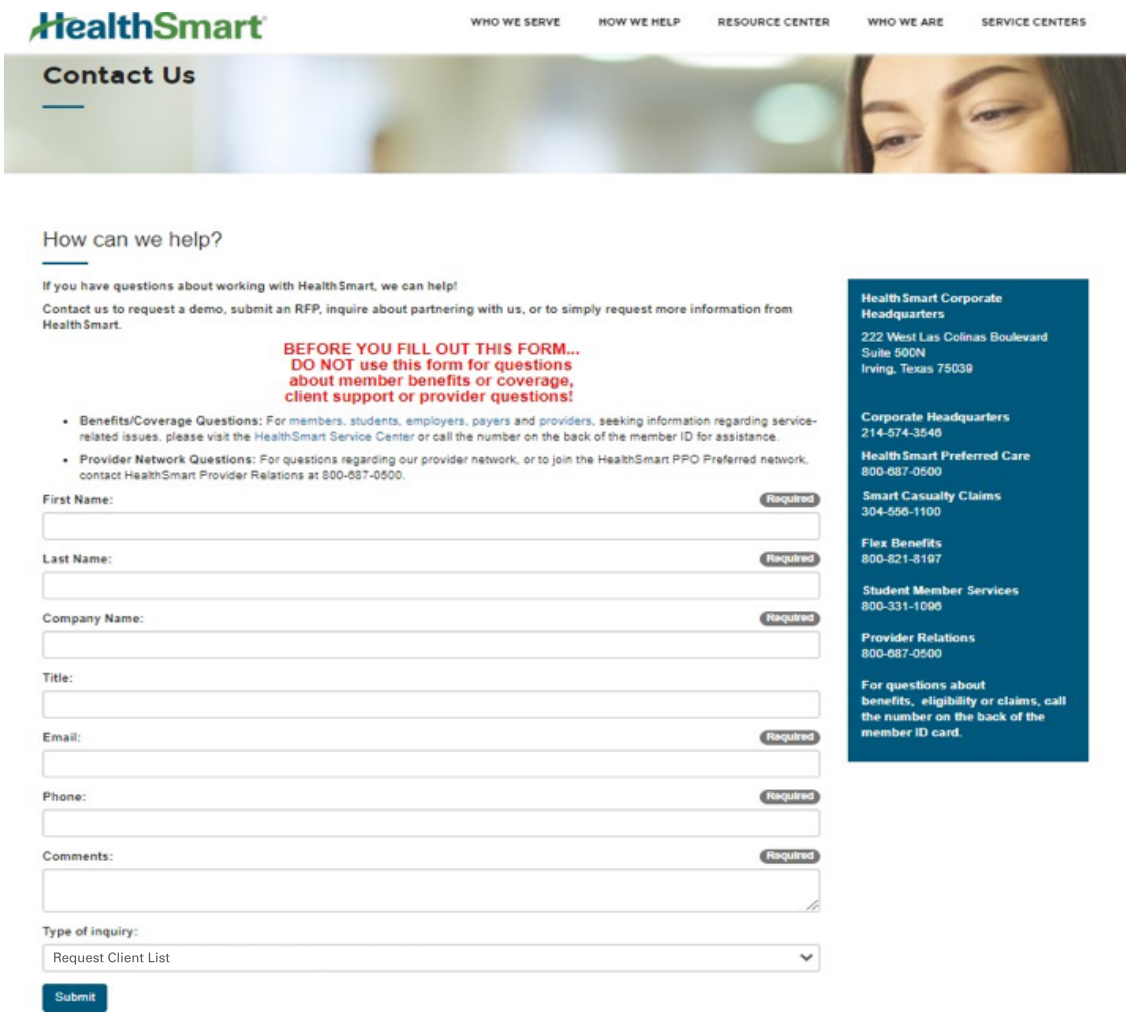
HealthSmart Complete Network Solutions has a variety of customer types. We work directly with our clients to customize a plan that meets their needs and the needs of their customers. Our goal is to be as flexible and affordable as possible while providing a high-quality product. HealthSmart Complete expects its clients to consider and observe the terms and conditions of our Participating Provider Agreements.

The customers who access our network products include but are not limited to:

+ Third Party Administrators (TPA)
+ Health Plans
+ Network Aggregators
+ Self-funded Unions
+ Bill Review Vendors

Client/Payor List

To obtain a current client list, please go to HealthSmart Complete.com/contact-us. When completing the form choose **"Request Client List"** in the **"Type of Inquiry"** drop down box.



Appendix

HealthSmart Complete Participating Provider Reimbursement Guidelines for All Products

Anesthesia Payment Guidelines

All Anesthesia services shall be repriced using ASA Guidelines, units, and modifiers inclusive of A, P and Q modifiers. In the event an appropriate ASA code is not available Participating Provider shall use appropriate CPT-4 coding and/or modifiers.

AWP

All drugs and biological (HCPCS) codes shall have rates set utilizing Red Book AWP pricing. This pricing shall be maintained with updates no more than quarterly (Jan., April, July, and Oct).

Coding Guidelines

HealthSmart shall recognize standard DRG, ASC, ADA, NCCI, CPT-4, ASA, ICD-9, ICD-10 Medicare guidelines to re-price claims.

CPT Modifiers

HealthSmart shall recognize standard insurance HCPCS, CPT-4, ADA, and ASA modifiers in accordance with Medicare standards.

Coding Methodologies

HealthSmart shall recognize the following coding methodologies in accordance with published coding manuals and guidelines as described within Exhibit B-1. HealthSmart recognizes these publications will change from time to time. Therefore HealthSmart shall utilize current year at the time of service as a guide for re-pricing claims. Additional information on such coding methodology may be found at the following website locations:

CPT-4 www.ama-assn.org/go/cpt

ASA www.asahq.org

HCPCS www.cms.hhs.gov/medicare/hcpcs

ICD-9 www.cms.hhs.gov/medlearn/icd9code.asp

ICD-10 www.cms.hhs.gov/ICD10IC

DRG www.cms.hhs.gov

Revenue Codes www.cms.hhs.gov

Downcoding and Rebundling

HealthSmart does not currently apply down coding or rebundling methodologies in its re-pricing of claims. These guidelines are in no way intended to represent subsequent payor claims processing procedures, guarantee of payment or imply Covered Benefits. For payor claims processing procedures and Covered Benefit information please contact the payor directly.

Lab

RAST testing (86003, 86005, 86421, and 86422) are excluded from payment on Participating Provider billings, and will only be repriced if billed direct from the Lab.

Multiple Surgeries

Multiple outpatient procedures performed in the same surgical session, including but not limited to, procedures in the CPT 4 code range 10000-36414 and 36417-69999, will be reimbursed at 100% of allowable for the first procedure, 50% of allowable for the second, 25% of allowable for third procedure and 0% for subsequent procedures. Exceptions to this policy are allowed for CPT codes that are classified as "add-on or starred (*) procedures by AMA CPT Terminology. Each "add-on procedure shall be repriced at 100% of the allowable fee.

Physician Assistant (PA) & Mid-Level Practitioner Payment Rules

Physician assistant and Mid-Level Practitioners services are paid at 85% of the current contracted Physician Fee Schedule.

+ PA and Mid-Level Practitioner services furnished during a global surgical period shall be paid at 85% of the current contracted Physician Fee Schedule.

+ PA assistant-at-surgery services shall be paid at 85% of what a physician is paid under the Medicare Physician Fee Schedule. Since physicians are paid at 16% of the surgical payment amount under the Medicare Physician Fee Schedule for assistant-at-surgery services, the actual payment amount that PAs receive for assistant-at-surgery services is 13.6% of the amount paid to physicians. The AS modifier must be used.

Repricing Guidelines

The above represented claims re-pricing procedures reflect those of the HealthSmart only and are subject to change from time to time. Such procedures shall remain consistent with and in accordance with the Agreement and this Exhibit, as well as applicable State and Federal law. These guidelines are in no way intended to represent subsequent payor claims processing procedures, guarantee of payment or imply Covered Services. For payor claims processing procedures and Covered Benefit information please contact the payor directly. For a complete list of HealthSmart Payors, please visit HealthSmart.com/Contact Us