Zing Health Medicare Advantage
Provider Manual

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Section 1: Introduction to Zing Health

About Zing Health

The word "Zing" connotes energy, vigor, and excitement. Zing Health's goal is to provide Medicare-eligible seniors and disabled individuals with the care, services, information, and wellness programs they need to achieve amaZing health. Our mission is to provide managed care plans that address social determinants of health to reduce healthcare disparities among historically under-served populations.

Zing Health is a Medicare Advantage and Medicare Advantage/Prescription Drug Plan (MA-PD) organization with a Centers for Medicare and Medicaid Services (CMS) contract. Zing Health offers MA-PD products in select counties in Illinois, Indiana, and Michigan. All Zing Health MA-PD plans are subject to annual renewal approval by CMS. You can learn more about Zing Health's service areas by visiting its website: myzinghealth.com.

Provider Welcome

We are pleased you are part of the Zing Health provider network. As a participant in Zing Health network, you have the opportunity to make Zing Health beneficial for both you and the members you serve. Zing Health knows that providers are essential in delivering high-quality, cost-effective medical services to its members. Zing Health further recognizes that achieving its mission would not be possible without your participation. Zing Health is committed to earning your ongoing support and looks forward to collaborating with you to provide the best service possible to Zing Health's members.

This Provider Manual explains the policies and administrative guidelines. The provider manual also outlines day-to-day operational details for you and your staff. It will describe and clarify the requirements identified in the provider agreement between you and Zing Health. Updates to this manual will be posted on Zing Health's website and provider portals on a periodic basis. As your office receives communications from Zing Health, it is important that you and/or your office staff read the provider notifications, Zing Health's newsletters, and other special mailings, and retain them with this manual so you can integrate the changes into your practice.

All Zing Health provider materials, including the provider manual and provider directory, are available online at myzinghealth.com. Please note, the term "provider" as used throughout this manual is inclusive of all practitioners, individual and group affiliated, as well as facilities and ancillary service providers, as appropriate.

Medicare Advantage and Prescription Drug Plans (MA-PDs)

Zing Health is a managed care organization that administers coverage that encompasses all Original Medicare benefits plus additional benefits identified in Zing Health's Plan Benefit Packages (PBPs). Additional benefits include, but may not be limited to:

- No or low monthly premiums
- Competitive copays or coinsurance for in-network services
- Prescription drug coverage
- Routine dental, vision, hearing
- $0 copay preventive care from contracted providers

Zing Health's PBPs may change each year and may be unique based on the defined service area. You can find Zing Health's PBP information on its website (myzinghealth.com).

Zing Health Products

Below is a list of Zing Health'S MA-PD products. The list may change from year-to-year.

HMO **Health Maintenance Organization (HMO)**

Traditional MA-PD plan. All services must be provided within Zing Health's provider network except for emergency or urgently needed care, or in the event the service is not available in-network. Some services require prior authorization and/or referral by Zing Health.

PPO **Preferred Provider Organization (PPO)**

Members of Zing's PPO plan can receive services from Zing's in-network providers with the flexibility of seeing providers out-of-network anywhere in the United States. Out-of-network services do not require prior authorization or referrals; however, members may pay more to access services outside of the network. There is no guarantee that non-network providers will accept Zing Health insurance for non-emergency services.

C-SNP **Chronic Special Needs Plans (C-SNP)**

A C-SNP plan is a traditional Medicare Advantage product. It is designed to go beyond the basic provisions of Medicare Parts A/B services and standard care coordination that are required of all traditional Medicare Advantage plans. Although there exists both a Model of Care and Quality Improvement Program, C-SNPs are designed to restrict enrollment to special needs individuals with specific severe or disabling chronic conditions. Individuals eligible for C-SNPs have one or more comorbid and medically complex chronic conditions that are substantially disabling or life-threatening; have high risk of hospitalization or other significant adverse health outcomes; require specialized delivery systems across domains of care; and live within the plan service area. Zing Health's C-SNPs cover:


End Stage Renal Disease


Diabetes


Chronic Heart Failure


Cardiovascular Disease

D-SNP **Dual Eligible Special Needs Plans (D-SNP)**

A special type of plan that provides more focused healthcare for people who are eligible for both Medicare and Medicaid and live within Zing Health's service area. Like all Medicare Advantage plans, it is approved by CMS. These plans provide a coordinated Medicare and Medicaid benefit package that offers more aligned care than regular Medicare Advantage plans or Original Medicare. All services must be provided within Zing Health's provider network except for emergency or urgently needed care, or in the event the service is not available in-network.

SPECIAL NOTE: All members who receive renal dialysis services while temporarily outside their service area will pay the in-network cost share regardless of the rendering provider's network affiliation.

Standard Terms and Conditions

This provider manual (the "manual") is part of your contract with Zing Health. This manual sets forth certain policies and procedures that are used to administer Zing Health's MA-PD plans. Upon update and release/posting, the current provider manual supersedes all previous iterations of provider manual and policies and procedures. All capitalized terms used in this manual are defined in the Definitions or Acronyms sections of this document or the provider agreement.

Notification of Change

Facilities

Facilities shall notify Zing Health in writing in accordance with the facility agreement at least 30 days prior to any change in their (i) office address; (ii) billing address; (iii) phone number; (iv) facility vendors, such as addition or deletion of any facility vendors; (v) name or fictitious name; (vi) taxpayer identification number; (vii) ownership; (viii) dba or (ix) email address.

Facility shall provide Zing Health with 90 days prior written notice of any reduction in the scope of facility services offered by facility as of the effective date. A material reduction in the scope of facility services offered by facility as of the effective date, as determined by Zing Health in Zing Health's sole discretion, may be deemed a material breach of the agreement, as determined by Zing Health in Zing Health's sole discretion.

Providers

Providers shall notify Zing Health in writing in accordance with the provider agreement within 30 days of any change in their (i) office address; (ii) billing address; (iii) phone number; (iv) provider staff, such as addition or deletion of any provider staff; (v) name or fictitious name; (vi) taxpayer identification number, (vii) office facility location; (viii) office hours; (ix) ownership; (x) dba; (xi) group affiliation or (xii) email address.

Provider shall notify Zing Health in writing within 15 days in the event of the death of a member of the provider staff or if loss of licensure occurs.

If a provider or facility changes its billing address or tax identification number, it must notify Zing Health indicating the effective date of the change and provide a signed copy of a W9 form. Such notice shall be sent to Zing Health's Provider Services department via email to provider.services@myzinghealth.com.

Independent Contractor Relationship

Zing Health, in consideration of the compensation received from CMS to administer MA-PDs for Medicare members, agrees to arrange for the delivery of health care services in accordance with and subject to the benefit packages developed for each of Zing Health's Medicare plans. Provider and/or facility acknowledges that Zing Health, in so arranging for the delivery of health care services and supplies to members, provides such services or supplies through independently contracted providers and facilities.

In accordance with the provider or facility agreement, provider and/or facility and Zing Health, as applicable, are independent contractors. Zing Health shall not be liable for any negligent act or omission committed by a provider or facility or any provider staff or facility vendor who may, from time to time, furnish services or supplies to members. Provider and/or facility acknowledges and agrees that any decisions made by Zing Health concerning appropriateness of setting or whether any service is covered are made solely for purposes of determining whether benefits are authorized for payment under the applicable Zing Health Medicare plan, and not for purposes of recommending any medical treatment or non-treatment.

Protocols and Guidelines

Provider and/or facility acknowledges and agrees that (is) all decisions rendered by Zing Health in its administration of the agreement, including, but not limited to, all decisions with respect to the determination of whether or not a service is a covered service, are made solely to determine if payment of benefits under the applicable Zing Health Medicare plan is appropriate; and (ii) any and all decisions relating to the necessity of the provision or non-provision of medical services or supplies shall be made solely by the member and provider/facility in accordance with the usual provider/facility-patient relationship and provider and/or facility, as applicable, shall have sole responsibility for the medical care and treatment of members under their care. Providers and facilities should encourage members under their care to review their Zing Health Medicare plan's Evidence of Coverage concerning benefits, procedures, and exclusions or limitations prior to receiving treatment. Evidence of Coverage and other member materials can be found at myzinghealth.com.

Licensure

Providers and facilities shall maintain in good standing all required licenses, accreditations, certifications, registrations and permits, as required under all applicable local, state and federal laws and regulations and the agreement.

Secure Provider Portal

Zing Health offers secure technology options to save providers time using the Availity Essentials provider portal. This portal helps providers do business with Zing Health. We want providers' interactions with us to be as easy, convenient and efficient as possible. Giving providers and their staff self-service tools and access helps us accomplish these goals. Providers can use the information in this provider manual to register by visiting the section below entitled "How to Register," or view the Availity Quick Start Guide.

Provider Portal Features

Zing Health's secure online provider portal offers immediate access to what providers need most. Participating providers who create an account and are assigned the appropriate role/permissions can use the following features:

- **Claims**: Check claims status, real-time submission
- **Member eligibility check real-time copay information and more:** Verify member eligibility, and view copays, benefit information, demographic information, health conditions, visit history and more;
- **Secure Inbox:** View the latest announcements for providers and receive important messages from Zing Health in the Availity Payer Spaces section of the provider portal

Register Multiple Provider Office Locations

Registration for the Availity Essentials portal allows one user to have access to multiple locations. Organizations can be set up for separate departments withing a large hospital, or separate business locations. The administrator of the account will determine who within the organization has access. The setup is based off how the administrator's register each account.

Register Multiple Provider Office Locations

In order to use the Availity Essentials Provider Portal, you can go to www.Availity.com/Essentials and select *Register*, or call **1-800-AVAILITY** for assistance.

If you have any questions about the process, you may contact Zing Health at **(866) 946-4458** between 8:00 a.m. and 5:00 p.m., Monday through Friday, or email provider.services@myzinghealth.com. Provider Services will notify you with the information you will need to get started.

Provider Online Resources

Zing Health's website offers a variety of resource materials to help providers and staff navigate Medicare regulations and Zing Health plan rules. Available resources include:

- Provider manual
- Quick reference guide
- Clinical practice guidelines
- Clinical coverage guidelines
- Forms and documents
- Pharmacy and provider lookup tools
- Authorization lookup tool
- Training materials
- Provider newsletters
- Member rights and responsibilities (which can also be found in the Member Rights and Responsibilites section of this handbook)
- Notice of Privacy Practices

State and Federal Compliance Requirements

Non-Discrimination

Provider shall comply with Title VI of the Civil Rights Act of 1964 (as amended), the Americans with Disabilities Act of 1990, Section 504 of the Federal Rehabilitation Act of 1973, the Genetic Information Nondiscrimination Act of 2008, and all requirements imposed by the regulations implementing these acts and all amendments to the laws and regulations. The regulations provide, in part, that no person in the United States shall, on the grounds of race, color, national origin, sex, age, disability, political beliefs or religion, be excluded from participation in or denied any aid, care, service or other benefits, or be subjected to any discrimination under any program or activity receiving federal funds. All Zing Health contracted providers must comply with all State and Federal Anti-discrimination laws including, but not limited to:

- Title VI of the Civil Rights Act of 1964, (42 U.S.C. 2000D et seq) and applicable 45 CFR Part 80 or 7 CFR Part 15
- Section 504 of the Rehabilitation Act of 1973 (29 USC 794) and Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq)
- Age Discrimination Act of 1975 (42 U.S.C. 6101-6107)
- Executive Order 13279, and it is implementing regulations at 45 CFR Part 87 or & CFR Part 16

Compliance, Privacy, and Security

Providers must comply with current state and federal rules, including but not limited to the following:

- Environmental protection laws:
    - Pro-Children Act of 1994 (20 U.S.C. §6081 et seq.) regarding the provision of a smoke-free workplace and promoting the non-use of all tobacco products;
    - National Environmental Policy Act of 1969 (42 U.S.C. §4321 et seq.) and Executive Order 11514 ("Protection and Enhancement of Environmental Quality") relating to the institution of environmental quality control measures;

    - Clean Air Act and Water Pollution Control Act regulations (Executive Order 11738, "Providing for Administration of the Clean Air Act and Federal Water Pollution Control Act with Respect to Federal Contracts, Grants, and Loans");
    - State Clean Air Implementation Plan (42 U.S.C. §740 et seq.) regarding conformity of federal actions to State Implementation Plans under §176(c) of the Clean Air Act; and
    - Safe Drinking Water Act of 1974 (21 U.S.C. §349; 42 U.S.C. §300f to 300j-9) relating to the protection of underground sources of drinking water;
- State and federal anti-discrimination laws:
    - Title VI of the Civil Rights Act of 1964, (42 U.S.C. §2000d et seq.) and as applicable 45 C.F.R. Part 80 or 7 C.F.R. Part 15;
    - Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794);
    - Americans with Disabilities Act of 1990 (42 U.S.C. §12101 et seq.);
    - Age Discrimination Act of 1975 (42 U.S.C. §§6101-6107);
    - Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681-1688);
    - Food Stamp Act of 1977 (7 U.S.C. §200 et seq.);
    - Executive Order 13279, and its implementing regulations at 45 C.F.R. Part 87 or 7 C.F.R. Part 16;
- The Immigration and Nationality Act (8 U.S.C. § 1101 et seq.) and all subsequent immigration laws and amendments;
- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191), and
- The Health Information Technology for Economic and Clinical Health Act (HITECH Act) at 42 U.S.C. 17931 et. seq.

Confidentiality

In accordance with federal and state laws, Zing Health has established confidentiality policies and practices for its own operation and to outline expectations to our provider network. A copy of [Zing Health's Notice of Privacy Practices (NPP) can be viewed here].

All providers must comply with state and federal laws and regulations and Zing Health's policies on the confidential treatment of Member information in all settings.

All providers are to treat members' protected health information (PHI) - including medical records - confidentially and in compliance with all federal and state laws and regulations, including laws regarding mental health, substance abuse, HIV and AIDS, as well as the Health Insurance Portability and Accountability Act (HIPAA). It is the provider's responsibility to obtain the member's written consent for the purpose of sharing Member health information.

Providers are authorized to share members' protected health information with Zing Health for the purposes of treatment, payment, and health care operations, including requesting Zing Health to process claims and administer reimbursement for the same.

Providers rendering services to Zing Health's members are required to obtain special consent (authorization) from members for any uses or disclosures of protected health information beyond the uses of payment, treatment, and health care operations, unless otherwise permitted or required by law. Members have the right to specifically approve or deny the release of personal health information for uses other than payment, treatment, and health care operations. Examples of uses and disclosures that require special consent or authorization include data requested for workers' compensation claims, release of information that could result in the member being contacted by another organization for marketing purposes, and data used in research studies.

In cases where consent is required from members who are unable to give it or who lack the capacity to give it, Zing Health and its providers will accept special consent or authorization from persons designated by the member. Designated persons, such as parents or guardians, may authorize the release of personal health information and may obtain access to information about the member.

Member information transferred from Zing Health to another organization as permitted by routine or special consent will be protected and secured according to Zing Health's privacy policies and procedures and in compliance with state and federal privacy laws and regulations.

Provider agrees to cooperate with Zing Health's Quality Management Program and all other quality management activities, including the use of performance data. Provider performance data may include, but is not limited to, medical records, provider experience, patient experience, and claims. The data received will be used in the development or in the improvement of activities and initiatives, credentialing activities, and public reporting to consumers. Zing Health will use member information for quality studies, health outcomes measurements, and other aspects of health operations and will de-identify the information as required by law.

Zing Health's members are permitted to access, copy, and inspect their medical records upon request.

HIPAA Incident Reporting

Providers and facilities are required to review all member information received from Zing Health to ensure no misrouted PHI is included. Misrouted PHI includes information about members that a provider or facility is not treating. PHI can be misrouted to providers and facilities by mail, fax, email or electronic remittance advice. Providers and facilities are required to immediately notify Zing Health of the misrouted PHI and destroy the misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or redisclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, please call Zing Health's Customer Service at **(866) 946-4458**.

Suspected Adult Abuse or Neglect

Cases of suspected adult abuse or neglect might be uncovered during examinations. Abuse is the infliction of injury, sexual abuse, unreasonable confinement, intimidation, or punishment that results in physical pain or injury, including mental injury. Abuse is an act of commission or neglect.

Suspected cases of abuse or neglect must be reported to the Adult Protective Services Unit (APS). APS are services designed to protect elders and vulnerable adults from abuse, neglect, or exploitation. The Department of Elder Affairs (DOEA) and DCF have defined processes for ensuring that elderly victims of abuse, neglect, or exploitation in need of home and community-based services are referred to the aging network, tracked, and served in a timely manner.

State specific requirements are found in the links below:

- IL - Adult Protective Services (APS) (https://ilaging.illinois.gov/protectionadvocacy/abuse.html)
- IN - FSSA: Aging Home: Adult Protective Services (https://www.in.gov/fssa/da/adult-protective-services/)
- MI - Adult Protective Services (https://www.michigan.gov/mdhhs/adult-child-serv/abuse-neglect/adult-ps)

To report suspected abuse, neglect, or exploitation of children or vulnerable adults, providers should call the:

- Illinois Abuse Hotline for adults aged 18 and older at **1-866-800-1409 (TTY 1-888-206-1327)** 24 hours a day, seven days a week. If a provider sees a vulnerable adult in immediate danger, he/she should call 911.
- Indiana Adult Protective Services Hotline for adults aged 18 and older at **1-800-992-6978 (TTY 711)** 24 hours a day, seven days a week. If a provider sees a vulnerable adult in immediate danger, he/she should call 911.
- Michigan Elder Abuse Hotline at **1-855-444-3911 (TTY 711)** 24 hours a day, seven days a week. To report abuse in a nursing facility, call the Michigan Attorney General's Health Care Fraud Division at 1**-800-242-2873** If a provider sees a vulnerable adult in immediate danger, he/she should call 911.

Cultural Competency

Zing Health members will vary in language and culture (e.g., customs, religion, backgrounds). Participating providers must provide covered services to all Zing Health members in a manner that recognizes and respects the worth and dignity of each member, including providing simplified explanations for those with limited comprehension.

The objectives of the Cultural Competency Program are to:

- Identify members who have potential cultural or linguistic barriers for which alternative communication methods are needed.
- Use culturally sensitive and appropriate educational materials based on the member's race, ethnicity and primary language spoken.
- Make resources available to meet the unique language barriers and communication barriers that exist in the population.
- Help providers care for and recognize the culturally diverse needs of the population.
- Provide education to associates on the value of the diverse cultural and linguistic differences in the organization and the populations served.
- Decrease healthcare disparities in the minority populations that Zing Health serves.

By respecting and responding to the cultural needs of members, providers and their staffs can deliver culturally competent care and work effectively in cross-cultural situations. The components of Zing Health's program include:

- Data analysis
  - Analysis of claims and encounter data to identify the healthcare needs of the population
  - Collection of member data on race, ethnicity and language spoken
- Community-based support

    - Outreach to community-based organizations which support minorities and the disabled, to facilitate existing resources for members being used to their full potential
- Diversity of provider network
    - Providers are inventoried for their language abilities and this information is made available in the Provider Directory so members can choose a provider who speaks their primary language
    - Providers are recruited to ensure a diverse selection of providers to care for the population served
- Linguistic services
    - Providers will identify members who have potential linguistic barriers for which alternative communication methods are needed and will contact Zing Health to arrange appropriate assistance.
    - Members may receive interpreter services through a Zing Health vendor at no cost when necessary to access covered services. Contact Zing Health's Customer Service department for assistance.
    - Interpreter services available include verbal translation, verbal interpretation for those with limited English proficiency and sign language for those with limited hearing. These services will be provided by vendors with such expertise and are coordinated by Zing Health's Customer Service department.
    - Written materials are available for Members in large print format, certain non-English languages prevalent in Zing Health's service areas, and braille.
- Electronic media
    - Telephone system adaptations – Members have access to the TTY line for hearing assistance services. Zing Health's Customer Service department is responsible for any necessary follow-up calls to the member. The toll-free TTY number is 711 and can be found on the member identification card.
- Provider education
    - Zing Health's Cultural Competency Program provides a cultural competency checklist to assess the provider office's cultural competency.

Member Hold Harmless Provisions

Zing Health or provider/facility obligations:

In accordance with the contract between Zing Health and provider or facility, provider and facility shall not, and shall assure its contracted providers do not, in any event, including, but not limited to, non-payment by Zing Health or payor, Zing Health or payor's insolvency, or Zing Health's breach of this agreement, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Members or persons acting on behalf of the member for covered services.

Member hold harmless for dual eligible Zing Health members:

Providers agree that for all individuals eligible for both Medicare and Medicaid, Zing Health members will not be held liable for Medicare Part A and Part B cost sharing when the state is responsible for paying such amounts. Zing Health providers will be informed of Medicare and Medicaid benefits and rules for individuals eligible for Medicare and Medicaid. See Section 15 for more information on Zing Health's Dual Eligible Special Needs Plan (D-SNP). Providers may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under Title XIX if the individual were not enrolled in such a plan. Providers will:

- accept Zing Health's payment as payment in full, or
- bill the appropriate state source

Provider Standards

In accordance with generally accepted professional standards, participating providers must:

- Meet the requirements of all applicable state and federal laws and regulations, including without limitation, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and the Rehabilitation Act of 1973
- Agree to cooperate with Zing Health in its efforts to monitor compliance with its CMS contract(s) and/or CMS rules and regulations, and assist Zing Health in complying with corrective action plans necessary to comply with such rules and regulations
- Retain all agreements, books, documents, papers, and medical records related to the provision of services to Zing Health members as required by the Zing Health provider contract, as well as state and federal laws
- Provide covered services and administer treatment in a manner consistent with professionally recognized standards of healthcare
- Use physician extenders such as Physician Assistants (PA) and Nurse Practitioners (NPs) appropriately and manage Member care within the scope of practice established by the rules and regulations of the state and Zing Health guidelines
- Assume full responsibility to the extent of the law when supervising PAs and NPs whose scope of practice should not extend beyond statutory limitations
- Clearly identify their title (examples: MD., DO., NP, PA) to members and to other healthcare professionals
- Honor all member requests to be seen by a physician rather than a physician extender
- Respond within the identified time frame to Zing Health's requests for medical records to comply with regulatory requirements
- Maintain accurate medical records and adhere to all Zing Health policies governing the content and confidentiality of medical records
- Allow Zing Health to use Provider performance data for quality improvement activities.
- Cooperate with Zing Health QI activities
- Ensure that any subcontract agreements with employed physicians and other healthcare practitioners are in writing and that the obligations are consistent with and require adherence to the Zing Health provider contract
- Maintain an environmentally safe office with equipment in proper working order to comply with city, state, and federal regulations concerning safety and public hygiene
- Communicate timely clinical information between providers. Communication will be monitored during medical/chart review. Upon request, provide timely transfer of clinical information to Zing Health, the member, or the requesting party at no charge, unless otherwise agreed
- Preserve member dignity and observe the rights of members to know and understand the diagnosis, prognosis, and expected outcome of recommended medical, surgical, and medication regimen
- Not discriminate in any manner between Zing Health MA members and MA members who

are not Zing Health members. The hours of operation offered to Zing Health members are no less than those offered to patients with commercial insurance

- Not deny, limit, or condition the furnishing of treatment to any Zing Health MA member on the basis of any factor that is related to health status, including, but not limited to the following:
    - Medical condition, including behavioral as well as physical illness
    - Claims experience
    - Receipt of healthcare
    - Medical history
    - Genetic information
    - Evidence of insurability, including conditions arising out of acts of domestic violence
    - Disability
- Freely communicate with and advise members regarding the diagnosis of the member's condition and advocate on the member's behalf for the member's health status, medical care, and available treatment or non-treatment options, including any alternative treatments that might be self-administered regardless of whether any treatments are covered services
- Identify members who need services related to domestic violence, smoking cessation or substance abuse. If indicated, providers must refer members to Zing Health-sponsored or community-based programs
- Document the referral to Zing Health-sponsored or community-based programs in the member's medical record, and provide the appropriate follow-up to ensure the member accessed the services

Insurance

Providers and facilities shall maintain throughout the term, at their sole cost and expense, professional liability insurance and general liability insurance consistent with applicable law, Zing Health credentialing criteria, and this manual as necessary to insure it and its employees and contractors against any and all claims for damages arising by reason of death or personal injuries occasioned directly or indirectly in connection with providers' or facilities' acts or omissions in the performance of covered services pursuant to the agreement ("insurance"). Providers and facilities shall, to the extent they are reasonably able to do so, obtain Insurance on an occurrence basis.

If a provider or facility obtains claims-made Insurance, such provider or facility shall obtain "tail" coverage that is effective upon termination of the claims-made policy and a retroactive effective date of such policy to ensure there is no lapse in coverage. Providers and facilities shall provide verification of compliance with this provision to Zing Health upon Zing Health's request. Providers and facilities shall ensure that its liability insurance company is required to provide Zing Health with 15 days prior written notice of cancellation, termination or non-renewal of provider's or facility's insurance. The cancellation, termination and/or non-renewal of a provider's or facility's Insurance, as required under the agreement and this manual, shall be deemed to be a "material breach" of the agreement. Notwithstanding the foregoing to the extent permitted by applicable state law, in the event a provider or facility does not maintain Insurance, such provider or facility shall post any and all notices and statements relating to insurance coverage as required by applicable state law. Providers and facilities shall immediately notify Zing Health whenever a member files a claim or a notice of intent to commence legal action against such provider or facility, if known to the provider or facility, including the details of the nature, circumstances and disposition of such claim. Such notice shall be sent to Zing Health Provider Services.

Communication Materials

Any provider marketing for Zing Health must be approved by Zing Health in advance to ensure compliance with CMS guidelines. This mandatory review will include letters announcing affiliation with Zing Health, plan availability, events, health fairs, etc. Any gifts or promotional items must also follow CMS guidelines. Contact your Provider Services representative for more information.

Providers may make available and/or distribute Zing Health marketing materials and display posters or other materials announcing Zing Health contractual relationships in accordance with and subject to Medicare Marketing Materials Guidelines. However, providers may not make available, accept or distribute plan enrollment applications or offer inducements to enroll in a specific plan. Providers shall not offer anything of value to induce a prospective member to select them as their provider.

Designated Liaison

Each provider's office shall designate an office manager or administrator to be the primary contact person for Zing Health's Provider Services department. This person should have sufficient control to ensure the adherence with Zing Health's contractual requirements.

Member Rights and Responsibilities

Providers and facilities shall make available to member upon request a copy of the statement of member rights and responsibilities. In accordance with applicable laws and regulations, Zing Health's statement of member rights and responsibilities is presented below:

The following rights and responsibilities are set forth under state law. State law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

Member rights:

- You have the right to be treated with fairness, courtesy and respect, with appreciation of your individual dignity, and with protection of your need for privacy, including the protection of your medical records and personal health information.
- You have the right to a prompt and reasonable response to questions and requests.
- You have the right to know who is providing medical services and who is responsible for your care.
- You have the right to know what member support services are available, including whether an interpreter is available if you do not speak English.
- You have the right to know what rules and regulations apply to your conduct.
- You have the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

- You have the right to know your treatment choices and participate in decisions about your health care.
- You have the right to refuse any treatment, except as otherwise provided by law.
- You have the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for your care.
- You have the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- You have the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- You have the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- You have the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- You have the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- You have the right to know if medical treatment is for purposes of experimental research and to give your consent or refusal to participate in such experimental research.
- You have the right to make complaints which are either appeals or grievances related to your coverage or care.
- You have the right to see plan providers, get covered services, and get your prescriptions filled within a reasonable period of time.
- You have the right to use advance directives, such as a living will or power of attorney.
- You have the right to get more information about your rights by calling Customer Service at the number listed on your member materials or **1-800-MEDICARE (1-800- 633-4227)**. TTY users should call **1-877-486-2048**. You can call Medicare 24 hours a day, seven days a week, or you can visit www.medicare.gov on the web to order Your Medicare Rights and Protections or print it directly from your computer. You can also view information concerning the HHS Office for Civil Rights online at www.hhs.gov/ocr or by calling U.S. Department of Health and Human Services (HHS) toll-free at **1-800-368-1019**.

Member responsibilities:

- You are responsible for providing to the health care provider, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to your health.
- You are responsible for reporting unexpected changes in your condition to the health care provider.
- You are responsible for reporting to the health care provider whether you comprehend a contemplated course of action and what is expected of you.
- You are responsible for following the treatment plan recommended by the health care provider.
- You are responsible for keeping appointments and, when you are unable to do so for any reason, for notifying the health care provider or health care facility.
- You are responsible for your actions if you refuse treatment or do not follow the health care provider's instructions.
- You are responsible for assuring that the financial obligations of your health care are fulfilled as promptly as possible, including premiums, if any, and copayments you may owe for covered services. You must also meet the financial responsibilities that are described in the Evidence of Coverage.

- You are responsible for following health care facility rules and regulations affecting your care and conduct.
- You are responsible to get familiar with your coverage and the rules you must follow to get care as a member.
- You are responsible to act in a way that supports the care given to others in the provider office and help the smooth running of your doctor's office, hospitals and other offices.

Section 3: Operational Guidelines

Zing Health is committed to ensuring providers and facilities have an overall knowledge, understanding, and access to resources within Zing Health to provide and coordinate the care of the Zing Health membership.

Provider Services

Zing Health allocates provider services staff to each major area to support the Zing Health provider network. Each provider group will have provider services staff that will assist with operational and financial support services and data reporting. Providers will have access to a provider service representative to answer questions about Zing Health's operations, policies and procedures.

Customer Service

Zing Health also offers customer service for members, providers, and facilities to answer questions and to provide eligibility, co-payment, claim status, authorization status, and benefit information. Customer Service hours are as follows:

October 1 – March 31:
- Live Customer Service Representative (CSRs) available seven days a week, from 8:00 a.m. to 8:00 p.m. (CST); and
- Interactive voice response system or similar technologies are used for Thanksgiving and Christmas Day with messages returned within one business day.

April 1 – September 30:
- Live CSRs available Monday through Friday, from 8:00 a.m. to 8:00 p.m. (CST); and
- Interactive voice response system or similar technologies are used for Saturdays, Sundays and other Federal Holidays with messages returned within one business day.

Providers and facilities are asked to call between 8 a.m. and 5 p.m. (CST) to discuss issues and concerns about claim payments.

The telephone number for Zing Health Customer Service is **(866) 946-4458 (TTY 711)**.

Translator and Interpreter Services

Help for those with impaired vision, impaired hearing or in need of interpreter services is available. The Member Handbook is available in alternative formats for members with visual impairments. Additionally, for members with hearing impairments who use a teletype device (TTY), they can receive these services through the TTY 711 code.

Providers should assist in the coordination of interpreter services for members by contacting Zing Health's Customer Service to arrange appropriate assistance. Members can receive interpreter services at no cost to access covered services, including verbal translation, written translation of key

Zing Health plan materials, and sign language for the hearing impaired.

Pharmacy Call Centers

Technical Help

The Zing Health Pharmacy Help Call Center operates a toll-free pharmacy technical help call center to respond to inquiries from pharmacies and providers regarding the Zing Health member prescription drug benefit. This call center is operated by our Pharmacy Benefits Management company, Elixir Solutions. These inquiries may pertain to operational areas such as claims processing, benefit coverage, claims submission, and claims payment. This call center is available 24 hours per day. The telephone number for the Zing Health Pharmacy Technical Help Call Center is 855-476-6993 (TTY 711).

Coverage Determinations and Appeals

The Zing Health Coverage Determination and Appeals call center maintains a toll-free call center to respond to providers requests for information related to coverage determinations, including exceptions, prior authorizations, and appeals. This call center is operated by our pharmacy benefits management company, Elixir Solutions. The telephone number for the Zing Health Coverage Determination and Appeals call center is 855-476-6993 (TTY 711).

The Coverage Determination and Appeals call center is available 24 hours per day, seven days a week.

- For coverage determination calls resolution within 24 hours of call for expedited requests and 72 hours for standard requests;
- For appeals calls, resolution within 72 hours for expedited appeal requests and seven calendar days for standard appeal requests.

These timeframes are based upon receipt of all required information to complete the request.

Welcome Kits for Members

Once the member has selected Zing Health, we will send the member a welcome kit that includes the following:

- Welcome letter
- Member identification card
- Member Summary of Benefits
- EOC notice
- Formulary notice
- HIPAA Privacy Notice
- Plan benefit features
- Important contact numbers

Member Identification Cards

Zing Health will issue an identification card for each member. Members are always advised to keep their ID card with them and to present the card to their provider when services are rendered.

ID cards contain the following information:

- Member's name and date of birth;
- PCP group name and telephone number;
- Zing Health identification number;
- Zing Health contact information;
- Claims filing address; and
- Rx BIN and Rx PCN

Choosing a Primary Care Provider (PCP)

Making sure members have selected a PCPs is at the heart of Zing Health's approach to managing the care of its member population. Members may choose a PCP from Zing Health's provider directory when they enroll in a Zing Health Medicare plan or they will be assigned a PCP. The PCPs, in their role, provide members with primary and preventive care and arrange for other medically necessary services for members. Therefore, Zing Health acts quickly to make sure that members are linked to a PCP.

Assigning PCPs

Zing Health uses the following process for PCP assignments.

- **Member selection**
  - If the member selects a PCP and the PCP's office is accepting new patients, the member will be assigned to that PCP.
- **Primary care provider auto-assignment**
  - If the member did not select a PCP, Zing Health will identify all network PCPs located nearest the the member's physical address.
  - If the member does not have a physical address, the member's mailing address will be used.
  - If multiple PCPs are available, the nearest PCP will be selected

Changing PCPs

Circumstances may arise that may necessitate the need for a member to change their PCP. Common scenarios may include, but are not limited to:

- A provider retiring from practice;
- A provider moving office locations outside of Zing Health's service area;
- A provider voluntarily terminating its contract;
- A member electing to change PCPs; and/or
- A member moving within the Zing Health service area, but a significant commute from the PCP.

For all PCP activities that are impacted by a PCP no longer participating in the network, Zing Health makes a good faith effort to provide a 30 day notification to all members assigned to that PCP. Zing Health aids members in making a new PCP election. Additionally, a member may elect to change PCPs at their own discretion. Zing members can make the request by calling Customer Service at 866-946-4458. A new ID card will be sent to the member reflecting the change in their PCP selection.

Acceptance of Members

Provider and facility shall accept as patients all members who select or are assigned by Zing Health to provider. Zing Health recognizes that PCPs may occasionally need to limit the number of patients in their practices in order to deliver quality care. To request a panel be closed, PCPs must provide a 30-day advance written notice to Provider Services (provider.services@myzinghealth.com). The provider must maintain the panel of Zing Health's members who were assigned to the PCP before closing of the panel. If a PCP wishes to re-open his/her panel, a written notice must be sent to Provider Services (provider.services@myzinghealth.com) with a specific effective date they wish to re-open his/her panel.

Provider's panel may only be closed so that provider may refuse to accept any new member as a patient provider's panel may remain open only to existing patients who are members at the time provider's panel is closed ("existing members").

In such case, if a member desires to select a provider with a panel open only to existing members, Zing Health will contact provider to verify that the member meets the criteria for an existing member. If provider confirms that this is an existing member, Zing Health will open the panel to allow that member to select provider. Upon provider's or facility's acceptance of a member, provider, and facility may terminate the member from its panel or as its patient only upon satisfaction of applicable provisions of this manual and applicable law and regulation.

Member Dismissal from PCP Panel

If a member is non-compliant or does not comply with the member rights and responsibilities, as set forth herein, the provider and facility may notify the member of the situation in writing. However, the provider and facility may not terminate the member from their panel or services.

Provider and facility must request to Zing Health, in writing, that a member be removed from their panel; provided, however, that no such request can be based on the member's medical condition, which request shall be determined by Zing Health in Zing Health's sole discretion. Such requests and all supporting documentation must be sent to the Zing Health provider service representative.

Verification of Eligibility

Member eligibility can change and therefore, each provider or facility is responsible for verifying member eligibility with Zing Health before providing services. Providers may verify eligibility using the following methods. Prior to providing any services to a member, provider, and facility shall determine a member's eligibility by taking the following steps:

- Ask the member to present his/her Zing Health member ID card
- If this is the member's first visit, ask the member to present additional proof of personal identification, preferably a photo ID
- Verify eligibility real time or batch through Availity
- Electronic verification on Zing Health IVR
- Refer to the current member eligibility list to ensure member enrollment or call the telephone number provided on the member's ID card to determine eligibility and verification of the type of plan in which the member is enrolled

Zing Health shall determine members' eligibility for covered services and shall provide Eligibility Information to Providers and Facilities upon request. Zing Health shall ensure that each member's identification card identifies (i) the person as a member; (ii) the member's primary care physician, where the applicable Zing Health Medicare plan so provided; and (iii) the toll-free phone number established by Zing Health for verification of eligibility or other questions. Zing Health shall make reasonable efforts to confirm or deny eligibility using the most current information available to Zing Health; provided, however, that provider and facility comply with such verification procedures.

Telemedicine

Zing Health is pleased to provide telemedicine to its members. Please see the telemedicine link on the Zing Health website and for more information regarding telemedicine contact Customer Service.

The following items for services provided through telemedicine must include:

- A brief explanation of the use of telemedicine in each progress note;
- Documentation of telemedicine equipment used for the particular covered services provided;
- A signed statement from the member or the member's representative indicating their choice to receive services through telemedicine. This statement may be for a set period of treatment or a one-time visit, as applicable to the service(s) provided; and
- A review of telemedicine is included in Zing Health's fraud and abuse detection activities.

Delegation

Delegation occurs when Zing Health engages another entity to perform administrative and/or clinical functions on behalf of Zing Health. Functions that may be delegated include, without limitations, inpatient and outpatient authorizations, denials, concurrent review, case management, disease management, Provider appeals, claims payment, credentialing, network development, customer service, billing, sales and marketing, enrollment, quality improvement, and any portion of the overall functions listed.

While a function may be delegated to another entity, Zing Health retains overall accountability for completion of the tasks delegated. Zing Health is responsible for ensuring the delegated entity's compliance with internal Zing Health standards and requirements, as well as federal, state, and accreditation standards. Delegation oversight activities include, but are not limited to:

- Ensuring delegation agreements with each delegated entity specify the activities to be delegated and those to be retained by Zing Health, including data reporting standards
- Evaluating the entity's ability to fulfill delegation obligations through review of the entity's programs, policies, procedures, and service delivery, including use and handling of protected health information and other applicable HIPAA privacy and security concerns prior to delegation
- Performing ongoing performance monitoring via review of submitted data reports and ensuring that corrective action is taken, in a timely manner, to address any opportunities for improvement identified
- Completing a formalized performance review, including review of applicable program description based on annual audit work plan
- Recommending corrective action plans, sanctions, or revocation of delegation if the entity's performance is inadequate

Claims Processing

Timely Processing Requirements

Contracted (network) providers and facilities shall submit claims in accordance with the applicable provider, facility or ancillary Zing Health agreement within 365 of the date of service or the date of discharge unless otherwise specified in the provider agreement. Untimely claims will be denied when they are submitted past the filing deadline.

Resubmission of previously processed claims with corrections and/or requests for adjustments must be submitted within 60 days of notification of payment/denial. Resubmitted claims should be resubmitted on paper (indicate in FLD 22). Corrected claims can be sent electronically. All corrected claims should have the corrected claim indicator (a 7) on the claim and the original claim number that you are correcting.

Claims originally denied for missing/invalid information for inappropriate coding should be submitted as corrected claims. In addition to writing "corrected" on the claim, the corrected information should be circled so that it can be identified.

Claims originally denied for additional information should be sent as a resubmitted claim. In addition to writing "resubmitted" on the claim, the additional information should be attached.

Corrected and resubmitted paper claims are scanned during reprocessing. Please use blue or black ink only, and refrain from using red ink, white out, and/or highlighting that could affect the legibility of the scanned claim.

Corrected/resubmitted paper claims should be sent to:

Zing Health
Attn: Claims Department
P.O. Box 981718
El Paso, TX 79998-1718

Following these instructions will reduce the probability of erroneous or duplicate claims and timely filing denials on second submissions. Claims originally rejected for missing or invalid data elements must be corrected and resubmitted within a 60-day timeframe. Rejected claims are not registered as received in the claims processing system. Accordingly, the pended or rejected claim will be dismissed if the supplemental information and/or a corrected claim are not submitted within the 60-day timeframe.

Procedures for Claim Submission

Zing Health is required by state and federal regulations to capture specific data regarding services rendered to its members. The provider must adhere to all billing requirements in order to ensure timely processing of claims. When required data elements are missing or invalid, claims will be rejected by Zing Health for correction and resubmission. The provider who performed the service to the Zing Health member must submit the claim for a billable service. Claims filed with Zing Health are subject to the following procedures:

- Verification that all required fields are completed on the CMS-1500 or UB-04 forms;
- Electronic claims must be submitted via an ASC X12 837 professional claim file or ASC X12 837 institutional claim file meeting the 5010 HIPPA EDI standards;
- Verification that all diagnosis and procedure codes are valid for the date of service;
- Verification of member eligibility for services under Zing Health during the period in which services were provided;
- Verification that the services were provided by a participating provider or that the "out-of-network" provider has received authorization to provide services to the eligible member (excluding "self-referral" types of care);
- Verification that an authorization has been given for services that require prior authorization by Zing Health; and
- Verification that the claim includes the appropriate NPI number and taxonomy code.

In addition, Zing Health uses claim edit applications following NCCI, AMA, and CMS guidelines. Edits may include but are not limited to:

- Procedure unbundling (billing two or more CPT codes when one CPT code exists for same procedure);
- Incidental procedures (procedures performed at the same time as a more complex procedure but requires little to no additional physician resources or is clinically integral to the performance of the procedure);
- Mutually exclusive procedures (two or more procedures that should not be performed or billed for the same ,ember on the same date of service);
- Multiple surgical procedures (surgical procedures are ranked according to clinical intensity and are paid following percentage guidelines);
- Multiple Procedure Payment Reduction (MPPR) for selected therapies (applies to multiple procedures and multiple units);
- Duplicate procedures (procedures billed more than once on same date of service);
- Assistant surgeon utilization (reimbursement and coverage determination);
- Evaluation and management service billing (review the billing of services with procedures performed); and
- ER evaluation and management services (review the billing for consistency with ACEP guidelines).
- Any CPT/HCPCS level 1 or 2 codes that have been denied due to claims editing will be associated with the appropriate disposition code on the remittance advice.

Prior to submitting a claim, it is important to determine if any other payer has primary responsibility for payment of a claim. Coordination of Benefits (COB) allows plans that provide health and/or prescription coverage for a person with Medicare to determine their respective payment responsibilities (i.e., determine which insurance plan has the primary payment responsibility and the extent to which the other plans will contribute when an individual is covered by more than one plan).

The identification of the primary payer prior to claim submission will improve the efficiency and accuracy of the claim payment process. "Primary plan" means a plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration.

Rejected and Denied Claims

Rejected claims are defined as claims with invalid or missing required data elements necessary to adjudicate the claim. These claims will be returned to the provider or EDI source without registration in the claims processing system. The provider must submit a valid claim timely. This requirement applies to claims submitted on paper or electronically.

Denied claims are different than rejected claims and are registered in the claims processing system, but they do not meet requirements for payment under Zing Health's guidelines.

Interest on Late Payment of Clean Claims

For clean claims that are processed after the 30-day prompt pay period, Zing Health will pay interest as determined by the applicable rate on the day of payment as established by the United States Secretary of the Treasury, as published in the Federal Register. The amount of interest is reported on the remittance advice to the provider.

Claim Mailing Instructions

If you choose to utilize paper claims, please submit to Zing Health at the following address:

Zing Health
Attn: Claims Department
P.O. Box 981718
El Paso, TX 79998-1718

Claims Status Review

Providers may view claims status using any of the following methods:

- Electronic batch and real-time updates through Availity or Optum EDI options
- Telephone – You may also check claims status by calling Zing Health at 866-946-4458.

Notification of Denial via Remittance Advice

When a claim is denied , the claim should be corrected, marked as a corrected claim, and resubmitted within 60 days of notification of payment/denial either electronically or to the general claim address. Contracted providers receive remittance advice directly from Zing Health's delegated claims adjudicator.

Claim Forms and Field Requirements

The CMS-1500 claim form must be completed for all professional medical services, and the UB-04 claim form must be completed for all facility claims. All claims must be submitted within the timeframe referenced in the provider agreement.

Procedures for Electronic Submission

Electronic Data Interchange (EDI) is the preferred submission method of Zing Health and allows for faster, more efficient, and cost-effective claims submission for providers. EDI, performed in accordance with nationally recognized standards, supports the health care industry's efforts to reduce administrative costs. The benefits of billing electronically include:

- Reduction of overhead and administrative costs. EDI eliminates the need for paper claims submission. It has also been proven to reduce claim rework (adjustments).
- Receipt of reports as proof-of-claim receipt. This makes it easier to track the status of claims.
- Faster transaction time for claims submitted electronically. An EDI claim averages about 24 to 48 hours from the time it is sent to the time it is received. This enables providers to easily track their claims.
- Validation of data elements on the claim form. By the time a claim is successfully received electronically, information needed for processing is present. This reduces the chance of data entry errors that occur when completing paper claim forms.
- Faster claim completion. Claims that do not need additional investigation are generally processed more quickly.

Zing Health has partnered with Optum and Availity as its preferred EDI clearinghouses. You may connect directly with Availity or Optum. In some cases, your existing clearinghouse, billing service, or trading partner may have existing reciprocal agreements with Optum or Availity.

Optum - 1-866-678-8646, Option 2
Availity – 1-800-AVAILITY
Zing Health Electronic Payer ID: 83248

Claims Disputes

If a contracted provider or facility would like to dispute an administrative denial or believes the compensation rate applied is not correct, a dispute must be submitted securely within 60 days from the denial of the claim, with all necessary supporting documentation to:

Zing Health
Attn: Claim Payment Disputes
225 West Washington Street, Suite 450
Chicago, IL 60606
Provider.services@myzinghealth.com

Claims Reconciliations (50+ Claims)

If a provider or facility has more than 50 claims in dispute, it may request that all of the claims be reviewed by Zing Health's Provider Services team. To submit multiple claims to this team, prepare an Excel spreadsheet that includes the following data.

Header: Provider/facility name and tax ID
Columns:

- Zing Health provider ID number
- Member ID
- Member last name
- First name
- Date of service
- Billed charges
- Balance
- Claim number, if available
- Authorization number
- Authorization issues (number of days)
- Account number
- Comments

Spreadsheets must be password protected and should be sent via email to Zing Health Provider Services team (provider.services@myzinghealth.com). The password must be communicated separately from the spreadsheet.

The Provider Services team will provide a response to the provider/facility within 45 calendar days on the review outcome.

Overpayment Recoveries

If a claim is overpaid, the provider/facility will receive a letter from Zing Health requesting the return of monies paid in error in accordance with state statute. If there are any questions about the information in the notice/website or concerns about an Explanation of Payment entry for a negative amount, please email us at provider.services@myzinghealth.com. Providers/facilities shall adjudicate and pay all claims for overpayment in accordance with applicable laws and regulations.

Self-Identified Overpayment

When an overpayment is identified, the provider should call Customer Service at **866-946-4458** to report the overpayment. Claim details will need to be provided, such as reason for refund, claim number, member number, dates of service, etc. The claim will be adjusted, the money will be recovered, and the transaction will be reported on the Remittance Advice. There is no need to submit a refund check.

Provider Dispute of Overpayment

If the provider notifies Zing Health of their intent to dispute the overpayment, the overpayment recovery tracking is noted and the team will monitor the dispute resolution process.

Non-Contracted Providers

Claims Submission

Non-contracted providers should submit EDI claims to Zing Health utilizing payor ID 83248 as well. Non-contracted provider claims are subject to Original Medicare rules governing the timely submission of claims from the date the services were rendered (e.g., claims must be submitted within 365 days of the date services were rendered). The timely submission threshold applies to any claims that require corrections. Any claims (or corrected claims) received from non-contracted providers that are submitted beyond the 365-day threshold post-date of service will be denied for untimely filing.

Exceptions to Timely Filing Limitation

In the event of an untimely filing denial, non-contracted providers have four avenues to pursue to establish good cause for the processing of the claim past the 365-day filing deadline.

Administrative Error

This exception is available when an error or misrepresentation is provided by an employee, Zing Health or an agent of CMS. Under these situations, timely filing will be extended by 180 days following the month in which the non-contracted provider or the Zing Health Member received notice that an error or misrepresentation was corrected. Examples of errors or misrepresentations include, but are not limited to:

- Advice provided to the Member that certain services were not covered under Part A or Part B when they are covered services;
- Excessive delay by Zing Health in providing information necessary for filing a claim; and/or
- Advice pending from Zing Health or CMS that resulted in a delay of the filing of a claim.

Retroactive Medicare Entitlement

This exception is available when services are rendered to an individual who is not entitled to Medicare but is later notified by the Social Security Administration that s/he is entitled to Medicare with a retroactive effective date of coverage that pre-dates the date on which the non-contracted provider rendered services to the individual. Under this scenario, the non-contracted provider may request a filing extension that is accompanied by all supporting documentation that verifies the retroactive Medicare entitlement (e.g., a copy of the letter from the Social Security Administration to the individual). When the extension request and documentation requirements are satisfied,

Zing Health will extend the filing deadline by 180 days from the month in which the member or the non-contracted provider received notice of the retroactive Medicare entitlement.

Retroactive Medicare Entitlement Involving State Medicaid Agencies

This exception is available when at the time services were rendered, the Member was entitled to Medicaid (not Medicare) and later is notified that s/he is entitled to Medicare. If the state Medicaid agency recoups the money it paid you six months or more after the date of service, you may be given an extension to file the claim to Zing Health for Medicare coverage. You must provide documentation verifying the date the state Medicaid agency recouped the money from you, that the beneficiary was retroactively entitled to Medicare on or before the date of service, and the date on which you rendered the service(s). Upon receipt of all documentation, the timely filing will be extended 180 days from the month in which the state Medicaid agency recouped its money.

Retroactive Disenrollment from Zing Health's Medicare Advantage Plan

This is exception is available when a Zing Health member later becomes disenrolled and Zing Health recoups its payment. If Zing Health recoups its money six months or more after the date of service, you may be granted an exception to file claims to Original Medicare. You must provide documentation that verifies prior enrollment in Zing Health, that you were notified that the member is no longer enrolled with Zing Health, the effective date of the member's disenrollment, and that Zing Health had recouped money from you for services rendered to the member. When this exception is met, timely filing will be extended 180 days from the month in which Zing Health recouped its money.

Payments

Under Medicare rules, non-contracted providers must accept as payment in full payment amounts applicable for Original Medicare. This provision of law imposes a cap on payment to non-contracted providers of provider payment amounts plus Member cost-sharing amounts applicable under Zing Health's Medicare products.

If there is an appeal from a non-contracted provider:
Zing Health must also receive the non-contracted provider's signed Waiver of Liability (WOL) form within 60 calendar days prior to approved claims being paid. The WOL ensures that the non-contracted provider does not balance bill Zing Health's members for any other amounts except for Medicare plan cost-sharing amounts (where applicable).

If the non-contracted provider's bill is less than the Original Medicare amount, Zing Health is only required to pay the billed amount. Non-contracted providers are subject to federally-imposed penalties if they accept more than the Original Medicare amounts.

Referrals to Non-Contracted Providers

If a Zing Health contracted provider refers a member to a non-contracted provider for a service that is covered by Zing Health, then Zing Health is required to process that claim as if the service was rendered in-network. This is recognized by CMS as "plan directed care" and the member cannot be penalized based on a network provider not following Zing Health's rules and referring to an out-of-network provider. The member is financially liable only for the applicable plan-defined cost-sharing for that service. Contracted providers are expected to coordinate care or work with Zing Health prior to referring a member to a non-contracted provider to ensure, to the extent possible, that members are receiving medically necessary services covered by Zing Health.

Services Covered Out of Network

Zing Health covers the following services if a member obtains these services from a provider or supplier that does not contract with Zing Health:

- Ambulance services dispatched through 911;
- Emergency or urgently needed services (as defined by CMS);
- Maintenance and post-stabilization care services (as defined by CMS);
- Medically necessary dialysis from any qualified provider selected by a member when the member is temporarily out of Zing Health's service area;
- Services that were initially denied by Zing Health and found on appeal to be services the member was entitled to have furnished or paid for by Zing Health; and
- Specialty care required outside of Zing Health's network.

Claim Development of Non-clean Non-Contracted Provider Claims

Zing Health will pay or deny all non-clean claims from non-contracted providers within 60 calendar days of the date of receipt. If Zing Health fails to process (pay or deny) the claim received from a non-contracted provider within the 60-day period, then the claim is treated as a denial and appeals rights will be communicated pursuant to below.

Balance Billing

Zing Health's members are responsible for paying contracted providers only the plan-allowed cost-sharing for covered services. Contracted providers are prohibited from balance billing Zing Health members for covered services. Zing Health, not its vmembers, is obligated to pay for covered services. Additionally, if a member inadvertently paid any contracted provider's balance billing invoice, then Zing Health will refund the balance billing amount to the member and required the contracted provider to submit a claim for the services to Zing Health. All Zing Health coverage rules apply to the adjudication of the claim.

Non-contracted Medicare Participating Providers

If a non-contracted provider is a Medicare participating provider, then Zing Health must pay the non-contracting, participating provider the difference between the member's cost-sharing and the lessor or the original Medicare limiting charge ar the provider's billed charges, which is the maximum amount that original Medicare requires Zing Health to reimburse a non-contracted provider. The member only pays plan-allowed cost-sharing. The non-contracted, Medicare-participating provider accepts the Zing Health (Medicare approved amount) as full payment.

Non-contracted non-Medicare Participating Providers

A non-contracted provider, non-Medicare participating provider accepts Medicare insurance but has not agreed to take assignment in all cases. This means that the non-contracted, non-Medicare participating Provider will accept Zing Health's payment but may also charge up to 15% more than the Medicare approved amount for the cost of the Member's services. Some states may restrict the limiting charge when a Member sees a non-Medicare participating provider.

Opt-out Providers

Opt-out providers are those that do not accept Medicare at all and have signed an agreement to be excluded from the Medicare program. This means they can charge whatever they want for services but must follow certain rules to do so.

Neither Zing Health nor Medicare will pay for care members receive from an opt-out provider (except in emergencies). Members are responsible for the entire cost of their care. The opt-out provider must provide the Zing Health member with a private contract describing their charges and confirming that the member is responsible for the full cost of their care and that neither Zing Health nor Medicare will reimburse the member. Opt-out providers will not bill Zing Health or Medicare for services the member receives.

Claim Denial, Notification and Appeal Rights

For all non-contracted provider claims denied in full (100%), Zing Health notifies the non-contracted provider of the specific reason for the denial and provides a description of the appeals process. The description of the appeals process may be included on the remittance advice, in a notice or a similar documents. The notice indicates the non-contracted provider:

- has the right to request a reconsideration of the plan's denial of payment.
- must submit a Waiver of Liability (WOL) form (available through the direct link provided on the notice) holding the member harmless regardless of the outcome of the appeal.
- has 60 calendar days from the remittance notification date to request a reconsideration.
- should include documentation, such as a copy of the original claim or remittance notification showing the denial and must include any clinical records and other documentation that support the provider's argument for reimbursement.
- should return the request for reconsideration to Zing Health following the instructions provided on where to send the request.

If the non-contracted provider submits an appeal but does not return a fully executed WOL within the 60 calendar days, the appeal will be dismissed. See Appendix 3 of this manual for a sample of the WOL form.

Capitation

Zing Health prepares capitation reimbursement for providers contracted to receive per member per month (pmpm) payment once a month. Capitated providers will receive their capitation reimbursement on or about the 15th day of each month. A detailed explanation of the capitation calculation will be transmitted to the provider.

If you have any questions or concerns about your capitation, please contact Provider Services at (866) 946-4458.

Encounter Data

As required by Zing Health and applicable law, providers shall submit complete encounter data to Zing Health on a daily basis or no less frequently than on a monthly basis on or before the last day of each month, or such lesser time period as may be required by Zing Health or applicable law, for encounters occurring in the immediately preceding month.

Providers shall submit encounter data in accordance with this manual or as otherwise required by Zing Health or state or federal laws or regulations, and shall certify the accuracy, completeness and truthfulness of such encounter data in such form as required by this manual.

Providers acknowledge and agree that in the event a provider fails to comply with such requirements, (I) Zing Health may withhold any and all payments due by Zing Health to provider until such time as Zing Health receives the current and complete encounter data that it requested; and (ii) such failure may be deemed a material breach of the agreement, as determined by Zing Health in Zing Health's sole discretion. Encounter data shall be submitted on a CMS-1500 or in an electronic format defined by Zing Health.

Provider's Role

Encounter data and claims submitted by providers and facilities are the sources of data for the risk adjustment model. It is important for providers and facilities to understand the key role they play in this process. Each PCP's office also shall designate an encounter data coordinator to ensure that encounter data is complete and submitted to Zing Health. Providers and facilities should:

- Submit encounter data or claims to Zing Health for every date of service with a member.
- Use the most recent ICD-10 codes as defined by HIPAA for coding and reporting; e.g. CPT, DRG, ICD, HCPCS, revenue codes, and modifiers.
- Report to Zing Health ALL diagnosis codes that are generated as a result of a face-to-face visit.
- Always code accurately to the highest level of specificity for all conditions at the time of a visit. Always use the 3rd, 4th and 5th digit where applicable as this will impact the risk score.
- Document and code all conditions that affect the member's care and treatment at the time of the visit.
- Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).
- Remember to document all services rendered.

Risk Adjustment

CMS is required by law to adjust payments to Medicare Advantage (MA) organizations based on the health status of Medicare members. Risk adjustment is used to align payments made to Zing Health by CMS based on the health status and demographic characteristics for a member. CMS requires Zing Health to submit procedure and diagnosis data including physician, inpatient, and outpatient facility encounters, Therefore, Providers are required to submit accurate and complete procedure and diagnosis information to Zing Health.

Medicare Advantage members are classified into diagnostic cost groups, using the Hierarchical Condition Category (HCC) payment model which applies the diagnosis codes reported by the physician to determine the risk-adjustment factor (RAF) for each member. The cost groups identify those Members with chronic conditions, such as diabetes or congestive heart failure, which are often the most expensive to treat.

Health Services Department

The Clinical Risk Management, Health Services department, and Information Technology department at Zing Health works closely with Providers to support accurate documentation of conditions used for risk scores, quality initiatives, case management and disease management. The departments review and analyze data internally. In addition, Zing Health will assist offices in ensuring that all CMS guidelines are followed as they relate to Medicare Risk. For questions, further information or assistance with Medicare Risk, call Clinical Risk Management at (312) 205-7948, ext. 205.

Provider Network Roles & Coordination

Primary Care Physicians (PCP)

PCPs are responsible for coordinating and managing the healthcare of their assigned members in accordance with the applicable Zing Health Medicare plan, this manual, Zing Health policies and procedures, and the provider agreement. Primary Care Services are generally provided by PCPs to all their patients and coordinate all other covered services, including specialist services.

A participating provider practicing is a general or family provider, internist, advanced registered nurse provider, physician assistant, or other specialty furnishing primary care and patient management services to a member. The PCP must have admitting privileges at a hospital or a formal referral agreement with a provider possessing admitting privileges, and the PCP agrees to provide primary health care services to individuals 24 hours per day, seven days per week.

It is the provider's responsibility to provide appropriate and adequate medical care to Zing Health's members, and no action of Zing Health or any entity on the plan's behalf, in any way, absolves, relieves, or lessens the provider's responsibility and duty to provide appropriate and adequate medical care to all patients under the provider's care. Zing Health agrees that regardless of the coverage limitations of the plan, the provider may freely communicate with members regarding available treatment options and that nothing in this manual shall be construed to limit or prohibit open clinical dialogue between the provider and the member.

Zing Health will monitor the PCP's actions to ensure he/she complies with Zing Health's policies and provider contract including, but not limited to, the following:

- Maintaining continuity of the member's health care;
- Exercising primary responsibilities for arranging and coordinating the delivery of medically-necessary health care services to members;
- Making referrals for specialty care and other medically necessary services, both in and out of network, if such services are not available within Zing Health's network;
- Maintaining a current medical record for the member, including documentation of all PCP and specialty care services, including periodic preventive and well-care services, and providing appropriate and timely reminders to members when services are due;
- Discussing Advance Medical Directives with all members as appropriate. See Advance Directives later in this section;
- Providing primary and preventative care, recommending or arranging for all necessary preventive health care. Documenting all care rendered in a complete and accurate medical record that meets the specifications delineated in Section 10 of this provider manual;
- Screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems;
- Arranging and referring members when clinically appropriate to behavioral health providers;
- Providing periodic physical examinations as outlined in the Preventive Health Guidelines;
- Providing routine injections and immunizations;
- Providing or arranging 24-hours a day, seven days a week access to medical care. For

additional information, see Section 6: Access Standards;
- Arranging and/or providing necessary inpatient medical care at participating hospitals; and
- Providing health education and information.

It is the responsibility of all PCPs to manage the care of their Zing Health members and to direct the members to specialty care services when necessary.

Primary Care Panel

Every month, PCP receives a monthly member eligibility list of members who have selected him or her. It is advisable to verify eligibility at, or before, the time of service using the online eligibility tools at myzinghealth.com or by calling Customer Service.

Even with this verification, there are times when CMS retroactively terminates eligibility for certain members. In these circumstances, Zing Health may recoup any amounts paid to providers for these patients.

PCP shall contact all new members assigned to their panel to ask if they need any assistance or to schedule an office visit for continued medical care.

Each PCP's office also shall designate a referral coordinator to ensure that referrals are complete and submitted to Zing Health and the member.

Closing Provider Panel

Zing Health contracted providers must the following process prior to either closing its panel to new patients and/or transferring Zing Health members:
- Submit the request in writing at least 60 days (or the timeframe established in the Zing Health contract) prior to the effective date of closing the panel.
- Keep the panel open for Zing Health members who were provided services before the closing of the panel.
- Notify Zing Health when reopening the panel and provide the effective date.

The request may be submitted via Zing Health's secure provider portal or by contacting your Provider Relations representative.

Member Reassignment to New PCP Panel

PCPs are allowed to request that Zing Health reassign a current patient to another network PCP based on the member's specific needs or behavior that requires special handling. Examples of appropriate reasons for reassignment include:
- Frequent missed appointments;
- Member fraud;
- Abuse, threatening or hostile actions by the member;
- Special medical needs;
- Breakdown of the PCP-patient relationship;
- Member is accessing primary care from a provider other than the assigned PCP; or

- A previously approved reassignment that was inadvertently overwritten through the auto-assignment process.

Directing Members to Appropriate Place of Care

If the Member calls the PCP's office prior to going to a hospital emergency room (ER), and if the situation can be managed in the PCP's office, it is the PCP's responsibility to comply with Zing Health's access standards. A referral or an authorization is not required for a member to be seen in the ER. It is also the responsibility of the PCP, per his or her contract with Zing Health, to have after-hours call service seven days a week, 24 hours per day. Use of Zing Health 24-Hour Nurse Advice Line is not an acceptable alternative to after-hours call service.

Giving members easily understood instructions during regular office visits may help avoid after-office-hours calls or ER visits. Reviewing home treatment for common conditions may give members or their caregivers more confidence in managing these conditions when they arise. Providing written instructions to be used as a reference may also be helpful.

Adult Member Preventive Care and Immunization Schedules

In its efforts to improve member awareness of nationally established screening guidelines for common disease states, Zing Health supports the preventive care screening guidelines for adults recommended by the United States Preventive Services Task Force (USPSTF). Providers may access the USPSTF periodicity screening in its entirety at http://www.ahrq.gov/clinic/pocketgd.htm. Providers are encouraged to familiarize themselves with these guidelines and to incorporate them into their daily practice. As with all guidelines, they are intended to assist in the prevention of disease and in the identification and treatment of asymptomatic patients with pre-clinical disease. This guideline is referenced with the understanding that a physician's screening and treatment plan for any particular patient will be individualized. Zing Health will review the above referenced guidelines annually. It is important to note that alternative screening guidelines exist, and physicians and Members are encouraged to refer to other authoritative sources as their individual clinical situation may require.

Plan-Directed Care

Plan-directed care is when a Member reasonably believes that s/he was instructed to obtain by a Zing Health representative or a Zing Health contracted provider. Except for items or services that are clearly never covered, or in cases when a Member is individually notified in writing of an adverse coverage decision in advance, CMS requires plans to pay for all plan-directed care, and members are never liable for more than their in-network cost sharing. Accordingly, Zing Health network providers must obtain authorization from Zing Health prior to referring members to out-of-network providers. If a network provider refers a member to a non-contracted provider without obtaining prior authorization, Zing Health may hold the referring provider liable for the cost of the member's out-of-network care.

Referral

Under specified Zing Health Medicare plans, a referral or prior authorization is required for the Member to obtain care from a specialist, ancillary providers, facilities and other healthcare providers. These wproviders are listed in the Zing Health provider directory, which was made available to the PCP at the time of contracting with Zing Health. To obtain a copy of the provider directory, contact the appropriate provider representative. See the Zing Health Contact Information section in this Manual for phone numbers. A PCP Referral may be completed on a paper form (See Appendix 3 of this manual) or electronically based on your office's capability. Zing Health has also provided a sample referral form in the Provider section of the Zing Health website at myzinghealth.com.

For plans requiring a referral, a referral issued by anyone other than a network physician is not valid and will result in a denied claim. No referral is required for any care listed under the direct access provision of this manual. Except in the case of emergency services, urgently needed services, as otherwise permitted under this manual or applicable state or federal law, upon the prior written approval of Zing Health's Medical Director or his/her designee, or as otherwise permitted under the applicable Zing Health Medicare plan, all referrals shall be made in accordance with this manual. Any laboratory services provided to members in providers' office shall not be reimbursable covered services, unless otherwise expressly provided in the agreement.

PCP shall use his/her best efforts to provide members with any necessary referral or obtain any required pre-authorization from Zing Health while the member is in the PCP's office.

Pre-authorization requirements and procedures are located in Section 14 of this manual.

Termination of a Member

A provider may not seek or request to terminate his or her relationship with a member or transfer a member to another provider for care based on the member's medical condition, amount or type of care required or the cost of covered services required by the member.

Reasonable efforts should always be made to establish a satisfactory provider and member relationship in accordance with practice standards. If a provider desires to terminate his or her relationship with a member, the provider must complete a PCP Request for Transfer of Member form and attach documentation of the member's non-compliance with treatment or uncooperative behavior that is impairing the ability to care for and treat the member effectively. The form should be faxed or emailed to Zing Health's Provider Relations department. The request for transfer of member form is at myzinghealth.com. Select the appropriate state from the drop-down menu and click on *Forms* under Medicare in the Providers drop-down menu.

Once the form has been submitted, the provider will continue to provide medical care for the member until the provider receives Zing Health's written notification confirming that the member has been successfully transferred to another provider.

Participating Providers

Except in the case of emergency services, urgently needed services, as otherwise permitted under this manual, applicable state or federal law, upon the prior written approval of Zing Health's Medical Director or his/her designee, or the applicable Zing Health Medicare Plan, all referrals shall be made to participating providers in accordance with this manual.

Specialist Physicians

Specialist physicians are the providers responsible for coordinating the provision of specialist services with the member's PCP. The specialist and the PCP work together to provide medical care for the member. The specialist should only provide medical services to members with a referral from the member's PCP. Specialists are NOT allowed to issue referrals for a member for any service.

Specialty care providers provide care to members referred to him/her by the member's PCP. The specialty care provider must coordinate care through the PCP and must obtain necessary prior authorization for hospital admissions or specified diagnostic testing procedures. Refer to Section 14 for a complete listing of procedures requiring prior authorization from Zing Health's UM department.

Referrals for Specialist Services

Except for emergency services, urgently needed services, as otherwise permitted under Zing Health policies or applicable state or federal law or upon the prior written approval of Zing Health's Medical Director or his/her designee, specialist shall not provide specialist services to members unless the member or member's PCP furnishes specialist with a referral from the member's PCP or another network provider.

Specialty providers must review the referral section of the PCP referral form to determine which services have been referred. The specialist must contact the PCP/network provider if he or she intends to provide services in excess of those initially requested. In these cases, the PCP/network provider must generate a second referral to cover the additional services.

It is important that the specialty care provider communicates regularly with the PCP/network provider regarding any specialty treatment. Specialists are to report the results of their services to the member's PCP just as they would for any of their patients. The specialist should copy all test results in a written report to the PCP. The PCP is to maintain referrals and specialist reports in the member's central medical record and take steps to ensure that any required follow-up care or referrals are provided.

Follow-Up Care

Specialist shall coordinate the provision of specialist services with the member's PCP in a prompt and efficient manner and, except in the case of an Emergency Medical Condition, shall not provide any follow-up or additional specialist services to members other than the covered services indicated on the applicable referral form provided to specialist by Zing Health or the PCP. Within 10 business days of providing specialist services to a member, specialist shall promptly furnish the member's PCP with a written report regarding the member's medical condition in such form and detail reasonably acceptable to the member's PCP and Zing Health. Specialist shall at all times promptly and openly communicate with the member's PCP regarding the member's medical condition, including, without limitation obtaining the appropriate pre-authorization should a member require additional or follow-up covered services. Except in the case of emergency services, urgently needed services, as otherwise permitted under the applicable Zing Health Medicare plan, applicable law or upon the prior written approval of Zing Health's Medical Director or his/her designee, specialist shall refer members back to the member's PCP in the event specialist determines the member requires the services of another specialist physician.

Hospitalist Program

Under the Zing Health's Hospitalist Program (the "program"), PCPs acknowledge and agree that hospitalist physicians provide primary care services which Providers are otherwise obligated to provide under the Agreement on behalf of Members assigned to or who select the provider as their primary care provider ("PCP members") who present to or are admitted as inpatients to a facility, including, but not limited to:

- evaluation of PCP members presenting to the facility's emergency room;
- conducting daily facility rounds of PCP members;
- coordinating care of PCP members and ensuring timely provision of covered diagnostic tests and procedures;
- communicating regularly with provider, PCP members and the PCP members' families, as appropriate;
- and overseeing and coordinating discharge planning of PCP members with the provider, Zing Health and the facility.

Providers who elect to participate in the program shall assign responsibility of PCP members to hospitalist physicians when PCP members present to the emergency department or are inpatients of a facility. Except in cases where a provider elects not to participate in the program, providers shall not document any progress notes in the PCP member's record or issue any orders on behalf of a PCP member who is an inpatient in a facility; provided, however, that PCPs shall continue to perform all other primary care services with respect to PCP members, including, but not limited to:

- resuming responsibility for all care, including follow-up care, of a PCP member immediately upon the PCP member's discharge from the facility;
- communicating all medical information/history to the hospitalist physician or other physician attending to a PCP member which is necessary to the PCP member's care and treatment in the Facility; and
- performing any and all other requirements as requested by Zing Health in connection with the PCP's participation in the program.
- Facilities acknowledge and agree that if a PCP member presents to the emergency department, the facility shall notify PCP member's PCP and/or hospitalist physician participating in the Zing Health Hospitalist Program.

Advance Directives

Members have the right to control decisions relating to their medical care, including the decision to have withheld or taken away the medical or surgical means or procedures to prolong their life. Advance directives may differ among states.

Each member (age 18 years or older and of sound mind) should receive information about advance directives. These directives allow the member to designate another person to make medical decisions on the member's behalf should the member become incapacitated.

Information about advance directives should be made available in provider offices and discussed with the members.

Providers and facilities shall document whether or not a member executed an advance directive. If the advance directive has been executed, it must be placed in a prominent part of the member's medical record. Providers and facilities shall certify if he/she/it cannot implement an advance directive on grounds of conscience as permitted by state law. Please contact your provider service representative for additional information on advance directives, if necessary.

Providers and facilities must comply with state and federal regulations for advance directives and shall document whether or not a member executed an advance directive in a prominent part of the member's medical record. Providers and facilities shall certify if he/she/it cannot implement an advance directive on grounds of conscience as permitted by state law. Advance directives include living will, health care Power of Attorney, and mental health treatment declaration preferences.

Provider's Responsibilities

Provider's responsibilities include the following:

- Discussing the member's wishes regarding advance directives for care and treatment at the first visit, as well as during routine office visits when appropriate;
- Documenting in the member's medical record the discussion and whether the member has executed an advance directive;
- Providing the member with information about advance directives, if asked;
- Filing the advance directive in the Member's record upon receipt from the member;
- Not discriminating against a member because he or she has or has not executed an advance directive; and,
- Communicating to the member if the provider has any conscientious objections to the advance directive as indicated above.

Facility Care

Providers must have admitting privileges to a Zing Health's network hospital or facility for all patient groups for whom they are providing care to. A provider may arrange for another participating provider to provide inpatient coverage.

Consultations

Providers and facilities shall participate in all programs instituted by Zing Health to consult with its providers and facilities to assure compliance with federal, state and accreditation organization standards.

Regulation and Accreditation

Providers and facilities shall comply with the applicable provisions of this manual and cooperate with and participate in all internal and external Quality Improvement Organization (QIO) review processes; independent quality review and improvement organizations' activities; utilization management, including patient assessment and disease management programs, credentialing and re-credentialing, and quality assurance and management and other administrative activities, including site medical audit reviews and medical record charting and compliance audits, financial audits and post audit interviews by Zing Health personnel or internal or external financial or other audit programs; performance improvement projects; HEDIS® reporting requirements and performance measurement and reporting activities, in each case consistent with applicable law as may be established or implemented by Zing Health or its designees from time to time, including but not limited to Zing Health nurse reviewers.

Providers and facilities shall comply with all final determinations rendered by Zing Health in connection with any of the foregoing. Providers and facilities shall cooperate and participate in all programs required for Zing Health's compliance with the Medicare programs and all other federal or state laws and regulations or the rules and regulations of accreditation organizations. Providers and facilities shall grant Zing Health, CMS, OIR, any accreditation organization, any QIO, and any other agency with governing, or accreditation, authority over Zing Health access to its facilities and records on reasonable notice during ordinary business hours for the purpose of conducting any reviews, audits or site visits in connection with the foregoing in accordance with the Agreement and this manual.

To the extent permitted by applicable law, providers and facilities shall provide such medical and other records or data required by Zing Health or any regulatory agencies governing Zing Health in connection with the foregoing within 10 days of written notice to the provider or facility without cost to Zing Health or such sooner time as requested by Zing Health in order for Zing Health to comply with applicable law and regulations. For appeals and prior authorizations, these records should be submitted with the request.

Provision of Services

Provider shall provide services to members in accordance with the terms and conditions of the agreement, and shall be available, either through provider, a covering physician, or answering service 24 hours a day, seven days a week, to provide services to members.

Provider shall maintain an appropriately staffed office to provide services to members. Provider, a covering physician, admitting panel physician, or a hospitalist physician, as applicable, shall maintain appropriate staff privileges with at least one participating facility.

Facility shall provide services to members in accordance with the terms and conditions of the agreement and shall be available 24 hours a day, seven days a week, to provide facility services to members. Facility shall maintain an appropriately staffed facility to provide facility services to members.

Access Standards

All providers must adhere to standards of timeliness for appointments and in-office waiting times. These standards take into consideration the immediacy of the member's needs.

Zing Health will monitor providers against the standards below to help members obtain needed health services within acceptable appointment times, in-office waiting times, and after-hours standards. Providers not in compliance with these standards will be required to implement corrective actions.

Members can access care according to the following standards:

- Emergency care: immediately
- Urgently needed care: less than 24 hours
- Services that are not emergency or urgently needed but do require medical attention: within one week
- Routine, preventive care and specialist referrals: within 30 days

Type of Appointment	Access Standard
PCP - Emergent	Immediately
PCP - Urgent care	≤ 24 hours
PCP - Non-urgent sick care	≤ 1 week
PCP - Routine care	≤ 30 days
Specialist	≤ 30 days
Behavioral health	See Section 14 of this provider manual

In-office wait times shall not exceed 15 minutes.

PCPs must provide or arrange for coverage of services, consultation, or approval for referrals 24 hours per day, seven days per week. To ensure access and availability, PCPs must provide one of the following:

- A 24-hour answering service that connects the member to someone who can render a clinical decision or reach the PCP
- Answering system with option to page the physician for a return call within a maximum of 30 minutes
- A nurse who will answer after-hours calls and provide the member with access to the PCP or on-call physician within a maximum of 30 minutes

During site visits to the provider's office for credentialing, re-credentialing, medical record documentation reviews and other provider representative office visits, Zing Health will verify access standards by reviewing the providers' schedules of available appointments. Provider Services will review and intervene, when appropriate, based on member complaints about access to care and service and Provider's adherence to these standards.

Authorizing Treatment for Members

Providers and facilities must contact Zing Health via telephone or fax to obtain a pre-authorization prior to scheduling a member for any medical service listed as indicated in the member's benefit plan, which may be amended by Zing Health on an annual basis. Providers and facilities shall use the Pre-Authorization Request Form found in Appendix 3 of this manual or on the Zing Health Provider Portal.

Zing Health may require the submission of clinical information to support a pre-authorization request. If the service is pre-authorized by Zing Health, provider shall place the pre-authorizatin number issued by Zing Health on the referral form given to the member in order to ensure the provider or facility to which the member is referred is properly paid. Facilities shall notify Zing Health of an admission occurring subsequent to the provision of emergency services.

Providers must contact Zing Health to obtain pre-authorization for the provider types or services listed on the tables linked under Appendix 3 of this manual.

Clinical information will be required to substantiate request. The Zing Health authorization list is subject to change. To contact Zing Health for an authorization:
Phone: (844) 946-4458
Fax request form to: (844) 946-4458

For rehabilitation therapies, issue a referral to the correct participating facility for one initial visit and assessment. After the initial visit, the authorization will be processed by the rehabilitation therapies network, working with Zing Health. Emergency services do not require pre-authorization.

The Pre-Authorization Request form and the following forms are on the Zing Health website at myzinghealth.com:

- Transition of Care/Continuity of Care form
- Care Management/Disease Management Referral form
- Prior Authorization list

Zing Health provides the opportunity for the provider to discuss a decision with the Medical Director, to ask questions about UM issue, or to seek information about the UM process and the authorization of care by calling the Health Services department at 844-946-4458.

Timeliness of Authorizations

Zing Health shall use its best efforts to provide requested pre-authorizations as quickly as the member's health condition requires but no later than CMS required timeframes. Routine pre-authorization requests will be completed within 14 business days of Zing Health's receipt of the medical request unless an extension is required or within 72 hours of the standard request for Part B drugs. Extensions are not permitted on requests for Part B drugs. Zing Health's review determination will be communicated verbally or in writing to the requesting provider and member at the time the decision is made. All denial determinations will be made by a Zing Health Medical Director. Any denial determination will be sent to the provider or facility by fax or mail and to the member by mail.

Urgent pre-authorization requests will be processed within 72 hours of Zing Health's receipt of the medical request unless an extension is required or within 24 hours of the request for Part B drugs. Extensions are not permitted on requests for Part B drugs. The review determination, approval or denial, will be verbally communicated to the requesting provider or facility and member at the time the decision is rendered followed by written notice within three calendar days.

Reportable Diseases

State of Illinois

The Illinois Department of Public Health requires that all health practitioners report suspected or confirmed cases of certain infectious diseases. These cases must be reported electronically through the Illinois' National Electronic Disease Surveillance System (I-NEDSS). If I-NEDSS cannot be utilized a provider should contact the local health department or the Illinois Department of Public Health Division of Infectious Disease at (217) 785-7165. Certain diseases must be reported immediately by telephone, those diseases are:

- Any suspected bioterrorist threats
- Any unusual case or cluster of cases that may indicate a public health hazard
- Anthrax
- Botulism, foodborne
- Brucellosis, if bioterrorism suspected
- Diphtheria
- Influenza A, variant
- Plague
- Poliomyelitis
- Q Fever if bioterrorism suspected
- Severe Acute Respiratory Syndrome (SARS)
- Smallpox
- Tularemia, if bioterrorism suspected

For the State of Illinois, mandated reporters, such as health care providers, hospitals and laboratories, must report suspected or confirmed cases of the following diseases to the local health department within the number of days or hours indicated in parentheses. For reporting purposes, “immediate” means within three hours. For your reference, the Illinois Communicable Disease Guide can be accessed at this link: https://dph.illinois.gov/topics-services/diseases-and-conditions/infectious-diseases/infectious-disease-reporting.html.

State of Indiana

In Indiana, communicable disease laws require individuals, schools, healthcare settings, emergency personnel and other stakeholders to comply with disease intervention activities (control measures) to help stop the spread of disease. The Indiana Department of Health publishes a list of reportable communicable diseases and their control measures on its website: https://www.in.gov/health/erc/infectious-disease-epidemiology/infectious-disease-epidemiology/communicable-disease-reporting/.

Indiana uses two different systems to capture reporting and tracking of potential health concerns:

- Indiana’s National Electronic Disease Surveillance System (I-NEDSS); and
- The Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE) system to monitor hospital emergency room and urgent care visit data for early detection of possible outbreaks or health concerns.

Physicians, hospitals, nurse practitioners and other clinical practitioners are required to report all communicable diseases to their local health department; however, HIV/AIDS reporting should be submitted to the Indiana State Department of Health. HIV reporting forms can be found at www.in.gov/isdh/programs/hivstd/caserpt_forms/index.htm.

All communicable diseases are to be reported using the Confidential Report (Form 43823) available using this link: https://www.in.gov/health/idepd/communicable-disease-reporting/.

You can locate the full list of addresses and phone/fax numbers of local health departments at this link: www.in.gov/isdh/links/local_dep/index.htm. You can also use the general contact numbers below.

	HIV	STD	All other CDs	24-Hour Emergency
Phone	317-233-7406	317-233-7426	317-234-7125	317-233-1325

State of Michigan

Public Health Law (Code) of the State of Michigan requires reporting of many diseases to protect the public against contagious, and possibly life threatening diseases. The duty to report extends to health care professionals (physicians, dentists, registered nurses, emergency medical personnel and emergency services personnel), long term and temporary care facilities (nursing homes, adult foster care, home health agencies, respite or hospice centers), laboratories and other industry stakeholders. You can find the most recent list of reportable diseases by pathogen at this link: https://www.michigan.gov/documents/mdch/Reportable_Diseases_Michigan_by_Pathogen_478489_7.pdf

Diseases may be reported by phone, fax or data entry into the online Michigan Disease Surveillance System, in person or by letter if no other means are available. Reports should be submitted to the local health department:

Location	Phone Number	Fax Number
Coldwater	517-279-9561 ext. 105	517-278-2923
Hillsdale	517-437-7395 ext. 307	517-437-0166
Three Rivers	269-273-2161 ext. 241	269-273-2452

Cultural Competency in Communications on Treatment Options

Provider and facility shall provide information in a culturally-competent manner to all members and consider and take measures to accommodate, at the provider's or facility's sole cost and expense, members' limited English proficiency, reading skills, diverse cultural and ethnic backgrounds and physical or mental disabilities, including but not limited to hearing and vision impairments, when discussing a member's treatment options, including the option of no treatment.

Direct Access and Cost-Sharing

Providers and facilities shall, as mandated by state or federal law, the applicable Zing Health Medicare contract and this manual:

- allow members direct access to certain specialist physicians.
- not inhibit members' self-referral for certain services, including mammography screening and influenza vaccinations; and
- not impose cost-sharing on any member for influenza or pneumococcal vaccines.
- to the extent permitted by applicable law and this manual, members may self-refer without a PCP referral for:
    - mental and behavioral health services,
    - gynecologists/obstetricians;
    - chiropractors;
    - podiatrists for routine care;
    - optometrists if such services are covered for the member;
    - dermatologists, for up to five visits a year for routine care, in addition to any other services for which applicable law allows direct access.

Member Responsibility

Providers and facilities acknowledge and agree that Zing Health shall have no financial or other liability with respect to a member's failure to pay providers or facilities amounts due the provider or facility for copayment, co-insurance, or deductible as required under the member's Zing Health Medicare plan or for non-covered services. Providers and facilities may not refuse to provide services to an eligible member solely because the member fails to pay the applicable popayment at the time services are rendered.

Continuity of Care

Upon termination of this agreement, provider and facility shall arrange and provide continuation of care for members utilizing provider or facility or for whom treatment is otherwise active with provider and facility until the earlier of:

- the completion of treatment of a condition for which the member is receiving care on the effective date of termination of the agreement;
- the date on which the transfer of such member's care to another provider or facility can be arranged by Zing Health; provided, however, that provider and facility shall not be required to provide such continuation of coverage and care to any member longer than six months after the effective date of termination of the agreement.

Notwithstanding the foregoing, Zing Health shall allow provider and facility and provider and facility shall continue to provide care after the termination of the agreement for any member who initiated a course of prenatal care, regardless of the trimester in which care was initiated, until completion of postpartum care, as applicable. Notwithstanding anything herein to the contrary, if termination of the agreement occurs during the insolvency of Zing Health or in the event that the contract between CMS and Zing Health terminates or is not renewed for any reason whatsoever, provider and facility shall provide provider services or facility services, as applicable, to members for the duration of the later of:

- the period for which the member made payment under his/her Zing Health Medicare plan or for the duration of the contract period for which CMS payments were made to Zing Health on behalf of the member, as applicable;
- the duration of any stay by the member in an inpatient facility on the date of insolvency or, in the event that the contract between CMS and Zing Health expires or terminates, until the member is discharged from such facility; or
- such longer period of time as may be necessary for Zing Health to remain in compliance with federal and state laws and regulations, including, without limitation, Medicare and Medicaid.

During any such continuation of care period, Zing Health shall compensate provider and facility in accordance with the agreement for care rendered to any member and provider and facility shall be bound by the terms of the agreement and this manual.

Notice of Certain Actions or Events

Provider and facility shall immediately notify Zing Health, in writing, of any of the following actions taken by or against provider and facility:

- the surrendering, revocation or suspension of any license, certification, registration or permit pertaining to the services provided under the agreement;
- any action to restrict, suspend or revoke provider's or facility's right to participate in the Medicare or Medicaid program or provider's clinical or staff privileges at any hospital or health care facility or if provider or facility voluntarily relinquishes any of the foregoing;
- any claim alleging provider's or facility's medical malpractice, Notice of Intent to Initiate Litigation filed against provider, or facility or summons or complaint alleging provider's or facility's medical malpractice;
- any lapse or material change in provider's or facility's professional liability insurance as required under the agreement and this manual;

- any indictment or conviction of provider or facility for a felony;
- any disciplinary action, fine, penalty, or other sanction imposed upon provider or facility by any other local, state or federal regulatory agency or notice of the commencement of a proceeding that could lead to any of the foregoing; or
- any other situation, including provider's or facility's bankruptcy or insolvency or loss of any board certification, which might materially adversely affect provider's or facility's ability to perform provider's or facility's duties and obligations under the agreement, or which would materially change the representations made in provider's or facility's credentialing or recredentialing application. Such notice shall be sent to:

  Zing Health
  Provider Services
  225 West Washington Street
  Suite 450
  Chicago, IL 60606

Non-Covered Services

In the event Zing Health determines certain facility services to be more appropriately provided in a setting other than facility, as determined solely by Zing Health, Facility shall not deem such facility services to be non-covered services so as to allow facility to directly bill a member for such services, unless otherwise determined to be non-covered services by Zing Health in Zing Health's sole discretion. Facility acknowledges and agrees that certain services that are not payable by Zing Health may in fact be covered services. For purposes of the agreement, a "non-covered service" is a service deemed not to be a covered service under the relevant Zing Health Medicare Plan by Zing Health in Zing Health's sole discretion.

Care Management

As required by applicable law, Zing Health has procedures to identify, assess and establish care plans for persons with complex or serious medical conditions. With respect to individuals with complex or serious medical conditions, facilities and providers shall assist Zing Health in:

- identifying such individuals;
- diagnosing, assessing and monitoring such individuals; and
- establishing and implementing treatment plans for such individuals that
  - are appropriate for their condition;
  - are time-specific;
  - are updated periodically;
  - ensure adequate coordination of care among providers; and
  - include an adequate number of direct access visits to providers consistent with the treatment plan.

Section 7: Facility Emergency Services

In the case of an emergency medical condition, facilities are not required to obtain pre-authorization from Zing Health prior to providing emergency services to members; provided, however, that upon admitting a member into facility, facility shall immediately notify Zing Health of such admission and obtain the required pre-authorization in accordance with this manual. Except for emergency services, coverage of all services rendered to members by the facility is subject to Zing Health's sole determination of whether such service is a covered service under the applicable Zing Health Medicare plan.

In the event it is determined that an emergency medical condition does not exist with respect to a member who presented to the facility, facility must comply with all pre-authorization requirements as set forth in this manual prior to providing any non-emergency services to a member. A facility's failure to so obtain all required pre-authorizations for non-emergency services may, in Zing Health's sole discretion, result in Zing Health's denial of payment for such services as set forth in the agreement. Facility shall comply with this manual and the agreement in providing non-emergency services to members. Facilities acknowledge and agree that Zing Health has the right to review the admission of any member for an emergency medical condition for appropriateness of continued stay in accordance with the manual.

Follow-Up Care

Facility shall coordinate the provision of facility services with the member's primary care physician in a prompt and efficient manner and, except in the case of an emergency medical condition, as otherwise permitted under the manual or applicable state or federal law or upon the prior written approval of Zing Health's Medical Director or his/her designee(s), shall not provide any follow-up or additional facility services to members other than the covered services in accordance with the pre-authorization for such services. Facilities shall at all times promptly and openly communicate with the member's PCP regarding the member's medical condition, including, without limitation obtaining the appropriate pre-authorization should a member require additional or follow-up covered services.

Covering Physicians

Provider shall make necessary and appropriate arrangements with covering physicians to ensure the availability of provider services to members 24 hours per day, seven days per week, including arrangements to ensure coverage of members after hours or when the provider is otherwise unavailable. Provider shall ensure that covering physicians are providers, except as otherwise consented to by Zing Health in writing or in the case of a locum tenens provider. provider shall ensure that covering physicians adhere to the terms of the agreement and this manual and that covering physicians seek required pre-authorization from Zing Health or refer the member back to the member's PCP, as required by this manual, except for emergency services or urgently needed services or as otherwise permitted under the applicable Zing Health Medicare plan.

Except for gospitalist physicians, with respect to capitated services (as defined in the agreement), provider shall be solely liable to covering physicians for the amount and manner in which covering physicians are reimbursed or otherwise compensated for services rendered to members on provider's behalf. Providers acknowledge and agree that Zing Health shall not have any financial obligation whatsoever to covering physicians with respect to capitated services. Providers shall ensure that covering physicians do not, under any circumstances, bill members for covered services other than for applicable copayments, deductibles, and co-insurance. Providers hereby agree to indemnify and hold harmless members, AHCA, OIR, and CMS against charges for covered services rendered by covering physicians. All charges incurred for services rendered pursuant to a pre-authorization or referral made by a covering physician, other than a referral back to the member's PCP, shall, unless such pre-authorization or referral was approved by Zing Health in advance and in writing or as otherwise permitted under the applicable Zing Health Medicare plan, be borne by providers who shall be liable for all costs, fees, charges and expenses associated with such services.

Section 8: Quality Improvement Program

Zing Health is committed to improving patient outcomes by addressing social determinants of health and connecting with doctors to effectively coordinate care. Zing Health supports the unique needs of our members by moving beyond the hospital and clinics and focusing on the community. The plan leverages technology and data analytics to address social determinants of health and ensure alignment with providers to optimize the impact of healthcare. This approach allows the plan to facilitate value-based care and ultimately improve health outcomes while lowering the cost of health care.

Zing Health is committed to ensuring that those who choose our plan receive the highest quality of health services possible. At Zing Health, we use a coordinated care approach that is designed to ensure all members receive the unique services and support they need to achieve and maintain the best health outcomes possible. Zing Health's chronic care and case management programs address a variety of needs from chronic conditions such as asthma, diabetes, and hypertension to more complex health challenges and issues that go beyond physical health needs. Zing Health is committed to the delivery of effective quality health services that focus on the member's quality of life, prevention, safety, and health outcomes.

Quality Improvement Goals, Objectives, and Scope

Goals

Goals are established to support the purpose of the QI Program. All goals are reviewed annually and revised as necessary and appropriate. The QI Program goals are primarily identified through:

- Ongoing activities that monitor health care and service delivery, including assessing the appropriateness and quality of care
- Issues identified by tracking and trending health outcomes data over time
- Issues/outcomes identified in the previous year's QI Program evaluation
- A demographic and morbidity analysis of member age, gender, and most frequently diagnosed disease categories (both inpatient and outpatient)
- Internal process reviews, including review by physicians of the processes followed in provision of health services
- Accreditation, regulatory, and contractual standards

Objectives

- Facilitate the integration, support, and commitment to continuous quality improvement throughout the plan for sustained improvements.
- Encourage and evaluate compliance to policies and procedures that standardize approaches to the completion of activities that reflect key program components.
- Develop and maintain a process through which clinical and operational performance is continuously measured, opportunities for improvement are identified, meaningful interventions are initiated as appropriate, and the results of actions taken to improve outcomes are evaluated.
- Select and conduct meaningful and relevant (high-volume, high-risk, and/or problem prone)

population-specific quality improvement initiatives that achieve, through ongoing measurement and intervention, sustained and significant improvement in aspects of clinical care and non-clinical services.

- Ensure availability of and access to qualified providers, adhering to established standards for credentialing and re-credentialing of network practitioners and providers.
- Adopt and disseminate Clinical Practice Guidelines (CPGs) that are evidence-based, widely accepted, meeting nationally recognized standards, thereby promoting the delivery of safe clinical practice. CPGs are distributed to network providers and to members, upon request.
- Promote a supportive environment that assists associates and providers to render culturally competent medical and behavioral health care and/or services.
- Encourage member and provider participation in plan programs and services through the dissemination of information that considers language and readability levels.
- Maintain established safeguards for member privacy, including confidentiality of member health information in accordance with the Health Insurance Portability and Accountability Act of 1996 and the regulations adopted there under (collectively, HIPAA).
- Engage members in managing, maintaining, and/or improving their current health status through preventive/wellness activities and other chronic care improvement initiatives.
- Maintain a process for members, providers, various healthcare associations and community agencies and stakeholders to receive updates, and offer suggestions, concerns, and recommendations regarding the QI Program and activities.
- Ensure all aspects of the QI Program and activities comply with contractual, state, and federal standards.
- Collaborate with internal stakeholders to ensure the Plan's information system supports the collection, tracking, analysis, reporting and historical record keeping of relevant QI Program related data.
- Establish standards and conduct continuous, comprehensive oversight of all delegated entities.
- Establish standards and objectives for serving members with complex health needs. These standards include but are not limited to the Model of Care (MOC) for our D-SNP and C-SNP members, the CCIP for our diabetic members, and multiple policies related to our care management and utilization management processes.
- Use Healthcare Effectiveness Data and Information Set ("HEDIS®"), Health Outcomes Survey (HOS), and Consumer Assessment of Health Plans Study ("CAHPS") results that evidence improvements in Plan initiatives to improve member experience, satisfaction, health, and wellness.
- Conduct population specific quality improvement ("QI") initiatives that achieve, through ongoing measurement and intervention, sustained and significant improvement in aspects of clinical care and non-clinical services.
- Stress health outcomes and monitor member's risk status to identify and implement actions that improve health outcomes.
- Identify critical metrics, routinely monitor performance in them, and implement improvement actions when necessary, as summarized in an Annual Quality Improvement Work Plan.
- Ensure appropriate remedial action/corrective action and quality improvement when determined that inappropriate or substandard services have been furnished or covered services have not been provided.
- Use systematic data collection of performance and member results and provide interpretation of results to Network providers to institute needed changes.
- Identify, communicate, operationalize, and provide administrative and educational support for supplemental compensation structures (pay for performance, etc.) that promote organization goals.

Scope

The QI Program is comprehensive, systematic, and continuous. It applies to all member demographic groups, care settings, and types of services offered. The QI Program addresses the quality of clinical care and non-clinical aspects of service. Key areas of focus include objective and systematic measures that include but are not limited to:

- Utilization management
- Chronic care and case management coordination/continuity of care
- Practitioner availability and accessibility
- Preventive, behavioral, and clinical health
- Quality of care and service utilization
- Credentialing
- Patient Safety
- Appeals/grievances/complaints

Structure and Accountability

Authority and Structure

The plan's Board of Directors (the Board) is the governing body of the plan and is responsible for the oversight and strategic direction of the QI Program. The Board has ultimate accountability and responsibility for the quality of healthcare and other services rendered to plan members. In association with oversight responsibilities, the QI Program description is reviewed by, and subject to the approval of, the Board. Zing Health's QI Committee Structure including composition and function are described in Appendix 2.

The Board has delegated the following responsibilities:

- Oversight of the day-to-day operations of the QI Program to the Chief Medical Officer (CMO).
- Authority to approve specific QI activities (including monitoring and evaluating outcomes and the effectiveness of the QI Program and initiating corrective action plans when appropriate) to the Quality Improvement Committee (QIC).

Quality Improvement Committee

Zing Health is building an enterprise-wide culture of quality. The Quality Improvement Committee (QIC) is central to this, being responsible for developing a continuous quality improvement approach, training all staff in basic quality improvement principles, methodologies, and tools, and monitoring performance on key quality metrics. Members of the Health Outcomes team are also available to assist and facilitate Zing departments with quality improvement activities.

Meetings: QIC meetings take place on a quarterly basis and are scheduled using remote meeting technology. A summary from the QIC meeting is presented to the Board.

Participants: Representatives from every department at Zing participate in the QIC. When appropriate, vendors and/or physicians or other representatives from partner provider organizations or other key stakeholders may be invited to attend QIC quarterly meetings. The Chief Medical Officer (CMO) is the chairperson of the QIC. Employees from the Health Outcomes team are responsible for the logistics of the QIC (scheduling meetings, developing agendas, creating and disseminating minutes, etc.)

Metrics: Zing incorporates metrics across the plan to drive, measure, and monitor performance as well as to select and implement improvement projects when necessary to address performance gaps. Not all metrics at Zing funnel through the QIC. For example, metrics related to Zing objectives and key results (OKR's) are not monitored at the QIC, though metrics monitored at the QIC are aligned with Zing OKRs. Metrics monitored at the QIC are those that relate to member experience, patient safety, and healthcare quality. Metrics are tracked at a frequency that is appropriate for the individual metric, but no less than twice yearly. Some metrics may be tracked in a Zing department as frequently as every week but will only be reviewed at the QIC on a quarterly basis. The Quality Improvement Work Plan Dashboard houses the reported metrics.

Improvement Methodology

Rather than confine Zing to one improvement methodology, Zing Health has drawn from multiple quality improvement models and methodologies to create the Zing CQI pathway. The Zing CQI pathway provides leaders with a guideline and common quality improvement tools to complete their CQI projects. For example, one may use the "Five Whys" or the "Fishbone" to perform Root Cause Analysis and the "Affinity Diagram" and "PDSA" to Plan the Test of Change.

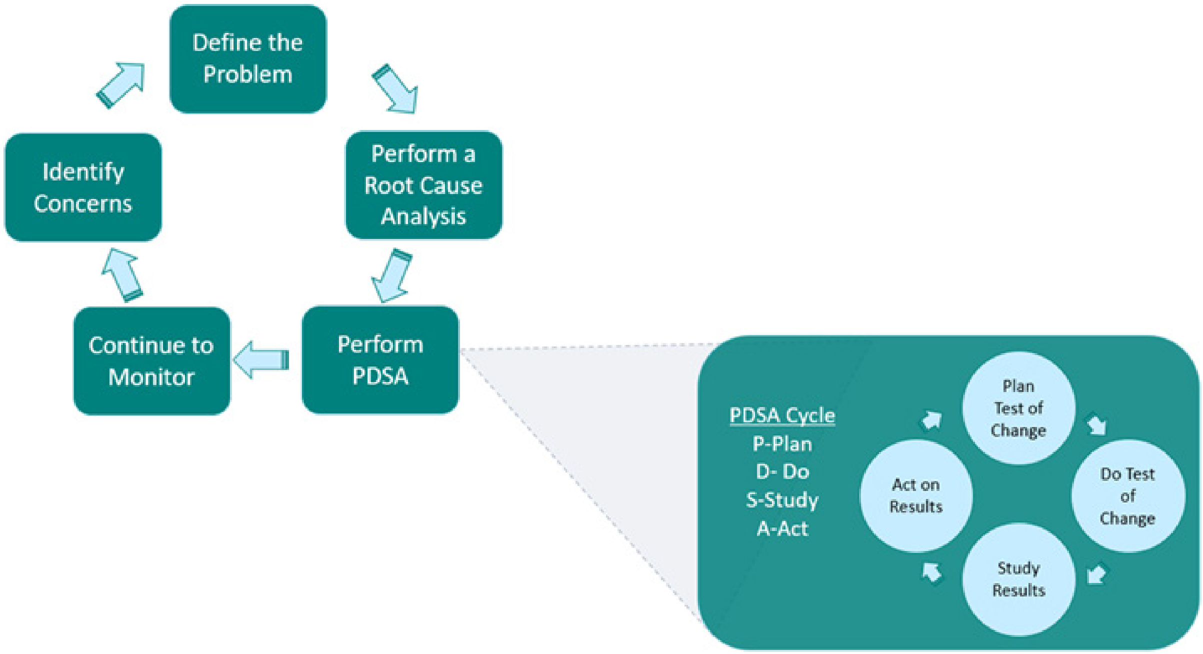


Figure 1. Zing Health CQI Pathway

Annual Evaluation

At least annually, the QI Department facilitates a formal evaluation of the effectiveness of the QI Program through the analysis of performance on established metrics, including progress made following the implementation of selected improvement actions. Additionally, all critical metrics identified in the Annual Quality Improvement Work Plan are reviewed including definitions, targets, and continued relevance to the program, and any new metrics are identified.

Analyses and QI Program reports are communicated to the QIC. Summary reports are presented to the Board. The QI Program Description and initiative/campaign outcomes are available to providers and members upon request. The QIC disseminates information regarding QI Program activities and outcomes internally to staff via departmental representatives to the QIC.

The Annual Evaluation addresses the overall effectiveness of the QI Program and includes the following:

- Summary description of QI Program activities over the year, including CCIP and MOC.
- Major accomplishments.
- Analysis and evaluation of outcomes including an assessment of the extent to which QI activities were completed and goals met.
- Identification and analysis of issues or barriers to achieving goals and limitations of the data or measure.
- Assessment of the adequacy of resources, training, scope and content of the QI Program
- Recommended interventions/actions to demonstrate improvements for the upcoming year.

The QI Annual Evaluations are developed with participation and support from all applicable parties and, are presented to the QIC and the Board for final approval and recommendations.

Quality of Care Concerns

Quality of care concerns may be reported by both internal and external customers such as members, providers, and advocates. All reported concerns are investigated and monitored for trends. In the event a quality of care concern is reported, Zing Health requires full cooperation with the investigation of the concern. This includes the timely submission of requested written response, medical records, and the implementation of corrective action plans, as applicable. Providers have the right to respond to reported concerns.

For more information regarding quality of care concerns, please contact the Quality Improvement department at **312-761-2609**.

In the event that Zing Health identifies health care services rendered to a Zing Health member by a participating provider that are outside the recognized treatment patterns of the organized medical community and quality management and/or credentialing standards, the provider may be subject to sanctions. The National Provider Data Bank (NPDB) may be notified of all negative outcomes if formal sanctioning proceedings are implemented and if the outcome is to last 30 days or more.

In addition to the above, Zing Health will exclude and/or penalize a provider under any of the following conditions:

- The plan has received recommendations to take such actions because of an investigation conducted by the Office of the Inspector General or other appropriate state and/or federal agency;
- The provider fails to cooperate with an investigation of alleged fraud and abuse; and
- The provider has been listed on the Medicare/Medicaid Sanctions Report.
- Possible sanctions for deviation from accepted quality management and/or credentialing standards and program integrity violations include:
- Limiting a PCP's panel, but not necessarily limiting the freezing of new member assignments;
- Termination of participating provider status;
- Withholds from future claims payments of amounts that are improperly paid or reasonable estimates of such amounts; and
- Suspension of claims activity.

The foregoing is reported to the Quality Improvement Committee for the determination on the type of actions required, including reporting to the appropriate regulatory agencies.

Chronic Condition Improvement Program

The Chronic Condition Improvement Program (CCIP) is a CMS-mandated program, designed to reduce ED visits, hospitalizations, morbidity and mortality associated with poorly controlled diabetes mellitus for our Medicare members diagnosed with diabetes.

The CCIP provides members and primary care providers with educational and other resources to achieve program goals. Zing Health identifies eligible members who may benefit from participation in the CCIP through its various data sources, such as medical records, medical and pharmacy and laboratory claims, HEDIS® reports, or health risk assessments. Zing Health analyzes these and other data sources to identify members who meet defined eligibility criteria.

The Zing Health Diabetes CCIP was implemented on November 1, 2021, for a three year period. Zing Health will evaluate the program for outcomes. Zing Health will follow CMS guidelines related to implementation of the CCIP after 2024.

Program Overview

The CCIP program will conduct the following activities:

- Identify members with the chronic condition of diabetes mellitus (DM) and the subset who inject insulin more than once daily.
- Support the relationship between physician and patient in
  - Initiating continuous glucose monitoring (CGM) for insulin-dependent diabetics who do not use CGM currently
  - Accessing CGM data
  - Using CGM data to make medication, dietary, and exercise adjustments
- Identify red flag barriers to care that prohibit patients from adhering to prescribed medication regimens and self-management practices and determine structural interventions to reduce barriers.
- Reduce cost of treatment for DM using evidence-based practices and member empowerment.

Members who participate in the CCIP will be monitored using quality improvement metrics specific to the CCIP. As with other metrics, root causes are identified for performance gaps and improvement actions that address those root causes are selected and implemented. Future monitoring reveals the impact of implemented improvement actions and the need for additional root cause analysis as appropriate. Root cause analysis results, selected improvement actions, and results of ongoing monitoring are shared with the QIC for feedback and approval, with subsequent review by the Board.

Targeted Chronic Condition(s)

Zing Health has selected diabetes as its targeted condition for the CCIP initiative. This is based on the prevalence of diabetes in the population, the health outcome and quality of life impacts of poorly controlled diabetes, and the historically poor outcomes with diabetes within this patient population. Higher rates of functional disability, muscle loss, premature death, and co-existing illness (e.g., hypertension, coronary heart disease, and stroke) are found in older adults with diabetes. They are also at increased risk of polypharmacy, cognitive loss, urinary incontinence, falls, chronic pain, and depression which can impact other health outcomes and quality of life.

In order to improve outcomes for our diabetics with concomitant improvements in quality of life, and, in keeping with the Zing Health mission of empowering members to achieve their health care goals, and Zing Health values of innovation, personal touch, and technology, this CCIP will focus on increasing and improving the use of CGM to drive better diabetes management.

Special Needs Plans Model of Care

Zing Health plans include Chronic Condition Special Needs Plans (C-SNPs) and Dual Special Needs Plans (D-SNPs). To be eligible for the C-SNP a member must have diabetes, heart failure, coronary artery disease, End Stage Renal Disease for the Indiana and Michigan markets, or any combination of these conditions. To be eligible for the D-SNP, a member must have both Medicare and Medicaid.

CMS requires that all Special Needs Plans (SNPs) have a Model of Care (MOC). for Zing Health SNPs, appropriate Models of Care are developed which include metrics that measure multiple aspects of the care received, including but not limited to plan adequacy, clinical care (quality, utilization, and preventive services), pharmacy, patient experience, case management, appeals and grievances, and timeliness of review. Metrics are collected, tracked, and monitored by the appropriate Zing Health department and included in their quarterly review for the QIC. Identification of root causes, selection and implementation of improvement actions, and subsequent monitoring is managed as already described in this document.

HEDIS®, CAHPS, HOS, Stars

Healthcare Effectiveness Data Information Set (HEDIS®)

HEDIS® is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA). CMS utilizes HEDIS® rates to evaluate the effectiveness of a managed care plan’s ability to demonstrate improvement in preventive health outreach to its members.

As Federal and State governments move toward a health care industry that is driven by quality, HEDIS® rates are becoming more and more important, not only to the health plan, but to the individual provider.

HEDIS® Rate Calculations

HEDIS® rates are calculated in two ways: administrative data or hybrid data. Administrative data consists of claim and encounter data submitted to the health plan. Measures typically calculated using administrative data include:

- Breast cancer screening (routine mammography)
- Use of disease modifying anti-rheumatic drugs for members with rheumatoid arthritis
- Osteoporosis management in women who had a fracture
- Access to PCP services,
- Utilization of acute and mental health services

Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of medical records to extract data regarding services rendered but not reported to the health plan through claims or encounter data. Accurate and timely claims and encounter data and submission using appropriate CPT II, ICD-10 and HCPCS codes can reduce the necessity of medical record review. Examples of HEDIS® measures requiring medical record review are:

- Diabetes care (Hemoglobin A1c, blood pressure control, and retinal eye exams)
- Colorectal cancer screening (colonoscopy, sigmoidoscopy, FOBT, CT colonography, or FIT-DNA test)
- Medication review post-hospitalization
- Controlling blood pressure (blood pressure results <140/90 for members with high blood pressure)

Who Conducts Medical Record Review (MRR) for HEDIS®?

Zing may contract with an independent national Medical Record Review (MRR) vendor to conduct the HEDIS® MRR on its behalf. Medical record review audits for HEDIS® can occur anytime throughout the year but are usually conducted March through May each year. Prompt cooperation with the MRR process is needed and appreciated.

As a reminder, sharing of Protected Health Information (PHI) that is used or disclosed for purposes of treatment, payment, or health care operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member. The MRR vendor will sign a HIPAA compliant business associate agreement with Zing that allows it to collect PHI on our behalf.

How can providers Improve their HEDIS® Scores?

- Understand the specifications established for each HEDIS® measure.
- Submit claims and encounter data for each and every service rendered. All providers must bill (or submit encounter data) for services delivered, regardless of their contract status with Zing. Claims and encounter data is the most efficient way to report HEDIS®.
- Submit claims and encounter data correctly, accurately, and on time. If services rendered are not filed or billed accurately, they cannot be captured and included in the scoring calculation. Accurate and timely submission of claims and encounter data will reduce the number of medical record reviews required for HEDIS® rate calculation.
- Ensure chart documentation reflects all services provided. Keep accurate chart/medical record documentation of each member service, including documentation of conversations with the member or their representative whether by phone, text, email, or portal.
- Submit claims and encounter data using CPT codes related to HEDIS® measures such as diabetes, eye exam, and blood pressure. Use CPT II codes when available and appropriate.
- If you have any questions, comments, or concerns related to the annual HEDIS® project or the medical record reviews, please contact the Quality Improvement Department.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

The CAHPS survey is a member satisfaction survey that is included as a part of the Star rating system. It is a standardized survey administered annually to members by CMS's certified survey vendor. The survey provides information on the experiences of members with Medicare Advantage Organization (MAO) and practitioner services and gives a general indication of how well practitioners and the MAO is meeting the members' expectations. Member responses to the CAHPS survey are used in various aspects of the Star rating program including monitoring of practitioner access and availability. CAHPS survey material that may reflect on the service of providers includes:

- Whether the member received an annual flu vaccine
- Whether members perceive they are getting needed care, tests, or treatment needed including specialist appointments and prescriptions
- Whether the member's personal doctor's office followed up to give the member test results
- Appointment availability and appointment wait times
- Whether the member's personal doctor is informed and up to date on care received from specialist

Health Outcomes Survey

The Health Outcomes Survey (HOS) is a patient-reported outcomes measure used in the Medicare Star rating program. The goal of the Medicare HOS is to gather data to help target quality improvement.

The HOS assesses practitioners' and a Medicare Advantage Organization's (MAO) ability to maintain or improve the physical and mental health of the MAO's Medicare members over time. Members report their perceptions of their physical and mental status as being better, the same or worse than expected.

To improve HOS scores, look for opportunities to discuss and address concerns regarding the following:

- **Mobility:** Address potential needs for assistive devices
- Physical Activity: Discuss starting, increasing, or maintaining members' level of physical activity
- **Mental health**: Address social interactions and other behavioral health needs that may require further follow-up.
- Fall risk prevention: Educate members on fall risk prevention by addressing any needs for assistive devices and reviewing any potential high-risk medications that could increase their fall risk
- Bladder control: Assess the need for bladder control education and potential treatment

Star Ratings

CMS uses a five-star quality rating system to measure Medicare beneficiaries' experience with their health plans and the health care system. This rating system applies to Medicare Advantage plans that cover both health services and prescription drugs (MA-PD).

The ratings are posted on the CMS consumer website, www.medicare.gov, to help beneficiaries when choosing an MA and MA-PD plan offered in their area. The Star Rating program is designed to promote improvement in quality and recognize providers for demonstrating an increase in performance measures over a defined period of time.

CMS's Stars Rating Program is based on measures in nine different domains.

Part C

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

Part D

6. Drug Plan Customer Service
7. Member Complaints and Changes in the Drug Plan's Performance
8. Member Experience with the Drug Plan
9. Drug Safety and Accuracy of Drug Pricing

How Can Providers Help to Improve Star Ratings?

- Encourage patients to obtain preventive screenings annually or as recommended including but not limited to:
  - Breast and/or colon cancer screening
  - Annual flu vaccine
- Monitor and assess the health and well-being of patients with known chronic conditions including but not limited to:
  - Diabetes care
    - Retinal eye exam
    - Kidney disease monitoring (via urine protein testing or ACE/ARB therapy)
    - Routine monitoring to ensure HbA1c control (<9)
    - Ensure members remain adherent to their diabetic medications and receive necessary statin therapy
  - Controlling high blood pressure (<140/90)
    - Ensure members remain adherent to their hypertension medications (RAS antagonists)
  - Statin therapy for patients with cardiovascular disease
    - Ensure members remain adherent with their cholesterol medications (statin therapy)
  - Provide timely osteoporosis management for women who have had a fracture through one of the following (within six months of the fracture):
    - Bone mineral density test
    - Medication therapy to treat osteoporosis
- Talk with your patients and document interventions related to
  - Improving or maintaining their mental and physical health
  - Issues with bladder control
  - Fall prevention
- Create office practices to identify noncompliant patients at the time of their appointment

The goal of Star Ratings is to improve the quality of care and general health status for Medicare beneficiaries and support the efforts of CMS to improve the level of accountability for the care provided by physicians, hospitals, and other Providers. Zing Health supports these goals, and the organization strives for the highest rating of 5 stars in all domains. The Quality Improvement Committee receives Star rating results annually.

Credentialing Overview

Zing Health is an applicant for accreditation by the Accreditation Association for Ambulatory Health Care (AAAHC) and complies with state and federal credentialing requirements that require that Providers be credentialed. All physicians, Facilities, ambulatory surgery centers (ASCs), skilled nursing facilities (SNFs) and allied health professionals must be credentialed by Zing Health or an approved delegate of Zing Health.

Initial credentialing applications will be given to providers and facilities by the Provider Services representative. Primary source verification will be completed for information reported on the application. In addition, Zing Health will query the National Practitioner Data Bank, state departments of health and such other databases and sources to obtain information about the applicant.

Providers and facilities shall and shall cause provider staff or facility vendors, as applicable, to comply with Zing Health's credentialing criteria by providing a completed credentialing application and such additional information concerning providers and/or provider staff, facility vendors, or facility's:

- licensure;
- education;
- experience;
- training;
- references;
- malpractice liability insurance;
- hospital staff status,
- hospital clinical privileges and
- hospital staff reappointment dates;
- eligibility for payment under Medicare,
- exclusion from or voluntarily opted out of the Medicare program;
- disciplinary status; and
- any other information as Zing Health may request from time to time, which is on Zing Health's
- forms and is executed and dated and includes an attestation by the facility, provider, provider staff, or facility vendors, as applicable, of the correctness and completeness of the application and other information submitted in support of the application.

Facilities and Providers authorize Zing Health to query the National Practitioner Databank and any and all other authorities with information regarding provider or facility. providers and facilities shall cause provider staff and facility vendors, as applicable, to notify Zing Health within 10 days of any change in the information provided to Zing Health in their credentialing or recredentialing application or any information submitted in support of such applications. All credentialing and recredentialing applications shall be incorporated into the agreement.

Zing Health's Credentialing Committee renders decisions on whether to grant or deny credentialing to the provider or facility. Credentialing is generally granted for a three-year period; however, the committee may choose to grant credentialing for a lesser time frame.

A credentials file is maintained on each provider and facility. Zing Health maintains credentialing files and supporting electronic systems in a confidential manner and uses all information collected solely for the purpose of credentialing. Credentialing decisions are made by Zing Health's Credentialing Committee and applicants are notified of committee decisions by letter. The Credentialing Committee meeting minutes and discussions are confidential.

Credentialing Requirements

The following information is considered by Zing Health's Credentialing Committee, in addition to any and all requirements of AAAHC and applicable federal and state law. Zing Health's verification time limits for:

- licensure, DEA license or CDS certificate, Board certification and professional liability claims is 180 calendar days from submission of a clean application;
- work history is 365 calendar days from submission of a clean application; and
- education is prior to the credentialing decision being made.

Consideration of the following information may change from time to time based on applicable accreditation and regulatory requirements.

- Physicians (MD, DO, DC, DMD/DDS, DPM, etc.)
    - Updates CAQH
    - Complete/signed credentialing application/roster template
    - Valid, current medical license
    - Status of hospital privileges
    - Valid, current DEA license (or Controlled Dangerous Substances (CDS) certificate)
    - Current Medicare Payor ID and minimum of "Standard" Medicare rating with no suspensions or exclusions in the last five years
    - Board certification
    - Proof of education and training
    - Work history
    - Professional Malpractice Insurance ($1,000,000/$3,000,000 required).
    - Professional malpractice history
- Other providers (ARNP, PA, etc.)
    - Complete/signed credentialing application/roster template
    - Valid, current state license
    - Board Certificate (if applicable)
    - Valid, current DEA license (if applicable; or CDS certificate)
    - Current Medicare Payor ID and minimum of "Standard" Medicare rating with no suspensions or exclusions in the last five (5) years, if appropriate
    - Proof of education and training
    - Work history
    - Professional malpractice insurance ($1,000,000/$3,000,000 required)
    - Professional malpractice history
- Facilities (facilities: acute care, rehabilitation)
    - Complete/signed facility credentialing application
    - Copy of current state license, pharmacy license, DEA registration (if applicable) and Medicare Payor ID

    - Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) Accreditation or a State Site Survey filed with AHCA
    - Professional malpractice insurance ($1M/$3M required) or self-funded or Sovereign Immunity
    - Minimum of "Standard" Medicare rating with no suspensions or exclusions in the last five years
    - State license (active and free of current sanctions, suspensions or revocations)
- Facilities (ambulatory surgery centers, invasive diagnostic, etc.)
    - Complete/signed facility credentialing application
    - Copy of current state license and Medicare Payor ID
    - Accreditation or application for accreditation with AHCA or OSHA site survey
    - Professional malpractice insurance ($1M/$3M required)
    - Minimum of "Standard" Medicare rating (with no suspensions or exclusions in the last five years)
    - State license (active and free of current sanctions, suspensions or revocations)
- Facilities (other)
    - Complete/signed facility credentialing application
    - Copy of current state license and Medicare Payor ID
    - If applicable, accreditation or application for accreditation with AHCA or OSHA site survey
    - Professional malpractice insurance
    - Minimum of "Standard" Medicare rating with no suspensions or exclusions in the last five years
    - State license (active and free of current sanctions, suspensions or revocations)

Recredentialing

Providers and Facilities shall cause provider staff and facility vendors, as applicable, to cooperate with Zing Health's recredentialing process that is conducted at least every three years or when their credentialing cycle expires, as required pursuant to applicable accreditation and regulatory requirements, Zing Health may conduct site visits in connection with its credentialing and recredentialing processes, and provider and facility shall fully cooperate with all Zing Health personnel conducting such visits.

Zing Health will utilize the Universal Credentialing Data Source developed by the Council for Affordable Quality Healthcare (CAQH) for the recredentialing purposes. The recredentialing application is available six months prior to the recredentialing due date. Completed recredentialing packets are due within 30 days. Providers are responsible for ensuring their information is up-to-date in the CAQH system, if the information is not current upon recredentialing Zing Health will notify the provider of the missing documentation via a second request notice, accompanied by a new attestation. If the information is not returned within thirty (30) days of the second notice, Zing Health will send a third and final notice from Zing Health's chief medical officer to the provider or facility. The final notice will be sent via certified, registered mail and will state the date of expiry of the current credentialing application and serves as a notice of termination from the network on the final day of that month.

Provider and facility must complete the credentialing process and be approved by the credentialing committee. All facilities and providers will be notified by letter of the Credentialing Committee's decision.

Recredentialing applicants will be contacted by Zing Health's Credentialing department if the application is not complete. Every effort should be made to provide missing information promptly. Zing Health will consider complaints and grievances regarding the provider or facility at the time of recredentialing.

Providers and facilities that fail to complete the recredentialing process or are denied recredentialing status on Zing Health's network of providers and are no longer eligible to see members. However, if the provider or facility acts within 30 days of expiry of the current credentialing application by providing the full recredentialing application, attestation and requests reinstatement, Zing Health may reinstate the Provider or Facility without having to perform a full, initial credentialing process.

Keeping Credentialing Files Current

Time sensitive documents must be kept current in the CAQH system. This includes, but is not limited to, medical license, DEA license, other state licenses, board certificates and proof of malpractice insurance.

Mid Cycle Reviews

Zing Health will routinely monitor Providers and Facilities to ensure any changes in licensure status, sanctions or other adverse actions are reviewed by the Credentialing Committee. Providers or facilities whose license was suspended or revoked are subject to termination by Zing Health.

All providers and facilities are required to report any adverse action taken by governmental, licensing, judicial or other agencies. Such actions must be reported directly to Provider Services or the provider and facility may mail documentation of adverse action to:

Zing Health
Provider Services
225 West Washington Street, Suite 450
Chicago, IL 60606

Corrective Action

In the event a provider, facility, provider staff, or a facility vendor fails to comply with Zing Health's Credentialing Criteria or with any corrective action plan imposed on them as a result of Zing Health's credentialing or recredentialing activities, they shall be subject to any and all enforcement actions imposed on such individual or entity by Zing Health in accordance with this manual as otherwise permitted under the agreement or pursuant to all applicable laws and regulations. Neither provider, facility, facility vendors nor provider staff shall provide any services to any member and Zing Health shall have no obligation to pay for any services provided to a member prior to the effective date or the approval of their credentialing application by Zing Health. In the event the provider, facility, facility vendor, or provider staff provides any service to any member prior to the effective date or the approval of their credentialing application by Zing Health, Zing Health shall have the right to automatically deny their credentialing application and terminate the agreement.

Board Certification

Zing Health requires contracted physicians to be board certified or board eligible. However, exceptions will be evaluated on a case-by-case basis. Considerations include, but are not limited to, physicians serving communities in which a special requirement is identified and where the population is otherwise underserved by Zing Health contracted physicians.

Credentialing Dual Specialties

Physicians who are board certified and participate as a PCP and who practice in subspecialties, such as Cardiology, Gastroenterology, Pulmonary Medicine, Hematology/Oncology, Allergy/Immunology, etc., must elect to participate as either a PCP or a specialist.

Specialists who are board certified and are practicing in sub-specialties must be credentialed for each sub-specialty. At the time of initial credentialing, all training and experience will be reviewed and considered by Zing Health's Credentials Committee. If sub-specialties are added after initial credentialing, Credentialing application must be completed and documentation submitted to support the sub-specialty being added.

General Medical Records Guidelines

Providers and facilities shall prepare and maintain complete medical records for members under their care in a manner that complies with the following:

- Applicable federal and state laws, licensing, accreditation, and reimbursement rules and regulations applicable to Zing Health, and accepted medical practice.
- In accordance with federal and state law and the agreement, each provider and facility must protect the confidentiality of members' patient records. To fulfill this obligation, providers and facilities must designate a person in charge of the provider's or facility's medical records, and such person's responsibilities include, but are not limited to, the following duties in accordance with federal and state law and the agreement:
    - Maintaining the confidentiality, security, and physical safety of patient records,
    - Retrieving member records in a timely manner upon the request of an authorized party, and
    - Supervising the collection, processing, maintenance, storage, retrieval, and distribution of records.

Providers and facilities are required to maintain legible, current, organized, and detailed medical records for every patient in accordance with national standards. The records must demonstrate all aspects of patient care, including any ancillary services. Documentation in the medical record shall be timely and permit effective and confidential patient care and quality review.

Complete medical records include, but are not limited to:

- Medical charts
- Prescription files
- Hospital records
- Provider specialist reports
- Consultant and other health care professionals' findings
- Appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided to the member

The member record shall be signed by the provider of service. Zing Health may conduct HIPAA privacy and security audits to assure compliance as required by Zing Health.

Medicare laws require that medical records be retained for a minimum of 10 years from the end of contract with Zing Health or the period under applicable laws, rules, and regulations whichever is later.

Medical Records Requests

In accordance with the agreement and this manual, the medical records must be available for utilization review, risk management and peer review studies, customer service inquiries, grievance and appeals, and quality improvement initiatives.

Providers and hospitals must make medical records for all Zing Health's members available for review and copying including electronic copies for any regulatory agencies requests free of charge.

Providers and facilities must respond and submit requested medical records to Zing Health's Grievance and Appeals department promptly to enable Zing Health to comply with federal and state laws governing grievances and appeals. Only those records for the time period designated on the request should be sent. A copy of the request letter should be submitted with the copy of the record. The submission should include test results, office notes, Referrals, telephone logs and consultation reports, as applicable.

Medical records may also be requested for Quality Improvement initiatives or Risk Adjustment chart reviews. Records must be provided to Zing Health Quality Department or designated HEDIS® vendor when requested for these instances within 30 days of request.

If a member changes PCPs, medical records should be forwarded to the new PCP within 30 days of receipt of a signed request.

Medical Record Alteration or Falsification

Alteration or falsification of medical records is unethical conduct for any medical professional. Any incident relating to unethical behavior regarding medical record documentation is subject to the following process:

- All incidents of possible medical record falsification are reported to Zing Health's Peer Review Committee and the Special Investigation Unit (SIU).
- The Peer Review Committee reviews the records in question and allows thepProvider or facility to explain the circumstances.
- The Peer Review Committee makes the final decision regarding the allegations of unethical conduct and takes appropriate actions.
- Health professionals not subject to the peer review process (nurse, lab personnel, etc.) may be reported to the appropriate agency and/or governing body.

For additional information on the peer review process, see Section 12 in this manual.

Transfer of Medical Records upon Termination of the Agreement

Upon the effective date of termination of the agreement (and the expiration of any period of any continuing care obligation), or such earlier date as a member may select or be assigned to another provider or facility, regardless of whether the agreement then remains in effect, pursuant to a member's or Zing Health's request, provider shall copy all such member's medical records in provider's or facility's possession and forward such records, at no cost to Zing Health or to the member, to (i) such other provider or facility as designated by Zing Health; (ii) the member; and (iii) Zing Health, as requested by Zing Health or the member.

Member Consent

Where required by law, providers and facilities shall obtain specific written authorization from a member prior to releasing such member's medical records. Providers and facilities acknowledge and agree that the consent by a member in the applicable Zing Health Medicare plan enrollment form and/or providers' and/or facility's standard consent form is hereby deemed satisfactory member consent for the release of members' records, to the extent required by applicable law.

Member's Rights to Access Medical Record

Providers and facilities shall ensure timely access by members to review, amend and obtain a copy of their medical records upon request, to the extent required by applicable law.

Zing Health's Pharmacy department is open from 8:00 a.m. to 5:00 p.m., Monday through Friday.

Zing Health utilizes a Pharmacy Benefit Manager (PBM), to administer its prescription drug program. The Pharmacy Benefits Management organization is Elixir Solutions. You may reach them 24 hours a day at 855-476-6993.

Providers may request a replacement for any covered chemotherapy injectable drug administered to a member at the provider's office or facility. A provider may also request a drug for use in the home. A copy of these request forms is available in Appendix 3 of this manual.

Drug List (Formulary)

A formulary is a list of covered drugs selected by Zing Health in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Zing Health will generally cover the drugs listed in our formulary as long as the drug is being used for a medically accepted indication as defined by Medicare, the prescription is filled at a Zing Health network pharmacy, and other plan rules are followed.
Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization:** requires approval from Zing Health before the member can fill the prescription. If approval is not given, Zing Health may not cover the drug. Click here for the Part D Coverage Determination form.
- **Quantity Limits:** For certain drugs, Zing Health limits the amount of the drug that Zing Health will cover. This may be in addition to a standard one-month or three-month supply.
- **Step Therapy:** In some cases, Zing Health requires a trial of certain drugs for treating a medical condition before another drug for that condition will be covered. For example, if Drug A and Drug B treat the same medical condition, Zing Health may not cover Drug B unless Drug A is tried first. If Drug A does not work or is likely to cause an adverse effect, Zing Health will then cover Drug B.

If a drug is not included in this formulary, you can prescribe a similar drug that is on the formulary and covered or ask Zing Health to make a coverage decision for the requested drug.

You can find out which drugs have requirements or limits by looking in the formulary or by calling us. To obtain a copy of the formulary, visit Zing Health's website at myzinghealth.com. Select *Members*; choose *Benefit Plans*; select correct Medicare plan. Finally, select *Formulary*.

Coverage Determinations

Part D Coverage Decisions

A coverage decision is a decision we make about benefits and coverage or about the amount we will pay for prescription drugs. An initial coverage decision about Part D drugs is called a "coverage determination." The member, member's appointed representative, or prescriber can ask for a coverage determination.

Here are examples of coverage decisions:

- Asking us to cover a drug on our formulary and you believe any applicable coverage rules (e.g. prior authorization) for the drug have been met.
- Asking us to make an exception, including:
- Asking us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level and cannot be provided at a lower cost-sharing level.
- Asking us to waive a restriction on the plan's coverage for a drug. For example, if a drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier.
- Members can ask us to pay for a prescription drug that was already bought. This is a request for a coverage decision about payment.

Generally, Zing Health will only approve your request for an exception if the alternative drugs included on the plan's formulary, or additional utilization restrictions would not be as effective in treating the member's condition and/or would cause the member to have adverse effects. When an exception is requested, a prescriber's statement indicating such factors is required to support the exceptions request.

If Zing Health denies a coverage decision, the member, member's appointed representative, or prescriber can appeal our decision. See Prescription Drug (Part D) Appeals for Medicare Members in Section 13 for additional information.

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "expedited" deadlines. A standard coverage decision means we will give you an answer as quickly as the member's health condition requires, but no later than 72 hours after we receive the request or prescriber's supporting statement for exceptions. If the member's health requires a quick response, you must ask us to make an "expedited coverage decision." An expedited coverage decision means we will answer as quickly as the member's health condition requires, but no later than 24 hours after we receive the request or prescriber's supporting statement for exceptions.

Requests for coverage determinations can be made orally or in writing. While written requests will be accepted in any format, a coverage determination request form is available for use in Appendix 3 of this manual. To request a coverage determination:

Fax us: 877-503-72312 or

Call us: 866-250-2005 or

Visit our website:
myzinghealth.com or

Write us:
Zing Health
225 West Washington Street,
Suite 450
Chicago, IL 60606

Part B Coverage Decisions

A coverage decision is a decision we make about benefits and coverage or about the amount we will pay for Part B prescription drugs covered under a member's medical benefit.

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "expedited" deadlines. A standard coverage decision means we will give you an answer as quickly as the member's health condition requires, but no later than 72 hours after we receive the request or prescriber's supporting statement for exceptions. If your member's health requires a quick response, you must ask us to make an "expedited coverage decision." An expedited coverage decision means we will answer as quickly as the member's health condition requires, but no later than 24 hours after we receive the request or prescriber's supporting statement for exceptions.

Requests for coverage determinations can be made orally or in writing. While written requests will be accepted in any format, a coverage determination request form is available for use in the Forms section of this manual. To request a coverage determination:

Fax us: 877-503-72312 or

Visit our website:
myzinghealth.com or

Call us: 866-250-2005 or

Write us:
Zing Health
225 West Washington Street,
Suite 450
Chicago, IL 60606

Part B v. Part D Decisions

For a Part B drug v Part D drug (Blvd.) coverage decision at the Point of Sale (POS) where neither the member nor the prescriber have requested a coverage determination, Blvd. rules to determine coverage are followed. When applicable, Zing Health's Pharmacy Benefit Manager (Elixir utilizes pharmacy claims data and/or beneficiary eligibility flags (i.e. dialysis and transplant indicators) for adjudication. Effectuation of a bad decision may require details outside of that which is captured on a pharmacy claim or from beneficiary eligibility flags, necessitating the exchange of additional information.

Note: CMS-approved utilization management criteria (prior authorization, step therapy, quantity limits) still apply to drugs determined to be Part D eligible.

Section 12: Disciplinary Action

In addition to other rights and remedies available under the agreement, Zing Health may take disciplinary action against a provider or facility as a result of any adverse quality of care, utilization, licensure, credentialing and/or administrative issues. Potential issues may be identified through a number of sources including but not limited to: medical record reviews, complaint investigation, adverse and untoward incident monitoring, credentialing issues, quality improvement studies, and review and discussion of over and under-utilization that continues after an opportunity to correct such practices is not addressed by the provider or facility.

The following Zing Health governing bodies have the authority to recommend and implement disciplinary action against a provider or facility:

- The Clinical Quality Improvement Committee
- The Peer Review Committee
- The Risk Management Committee
- The Credentialing Committee
- The Quality Improvement Committee
- The Chief Operating Officer may institute immediate disciplinary action in response to a state or federal license suspension, an imminent threat of patient harm, license revocation or licensure sanctions.

Peer Review Determination and Actions

As required by applicable law and regulations and Accreditation Organization requirements, all Potential Quality of Care Issues (PQIs) relating to the care and services rendered by Zing Health providers or facilities are investigated through the peer review process.

Zing Health's Peer Review Committee evaluates the case and determines whether the issue is a Validated Quality of Care Issue (VQI) or not. Zing Health's Peer Review Committee recommends an appropriate course of action to address Validated Quality of Care Issues.

For any Potential Quality Issue (PQI), the determination may be as follows:

Points	Level of Exposure to Morbidity/Mortality
0	Standard of care met
5	Confirmed quality problem with minimal potential for adverse effect on member
10	Non-compliance with request for medical records
10	Non-compliance with request for response to Letter of Inquiry
15	Failure to meet minimum standards of Corrective Action Plan
10	Confirmed quality problem with the potential for significant adverse effect on member
20	Confirmed quality problem with significant adverse effect on member, Reversible morbidity
25	Confirmed quality problem with significant adverse effect on member, Non-reversible morbidity
30	Confirmed quality problem resulting in member's death

A provider or facility accumulating (i) 25 points in a six month time period, or (ii) 75 points within three years will be referred to Zing Health's Peer Review Committee.

Types of Sanctions

Zing Health's Peer Review Committee may impose the following types of sanctions on any reviewed provider or facility:

Type	Explanation
Monitor	The Quality Management Department and the Peer Review Committee will continue to review this provider's or facility's performance
Educate	The Peer Review Committee may require the provider or facility to take additional CME programs on a specific clinical topic and provide proof of completion
Counsel Probation	Zing Health's Medical Director shall meet with and counsel the provider or facility. Zing Health will provide focused oversight on the actions taken by this provider or facility for a specified period of time; the provider's panel may be frozen during this period of time.
Suspension	The provider or facility may be suspended from the Zing Health network for a period of time.
Termination	The sgreement with the provider or facility may be terminated.

If the Peer Review Committee finds a Validated Quality of Care Issue, the Committee notifies the provider or facility of the determination within five working days of the meeting. The letter to the provider or facility will contain:

- the determination of the Peer Review Committee
- a general description of the basis for the determination
- specific actions the Provider or Facility must take in order to correct the issue/ problem and prevent recurrence
- a description of the process that will be used to evaluate the effectiveness of the intervention
- the Provider's or Facility's appeal and hearing rights.

The provider or facility may disagree with the determination of Zing Health's Peer Review Committee and decide to file an appeal. A provider or facility request for an appeal hearing must be in writing and must be received within 10 business days of receipt of the Peer Review Committee determination letter.

The appeal will be heard at the next scheduled meeting of Zing Health's Peer Review Committee. The provider or facility may provide additional information to the Peer Review Committee to support their appeal. The provider or facilityy may elect to participate in the appeal hearing in person or on the telephone.

Zing Health's Peer Review Committee will review all of the information submitted and presented at the appeal hearing. The Committee will either overturn or uphold their earlier determination, Sanction Points and Corrective Action Plan. The decision of Zing Health's Peer Review Committee will be communicated to the provider or facility in writing within five business days of the appeal hearing. Pursuant to the imposition of a Corrective Action Plan, the Peer Review Committee evaluates the effectiveness of the intervention.

The Committee makes one of the following determinations:

- The intervention was acceptable. A letter is prepared and sent to the provider or facility stating that the quality concerns were addressed.
- The intervention was not accepted. The Committee may recommend additional actions. A notification letter to the provider or facility will be sent to the provider or facility. The Committee may suspend the provider or facility, terminate the provider or facility, freeze or move the provider's or facility's membership. Issues that may be brought to the Committee that are not related to clinical competency include but are not limited to the following:
  - Failure to respond to notice of deficiencies in medical records
  - Failure to participate in Quality Management or Peer Review Activities
  - Failure to meet other contractual requirements not related to clinical competency
  - Evidence of illegal use of narcotics or other intoxicants
  - Unethical conduct
  - Failure to cooperate with Zing Health's quality improvement program
  - Failure to cooperate with Zing Health's utilization management program
  - Failure to respond to an investigational request
  - Failure to respond to or comply with a Corrective Action Plan
  - Failure to comply with Quality Management or Risk Management guidelines
  - Insubordinate activity by provider or facility, including but not limited to lack of cooperation with Zing Health, failure to comply with the terms of this Manual or for other business reasons.

Any of these failures may result in corrective action by Zing Health's Peer Review Committee, including but not limited to termination. Termination based on grounds not related to clinical competency shall not constitute grounds for a Peer Review Committee hearing.Information gathered in the Quality Management and Peer Review process shall be shared with the Credentialing Committee.

Reporting to Regulatory Agencies

Zing Health will report any decision to reduce, suspend or terminate a provider's or facility's participation in the Zing Health network as required by applicable law and regulations.

Hearing Rights

Zing Health shall provide hearing rights to all physicians with Zing Health Medicare members, terminated with or without cause; provided, however, that if the members' health is in imminent danger, Zing Health may terminate the practitioner in accordance with the agreement and subsequently offer the practitioner its hearing rights. All hearings will be held before a hearing panel consisting of members (i) the majority of who are peers of the affected practitioner and (ii) who are not in direct economic competition with the affected practitioner. A provider or facility afforded hearing rights may file an appeal within seven calendar days of receipt of the termination notice. Any appeal filed after this deadline will be rejected for late filing. The Zing Health Appeals Committee shall hear the reasons for the termination request and the grounds of the provider's or facility's appeal. Decisions of the Appeals Committee will be made within two workdays. The decision of the hearing panel is final and shall be communicated to the provider or facility via Certified Mail.

Section 13: Grievances and Appeals

Zing Health as an MA-PD plan with CMS has policies and procedures to address a medical or pharmacy complaint, grievance, or appeal received on behalf of Zing Health members.

Medicare Part C – Medical Services, Part A and B Drugs and Items

Member Grievances and Appeals (Reconsiderations)

Zing Health has established and shall maintain a grievance and appeal procedure for the resolution of grievances, appeals and expedited grievances and appeals involving members, a copy of which is available to providers, facilities, and pharmacies on request.

Providers and facilities agree that any dispute, complaint, grievance, appeal or claim asserted pursuant to the agreement, any Medicare plan or otherwise or in connection with the provision of covered services under the agreement shall be resolved in accordance with Zing Health's grievance and appeal procedure, including procedures for expedited review of determinations and reconsiderations upon the request of a member and in accordance with Medicare law.

Providers and facilities shall cooperate with Zing Health in connection with its resolution of any grievance or appeal, including gathering and forwarding any and all information, including but not limited to medical records, requested by Zing Health or any governmental agency in connection with the investigation and resolution of such grievance or appeal, at no cost to Zing Health within such timeframe requested by Zing Health or as otherwise required by applicable law or this manual.

Zing Health shall have final authority over the resolution of all grievances and appeals, and providers and facilities shall comply with all final determinations made by Zing Health pursuant to Zing Health's grievance and appeal procedure. In the event an oral or written grievance or appeal is presented to a provider or facility by a member, such provider or facility shall immediately notify Zing Health of such grievance or appeal and provide Zing Health with a copy of the grievance or appeal if in writing.

Grievance Process for Medicare Members

The grievance procedure applies to Medicare members who are dissatisfied with the health care services they received or any other aspect of Zing Health.

A written or oral grievance may be filed by a current or former Medicare member or his/her authorized representative. If a Medicare member wishes to act through an authorized representative, an Appointment of Representative form must be signed by the Medicare member, appointing another party to act on behalf of the Medicare member. Zing Health's Grievance and Appeals department will investigate the grievance and notify the Medicare member or the Medicare member's authorized representative in writing of a decision within 30 calendar days of receipt of the grievance. For grievances concerning quality of care issues, the investigation will include clinical peer review and/or medical director review, with formal reporting when appropriate.

Standard Reconsideration (Appeal) for Medicare Members

A reconsideration (appeal) consists of a review of an adverse organization determination or denial, in whole or part of a requested service. A member, his/her legal or appointed representative, or provider or facility may request a Reconsideration of an initial determination in writing via mail or via fax. The request must be filed within 60 calendar days of the date of notice of the adverse initial determination. Extensions, however, may be granted upon request if Zing Health determines that good cause exists. The request for reconsideration may be filed with Zing Health, the Social Security Administration or, when applicable, the Railroad Retirement Board. The Social Security Administration or Railroad Retirement Board will forward these requests to Zing Health.

Providers and facilities must redirect the member back to Zing Health for all requests for reconsideration. Zing Health's Grievance and Appeals department is responsible for receiving and processing all requests for reconsideration and ensuring that all supporting documentation is obtained. If a member submits a verbal appeal request, Zing Health will send a letter of acknowledgement to the member, authorized representative, or provider or facility within five business days of receipt of the request for reconsideration. A reconsideration decision will be made by someone other than the person involved in making the initial determination.

Expedited Reconsiderations (Expedited Appeals) for Medicare Members

Medicare members or their provider or facility may submit an oral or written request to Zing Health for an expedited reconsideration of the initial pre-service determination. Any physician's request for an expedited review will be processed under the expedited timeframe. If Zing Health determines that the member's request for an expedited review is managed under the standard timeframe for its Reconsideration could seriously jeopardize the life or health of the member or the member's unborn child or seriously impair the member's ability to regain maximum function, Zing Health will grant the request. Further, if a physician informs Zing Health that the standard timeframe for its reconsideration could seriously jeopardize the life or health of the member or the member's unborn child or seriously impair the member's ability to regain maximum function, Zing Health will expedite the reconsideration.

Further Rights to Review for Medicare Members

If Zing Health's reconsideration decision upholds the initial determination in whole or part, Zing Health will forward the member's case to a CMS contractor for an independent review in accordance with federal law. The CMS contractor will inform the member and/or provider or facility as well as Zing Health, of its decision. Zing Health will notify the provider or facility and member of decisions and actions.

If the CMS contractor upholds Zing Health's decision, the member and, when appropriate, the provider or facility will be informed of further rights to administrative and judicial review. Providers and facilities shall comply with and provide any care required by the ultimate decision rendered through the grievance and appeals process.

Medicare Part D – Prescription Drugs

Prescription Drug (Part D) Complaints for Medicare Members

A complaint regarding prescription drug benefits may be processed as a grievance, coverage determination, or an appeal, depending on the subject of the complaint. If the complaint is about decisions related to benefits, coverage, or payment, then the process for coverage decisions and appeals should be utilized. Complaints about the quality of care, waiting, times, customer service, and other concerns are considered grievances.

A grievance involves an expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. For example, a member may file a grievance if they have a problem with things such as waiting times when filling a prescription, the way a network pharmacist behaves, not being able to reach someone by phone, or having difficulty getting information.

Part D grievances are answered as quickly as the as quickly as the member's health condition requires, but no later than 30 calendar days after receiving the complaint. If the complaint was made because we denied the request for a "fast coverage decision" or a "fast appeal," we will automatically give an "expedited grievance" and provide an answer within 24 hours of receipt of the grievance.

Prescription Drug (Part D) Appeals for Medicare Members

An appeal can be requested if the member, member's appointed representative, or prescriber disagrees with our decision to deny a request for coverage of prescription drugs or payment for drugs already received. When a decision is appealed for the first time, it is called a "redetermination" or "level 1 appeal".

In this type of appeal, we review the adverse coverage decision, including the findings upon which the decision was based, and any other evidence submitted or obtained. The appeal is processed by different reviewers than those who made the original decision. All appeal reviews involving medical necessity are performed by a physician with expertise in the field of medicine that is appropriate for the drug in question.

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "expedited" deadlines. A standard appeal means we will give you an answer as quickly as the member's health condition requires, but no later than seven calendar days after we receive the request. If your member's health requires a quick response, you must ask us to make an "expedited appeal." An expedited appeal means we will answer as quickly as the member's health condition requires, but no later than 72 hours after we receive the request. Zing Health cannot extend the timeframe for processing a standard or expedited Part D redetermination request.

Requests for redeterminations can be made orally or in writing. While written requests will be accepted in any format, a redetermination request form is available for use in Appendix 3 of this manual. Redeterminations must be requested within 60 calendar days from the date on the written coverage determination denial notice. If the deadline is missed and there is a good reason for missing it, we may give you more time to submit an appeal. To request a redetermination:

Fax us: 877-503-72312 or

Call us: 866-250-2005 or

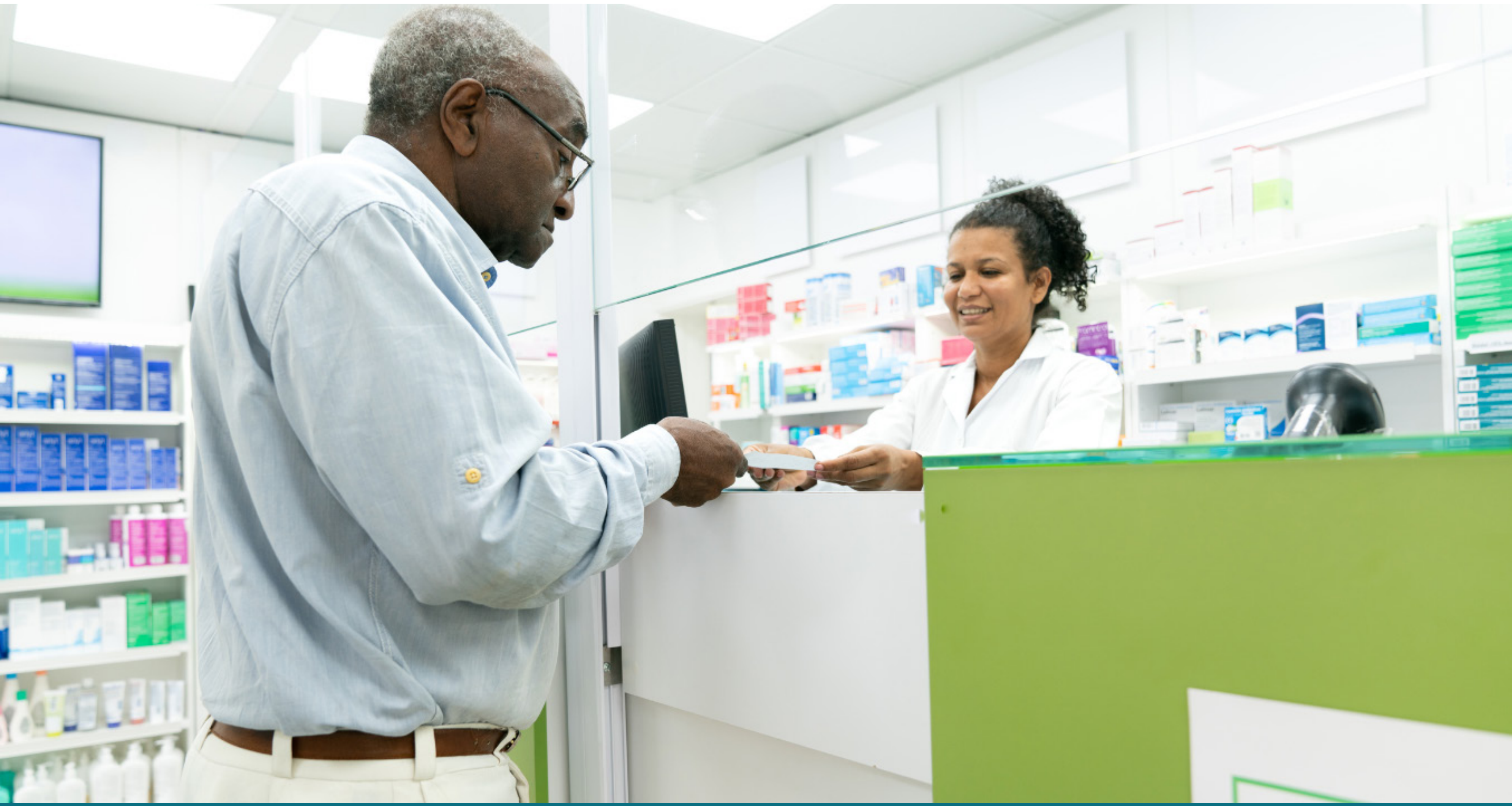
Visit our website:
myzinghealth.com or

Write us:
Zing Health
225 West Washington Street,
Suite 450
Chicago, IL 60606

Further Prescription Drug (Part D) Appeal Rights for Medicare Members

If Zing Health's redetermination decision upholds the initial determination in whole or part, the member, member's representative, or the prescriber (acting on behalf of the member) may request an independent review (i.e., "level 2 appeal") by a CMS contractor in accordance with federal law. The CMS contractor will inform the member and/or prescriber, as well as Zing Health, of its decision.

If the CMS contractor upholds Zing Health's decision, the member or prescriber (only if appointed as the member's representative) can request up to three additional levels of appeal after level 2 so long as the value of the drug appeals meets a certain dollar amount for the specific appeal level.



Clinical Practice Guidelines

Zing Health uses approved criteria and guidelines that are objective, and based on sound medical evidence in making organization determinations for medical necessity/clinical appropriateness and oversees the procedures for applying screening criteria appropriately and consistently. These criteria are approved annually and applied to individual cases, including medical, behavioral, and social factors, and based on the assessment of the local delivery system.

In the event that no criteria exist or has not yet been developed for a recent technology or a new application of an existing technology, Zing Health evaluates the technology and develops criteria for use in utilization management decision-making. Such evaluations may apply to medical and behavioral health procedures, pharmaceuticals covered under the medical benefit (not retail pharmacy), or medical devices. When Utilization Management is delegated to a Pharmacy Benefit Manager for Part D, Zing Health ’s development of criteria will be limited to pharmaceuticals covered under the Part C medical benefit.

Zing Health assigns a medical director to evaluate existing criteria and draft criteria when necessity. New criteria may be approved by the Chief Medical Officer and affirmed or revised at the next regular meeting of the Quality Improvement Committee.

The screening criteria used for evaluating medical necessity for organization determinations is as follows:

- National Coverage Determinations (NCDs)
- Local Coverage Determinations (LCDs)
- Medicare Policy and Benefit Manuals
- Zing Health Medical Policy
- Evidence based Criteria
    - Milliman Care Guidelines (MCG)

Utilization Management Approach

Utilization Management (UM) is the evaluation of the medical necessity, quality, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health plan benefits. “Medically necessary” or “medical necessity” means that the medical or allied care, goods, or services furnished or ordered must meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
- Be consistent with generally accepted professional medical standards as determined by the Medicare program, and not experimental or investigational;
- Be reflective of the level of service that can be safely furnished, Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider.
- “Medically necessary” or “medical necessity” for inpatient hospital services requires that those

services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
- The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods, or services medically necessary or a medical necessity or a covered service.
- Service-specific coverage requirements and medical necessity criteria can be found on the Provider Portal.
- Participating providers are required to obtain authorization for any medically necessary service to members, or when the service is not a covered service of the plan; or the amount, frequency, or duration of the service exceeds the limitations specified in the service-specific handbook or the corresponding fee schedule.
- UM decision making is based only on appropriateness of care and service, existence of coverage, and available criteria. Zing Health does not reward providers or other individuals conducting utilization review for issuing denials of coverage or services, and Zing Health does not encourage decisions that result in under-utilization.

Prior Authorizations

Prior Authorization – HMO Product

Prior authorization allows for efficient use of covered services by facilitating members to receive the most appropriate level of care in the most appropriate setting. Prior authorization may be obtained by the member's PCP or by a treating specialist or facility to which they were referred. Zing Health provides a process in order to make a determination of medical necessity and benefits coverage for inpatient and outpatient services prior to services being rendered. Prior authorization requirements apply to pre-service decisions.

Providers may submit requests for authorization by:
- Submitting an authorization request via Zing Health's secure Provider Portal at myzinghealth.com;
- Faxing a properly completed Authorization Request Form to (844)-946-4458; or
- Contacting Zing Health via phone for inpatient notifications and urgent outpatient services at (833)-946-4458

Sample forms are located in Appendix 3 of this provider manual. You can also locate all forms on Zing Health's website at myzinghealth.com.

UM Decision Timeframes

Standard Organization Determinations

An organization determination will be made as expeditiously as the member's health condition requires, but no later than 14 calendar days after Zing Health receives the request for service. An extension may be granted for 14 additional calendar days if the member requests an extension, or if Zing Health justifies a need for additional information and documents how the delay is in the interest of the member.

Standard Decision on Part B Drug

An organization determination will be made as expeditiously as the member's health condition requires, but no later than 72 hours after Zing Health receives the request for service. Extensions are not permitted on Part B drug determinations.

Expedited Organization Determinations

A member or any provider may request that Zing Health expedite an organization determination when the member or his/her provider believes that waiting for a decision under the standard time frame could place the member's life, health or ability to regain maximum function in serious jeopardy. The determination will be made as expeditiously as the member's health condition requires, but no later than 72 hours after receiving the member's or provider's request. An extension may be granted for 14 additional calendar days if the member requests an extension, or if Zing Health justifies a need for additional information and documents how the delay is in the interest of the member.

Expedited Decision on Part B Drug

An organization determination will be made as expeditiously as the member's health condition requires, but no later than 24 hours after Zing Health receives the request for service. Extensions are not permitted on Part B drug determinations.

UM Denials

An authorization request for a service may be denied for failure to meet guidelines, protocols, medical policies, or failure to follow administrative procedures outlined in the provider contract or in this manual. If criteria are not met resulting in a denied claim, members must be held harmless for denied services.

A Zing Health Medical Director renders all medical necessity denial decisions. Whenever a denial is issued, UM provides the name, telephone number, and title of the Medical Director who rendered the decision.

Concurrent Review

Zing Health facilitates the oversight and evaluation of members when admitted to hospitals, rehabilitation centers and skilled nursing facilities (SNF). This oversight includes reviewing continued acute care stays to promote appropriate utilization of healthcare resources and to promote quality outcomes for members.

Zing Health provides oversight when members receive acute care services in facilities mentioned above to determine the initial/ongoing medical necessity, appropriate level of care and appropriate length of stay, and to facilitate a timely discharge.

Concurrent review is initiated after Zing Health is notified of the admission. Subsequent reviews are based on the severity of the individual case, needs of the member, complexity, treatment plan, and discharge planning activity. The continued length of stay will be reviewed in accordance with appropriate medical necessity criteria in order to:

- Promote the delivery of services in a timely and efficient manner.
- Meet established standards of quality care.
- Implement timely and efficient transfer to a lower level of care when clinically indicated and appropriate.
- Complete timely and effective discharge planning.
- Identify cases appropriate for follow up by the care manager.

Concurrent review decisions are made using the following criteria:

- National Coverage Determinations (NCDs)
- Local Coverage Determinations (LCDs)
- Medicare Policy and Benefit Manuals
- Zing Health Medical Policy
- Evidence-Based Criteria
- Miliman Care Guidelines

These review criteria are used as a guideline. Decisions will take into account the member's medical condition and comorbidities. The review process is performed under the direction of a Zing Health Medical Director.

The frequency of the reviews for extension of initial determinations is based on the severity/ complexity of the patient's condition, necessary treatment and discharge planning activity including possible placement in a different level of care.

Retrospective Review

A retrospective review is any review of care or services that have already been provided. There are two types of retrospective reviews that Zing may perform:

- **Retrospective review initiated by Zing Health:** Zing Health requires periodic documentation including, but not limited to, the medical record, claim form and/or itemized bill to complete an audit of the provider-submitted coding, treatment, clinical outcome and diagnosis relative to a submitted claim. On request, medical records should be submitted to Zing Health to support accurate coding and claims submission.
- **Retrospective review initiated by providers:** Zing Health will review post-service requests for authorization of inpatient admissions or outpatient services. The review includes making coverage determinations for the appropriate level of services, applying the same approved medical criteria used for the pre-service decisions, and taking into account the member's needs at the time of service. Zing Health will also identify quality issues, utilization issues, and the rationale behind failure to follow Zing Health's prior authorization/pre-certification guidelines.

Zing Health will give a written notification to the requesting provider and member within 30 calendar days of receipt of a request for a retrospective determination.

Second Opinions

Zing Health gives members the right to a second medical opinion in any instance in which the member disputes Zing Health's or the provider's or facility's opinion of the reasonableness or necessity of surgical procedures or is subject to a serious illness or injury. If requested, the member may select a provider or a non-participating provider in the geographical service area of Zing Health.

If the member selects a provider, the PCP may issue a referral for the second opinion. If the member selects a non-participating provider, the PCP must request a pre-authorization from Zing Health.

Transition of Care

Transition of care benefits are available temporarily for newly eligible members who are in active treatment or who have a previously approved procedure(s) with a provider not contracted with the plan.
If a new member has an existing relationship with a provider who is not part of the Zing Health provider network, Zing Health permits the member to continue an ongoing course of treatment by the non-participating provider during a transitional period of:

- The lesser of the period of active treatment for a chronic or acute medical condition or up to 90 days, or
- The postpartum period for members in their second or third trimester of pregnancy, or
- When a longer period is required by state or federal laws or Medicare requirements.

For members transitioning to the plan, Zing Health will honor any written documentation of prior authorization of ongoing covered services for a period of 30 calendar days after the effective date of enrollment.

For all members, written documentation of prior authorization of ongoing services includes the following, if the services were prearranged prior to enrollment:

- Prior existing orders
- Provider appointments (for example, dental appointments, surgeries, etc.)
- Prescriptions (including prescriptions at non-participating pharmacies)

Zing Health may delay service authorization if written documentation is not available in a timely manner. Providers may contact the Claims department for claims payment or claims resolution issues and their Provider Relations representative for rate negotiations.

Members who are acute inpatients at the time of disenrollment from Zing Health will be covered by Zing Health throughout the acute inpatient stay. However, Zing Health will not be responsible for any discharge needs the member may have.

Provider Termination

When a provider terminates participation in Zing Health's network, or is terminated by Zing Health without cause, Zing Health provides coverage for members in active treatment either through the completion of their condition (up to 90 calendar days) or until the member selects a new provider.

Care provided after termination continues under the same terms, conditions and payment arrangements as in the terminated contract.

If an obstetrical provider terminates network participation without cause and requests an approval for continued coverage for treatment for a pregnant member who is in treatment, the member will be permitted to continue receiving benefits for that care until the member's postpartum visit is completed.

If a provider's network participation is terminated by Zing Health for cause, Zing Health may direct the member immediately to another participating provider for continued services and treatment, and may deny coverage for further services received from the terminated provider.

Section 15: Care Management Program

Care Management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality cost-effective outcomes.

The Care Management team monitors the participation rate of members being managed, the members' satisfaction with Care Management, members' utilization of services, readmission rates, admission rates and high-volume service utilization. Care Management also reviews continuity of care between the member's behavioral healthcare services and their medical care services, for those members who are receiving both. Care Management data is reported to Quality Improvement Committee on a quarterly basis.

Our Care Management program components include complex care management, disease management, behavioral health management and transitional case management. Care Management uses multiple data sets to identify and treat high-risk members. Care management services are also offered to members upon discharge from the facility, to help facilitate the receipt of post-discharge services administered by their provider.

Target Populations

Members who may benefit from case management are those with ongoing complex medical needs or those at risk for an avoidable adverse outcome/event. The following individuals may warrant case management; however, this listing is not meant to be all-inclusive:

- Individuals at risk for an avoidable outcome/event;
- Individuals with chronic physical health illnesses; and,
- Individuals with chronic behavioral health illnesses.

How are Referrals Generated?

Referrals to Case Management are received through many sources:

- Member Services line;
- Completed Health Risk Assessments (HRAs);
- Recently discharged members from hospitals, or members who have required emergency room care;
- Internal department referrals; and,
- Providers seeking care management for their patients.

How to Request Case Management Services

Members may self-refer, and providers and facilities may refer members to Zing Health's Care Management Programs. Providers may request assistance in the development of plans of treatment for members with complex or serious medical conditions. To make such a referral or to request assistance, please contact Care Management at (844) 946-4458. To refer a member to one of these programs, use the Disease and Care Management Referral Form in Appendix 3 of this manual. Fax the form to (844) 946-4458 or email to caremgmt@myzinghealth.com.

Behavioral Health Services

Behavioral health is integrated in the overall Zing Health care model. Special populations such as serious and persistent mental illness (SPMI) adults may require additional services and attention, which may lead to the development of special arrangements and procedures with our provider network to arrange for and provide certain services including:

- Coordination of services for members after discharge from state and private facilities to integrate them back into community. This includes coordination to implement or access services with network behavioral health providers or Community Mental Health Clinics (CMHCs);
- Targeted care management by community mental health providers for adults in the community with a severe and persistent mental illness.

The goals for members with behavioral health issues mirror those of the Utilization and Care Management programs. Our Care Management program is intended to decrease fragmentation of healthcare service delivery, promote appropriate utilization of available resources, and improve upon member health (physical and mental) outcomes through education, care coordination and advocacy services for the special needs populations served. It is a collaborative process using a multidisciplinary, member-centric model that integrates the delivery of care and services across the care continuum. It supports the Institute for Healthcare Improvement's Triple Aim objectives, which include:

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of healthcare.

Zing Health provides all medically necessary behavioral health aspects of care delivery that include recovery and are resiliency focused. This means that services provided by Zing Health allow individuals to have the greatest opportunities for decision-making and participation in the individual's treatment and rehabilitation plans.

Zing Health and its behavioral health providers work collaboratively on key initiatives, including appropriate medication management, instruction on routine tests needed for the dispensing of atypical antipsychotic medications, continuity and coordination of care between medical and behavioral health providers, and medical provider education regarding behavioral disorders commonly seen in primary care settings. This ensures Zing Health members have improved access to care, coordination and continuity of care through the delivery of mental health and substance abuse treatment.

Chronic Conditions Special Needs Plan (C-SNP)

The C-SNP plan is intended to meet the care coordination needs of beneficiaries who are diagnosed with cardiovascular disorders, chronic heart failure, diabetes, and/orEnd Stage Renal Disease (ESRD). Care Management helps ensure that SNP beneficiary's healthcare needs, preferences for health services and information sharing across healthcare staff and facilities are met over time. Care

Management maximizes the use of effective, efficient, safe, and high-quality patient services that ultimately lead to improved healthcare outcomes, including services furnished outside the SNP's provider network as well as the care coordination roles and responsibilities overseen by the member's caregiver(s).

Dual Eligible Special Needs Plan (D-SNP)

Individuals who have Medicare and Medicaid coverage are called "dual eligible." For dual eligibles, Medicaid may cover Medicare premiums, Medicare Part A and Part B cost share and certain benefits not covered by Medicare.

Dual Eligible Special Needs Plans (D-SNPs) are a type of Medicare Advantage plan that only enrolls dual-eligible members. D-SNPs provide a coordinated Medicare and Medicaid benefit package that may also offer more coordinated or integrated care than a regular Medicare Advantage plan.

Types of Dual-Eligible Members

See the chart below for the various categories of dual-eligible members. The categories that Zing Health enrolls are noted in red font.

Medicare Savings Program (MSP) Assistance	Part A Premium Covered?	Part B Premium Covered?	Part A & Part B Cost-Sharing Covered?	Full Medicaid Benefits Provided?
Qualified Medicare Beneficiary (QMB)	Yes	Yes	Yes	No
QMB Plus (QMB+)	Yes	Yes	Yes	Yes
Specified Low-Income Medicare Beneficiary (SLMB)	No	Yes	No	No
SLMB Plus (SLMB+)	No	Yes	Yes^	Yes
Qualifying Individual (QI)*	No	Yes	No	No
Qualified Disabled Working Individual (QDWI)	Yes	No	No	No
Full Benefit Dual-Eligible (FBDE)	Yes	Yes	Yes	Yes

**QI is someone who has income up to 135% of the Federal Poverty Limit (FPL). These individuals are considered partial dual members and Medicaid will cover the Part B premium for these individuals. QI members are responsible for paying their Part A and Part B cost share.*

^Depends on the State Medicaid program design.

For full definitions of the categories of dual-eligible members, see Appendix 1 of this manual.

Payments and Billing

Providers may not balance-bill Zing Health's cost-share protected members. This means providers may not bill these members for either the balance of the Medicare rate or the provider's charges for Part A or Part B services. The member is protected from liability for Part A and Part B charges, even when the amounts the Provider receives from Medicare and Medicaid are less than the Medicare rate or less than the Provider's customary charges.

Additionally, federal law prohibits Medicare providers from billing individuals who have QMB/QMB+ status. All Medicare providers and suppliers, including those that accept Medicaid, must not charge individuals enrolled in the QMB/QMB+ program for Medicare cost-sharing. While individuals enrolled in QMB do not pay Medicare deductibles, coinsurance, or co-pays, they may have a small Medicaid co-pay for certain Medicaid-covered services. QMB/QMB+ members keep cost-share protection even when crossing state lines to receive care. Further, QMB/QMB+ members cannot elect to pay Medicare cost share. Providers who bill QMB/QMB+ members for amounts above the Medicare and Medicaid payments (even when Medicaid pays nothing) are subject to sanctions.

The provider will receive an Explanation of Payment (EOP) that lists instructions on how to bill for any Medicare Part A and Part B cost-share amounts due. Generally, Medicare cost share amounts that are due as a result of the provision of services to a dual-eligible member are billed to the state Medicaid agency. Some D-SNP Plans will have a Part B deductible amount applied prior to payment, similar to how Medicare operates today. This deductible is considered a cost-sharing amount and covered by the state Medicaid agency or its designee if the state has managed Medicaid. Providers should bill Zing Health as they do today and submit the EOP provided by Zing Health to the state for payment.

Referrals for Dual-Eligible Members

When a provider refers a dual-eligible member to another provider for services, the referring provider should refer the dual-eligible member to a provider who participates with Zing Health. A directory of providers who participate with the state Medicaid can be found below.

- **Illinois:** State of Illinois | Provider Directory: Home
- **Indiana:** Indiana Medicaid: Members: Provider Directory
- **Michigan**: MDHHS - Health Care Providers (michigan.gov)

Zing Health's provider directory displays an indicator when the provider participates in Medicaid.

Members Who Lose Medicaid Eligibility

CMS requires Zing Health to provide its D-SNP members a period of at least 30 days and up to six months to allow those dual-eligible members who have lost Medicaid eligibility or had a change in status an opportunity to regain their eligibility. This period is called the "deeming period." A change in status occurs when a dual-eligible member either loses Medicaid eligibility or when a change in Medicaid eligibility occurs that affects the member cost-share responsibility. Zing Health provides a six-month deeming period for its D-SNP plans.

If a member has deemed into a cost-share protected status during the deeming period, Zing Health applies the appropriate payment methodology to process claims and pays 100% of the Medicare allowable for all plans. Providers must accept Zing Health's payment as payment in full and may not balance bill the member. If a member is cost-share protected, the provider's EOP will note the member's cost-share protected status.

SNP Care Management Program

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) mandates that Medicare Advantage Organizations conduct a health risk assessment, develop a care plan, institute an interdisciplinary care team for members and conduct an evaluation of care effectiveness.

Zing Health has developed Models of Care (MOC) for its C-SNPs and D-SNPs. Each MOC is tailored specifically to the targeted populations in an effort to meet the populations' functional, psychosocial and medical needs in a member-centric fashion.

Zing Health identifies, supports, and engages our most vulnerable members at any point in their healthcare continuum to help them achieve an improved health status. Zing Health provides member-centric services and targets the following goals for serving members with complex and special needs:

- Completing an annual population assessment to identify the needs of the population and subpopulations, so Care Management processes and resources can be updated to address member needs;
- Promoting preventive health services and the management of chronic diseases through programs that encourage the use of services to decrease future morbidity and mortality in members;
- Conducting comprehensive assessments that identify member needs and barriers to care;
- Developing and implementing individualized care plans that target a member's specific complex and special needs;
- Coordinating transitions of care for members to assist in navigating the complex healthcare system and accessing provider, public and private community-based resources;
- Improving access to primary and specialty care for members with complex health conditions so they receive appropriate services;
- Consulting, through the use of Interdisciplinary Care Teams, with specialized healthcare personnel such as medical directors, pharmacists, social workers and behavioral health professionals, etc.
- Ensuring that members' socioeconomic barriers are addressed.
- The effectiveness of the MOC program is evaluated annually through the identification of objective, measurable, and population-specific quality indicators. Indicator data is collected on a routine and ad hoc basis, outcomes are analyzed, interventions are implemented for goal attainment, and reports are generated. Data sources include claims, survey data, medical record documentation, pharmacy claims data, or a combination of sources.

Zing Health has established performance outcomes for its SNP plans to evaluate and measure the quality of care, quality outcomes, service, and access for members. For each metric, benchmarks have been established based on evidenced-based medicine found in current literature, standards, and guidelines. Root cause analysis is conducted and interventions identified for each indicator that falls below the desired value. The analysis, process improvement plan, implementation of interventions, and improvements are reported to the QIC for review, feedback, and approval.

Health Risk Assessment

Zing Health's MOC process begins with the Health Risk Assessment (HRA). Once completed, the HRA is risk stratified and then reviewed by a care manager. The stratification (acuity) of the HRA is an indicator of the needs of the member. Zing Health has three levels of stratification starting with level 1 (low risk) and going to level 3 (high risk). The dual-eligible member is then contacted so the Care Management process can begin. Zing Health conducts an initial assessment within 90 days of enrollment and conducts reassessments based on triggering events and annually.

Individualized Care Plan

Once the care manager, the member, and/or the member's authorized representative or caregiver completes the HRA, an Individualized Care Plan (ICP) is created that reflects the member's specific problems, prioritized goals and interventions. The care manager and the member and/or authorized representative or caregiver, if appropriate, agree on the care plan and set goals. The ICP tracks dates and progress on meeting the goals. The frequency of contact varies on the risk stratification of the member and the specific goal time frames established. The ICP is shared on periodic basis with the member and the members identified PCP.

Interdisciplinary Care Team

The care manager shares the ICP with all Interdisciplinary Care Team (ICT) participants to promote collaboration and encourage feedback regarding the member's goals and current health status. At a minimum, the ICT includes the member, the member's authorized representative or caregiver (if appropriate), the member's PCP, other relevant specialists (as needed) and the Zing Health care manager. Other members of the ICT can include social service support, behavioral health specialists and others depending on the member's specific needs. The care manager communicates and coordinates with the ICT participants to educate the member, provide advocacy and assist the member as they navigate the healthcare system.

Provider Required Participation in the Model of Care

Providers must participate in the MOC for all Zing Health SNP members. The requirements for participation are as follows:

- Complete the required MOC training provided by Zing Health. Zing Health has an online training presentation that requires the provider to complete. Providers are required to track completion of training and present to Zing Health upon request.
- Be familiar with Zing Health's Clinical Practice Guidelines. See Section 14 of this manual for more information.
- Review and update the member care plan faxed by the Care Management department as a part of the ICT.
- Participate in the ICT for all SNP members in a provider's patient panel and give feedback as appropriate. The care manager will communicate with the members of the ICT for any updates to the ICP and will be available to assist the member to meet the goals of the ICP.

Overview of Member Processes

Zing Health makes information available to its members on the role of the PCP, how to obtain care, what to do in an emergency or urgent medical situation, as well as members' rights and responsibilities (see, Section 2 of this manual for the member rights and responsibilities).

Core Member Materials

Evidence of Coverage

All members receive an Evidence of Coverage booklet no later than 10 calendar days from receipt of CMS confirmation of enrollment or by the last day of the month prior to the effective date, whichever is later, and annually thereafter.

Provider and Pharmacy Directories

All members have access to Zing Health's provider and pharmacy directories at myzinghealth.com. Zing Health monitors its provider and pharmacy networks on an ongoing basis and makes updates to its online provider directories within 30 days of the requested changes. Members have the right to request a printed version of this document to be mailed to them.

Drug List (Formulary)

Zing Health's Drug List is also made available to members on Zing Health's website per CMS requirements. Zing Health posts an updated Drug List to its website by the 1st of each month. Members have the right to request a printed version of this document to be mailed to them.

Member Identification Cards

Member identification cards are intended to identify Zing Health members, including the type of plan they have, and facilitate their interactions with healthcare providers. Information found on the member identification card may include:

- Member's name
- Identification number
- Plan type
- PCP's name and telephone number
- Health plan contact information
- Claims filing address
- Rx information.

Possession of the member identification card does not guarantee eligibility or coverage. Providers are responsible for verifying the current eligibility of the cardholder.

Eligibility

A member's eligibility status can change at any time. Therefore, all providers should request and make a copy of the member's identification card, along with additional proof of identification such as a photo ID, and file them in the patient's medical record.

Providers may do one of the following to verify eligibility:

- Access the provider portal at myzinghealth.com
- Contact Zing Health's Provider Services department

Providers will need their provider ID number to access member eligibility through the avenues listed above. Verification is always based on the data available at the time of the request, and since subsequent changes in eligibility may not yet be available, verification of eligibility is not a guarantee of coverage or payment. See the agreement for additional details.

Enrollment

Zing Health must obey laws that protect from discrimination or unfair treatment. Zing Health does not discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age or national origin.

Upon enrollment with Zing Health, members are provided the following:

- Terms and conditions of enrollment;
- Description of covered non-emergency services in-network and out-of-network, if applicable;
- Information regarding coverage of out-of-network emergency/urgent care services;
- Information about PCPs, such as location, telephone number

Choice of PCP

Members may change their PCP at any time by calling Zing Health's Customer Service department.

Interpreter and Language Assistance Services

Hearing-impaired, interpreter and sign language services are available to members through Zing Health's Customer Service department. PCPs should coordinate these services for members and contact Customer Service if assistance is needed. For Provider Services phone numbers, please refer to the Quick Reference Guide link in Appendix 3 of this provider manual.

Appendix 1: Definitions

All capitalized but not otherwise defined terms shall have the meanings ascribed to such items in the applicable agreement.

A

ABUSE – actions that may, directly or indirectly, result in: unnecessary costs to the Medicare program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

ACCREDITATION ORGANIZATION – any organization engaged in the business of accrediting or certifying health maintenance organizations that accredits Zing Health.

ADVERSE or UNTOWARD INCIDENT – an event, over which provider or facility could exercise control, which is more probably associated, in whole or in part, with the medical intervention rather than the medical condition for which such medical Intervention occurred, and which results in one of the following:

- death;
- brain or spinal damage;
- permanent disfigurement;
- fracture or dislocation of bones or joints;
- a resulting limitation of neurological, physical, or sensory function which continues after discharge from the facility;
- any condition that required specialized medical attention or surgical intervention resulting from non-emergency medical intervention, other than an emergency medical condition, to which the member has not given his/her informed consent; or
- any condition that required the transfer of the member, within or outside the facility, to a unit providing a more acute level of care due to the adverse Incident, rather than the member's condition prior to the adverse Incident, including:
- The performance of a surgical procedure on the wrong patient, a wrong surgical procedure or wrong-site surgical procedure, or a surgical procedure otherwise unrelated to the member's diagnosis or medical condition;
- required surgical repair of damage resulting to a member from a planned surgical procedure where the damage was not a recognized specific risk, as disclosed to the member and documented through the informed-consent process;
- a procedure to remove unplanned foreign objects remaining from a surgical procedure; or
- Any complaint or allegation of sexual misconduct and abuse or contact by provider or by facility employee or agent of provider and facility.

ADMITTING PANEL PHYSICIAN – a provider who is responsible for admitting a member to a facility or other inpatient health facility on behalf of the member's primary care physician.

ADVERSE INCIDENT – an event over which the health care personnel could exercise control and which could or did result in injury to a member. Examples of adverse incidents include, but are not limited to:

- Death or injury caused by the health care rendered, or failure to render, and not caused by the member's medical condition (including brain or spinal injury).
- Suicide of a patient in a setting with round the clock care
- Equipment failure or malfunction
- Surgery on the wrong member, wrong site
- Surgery unrelated to the member's diagnosis or condition or medical need

AGREEMENT – that certain agreement entered into by and between provider and Zing Health or between facility and Zing Health pursuant to which provider and facility shall render provider services or facility services to members, as applicable, and any and all amendments thereto.

ALLOWANCE – the allowance shall be the pre-negotiated amount provider or facility agreed to accept for covered services under the agreement for members enrolled in the (i) Zing Health Medicare plan for Preferred Provider Organization Benefit Program; (ii) Zing Health Medicare Plan for Point of Service Benefit Program, solely for the out-of-network component of such Benefit Program; or (iii) other Benefit Program, as Zing Health may determine, at Zing Health's sole discretion under the applicable Zing Health Medicare plan.

APPEAL – the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or Part D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug. These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review.

AUDIT – a process conducted by Zing Health and/or its designee to determine whether data in facility's records and/or policies and procedures supports those services listed on facility's bill for services provided to a member and whether the claim was properly paid in light of such data.

B

BILLED CHARGES – Provider's orfacility's usual and customary rate for a particular service provided to members in effect on the effective date.

C

CAPITATION FEE – the fixed amount per member per month provider receives from Zing Health to provide provider services, as specifically set forth in the agreement, if any, adjusted by a percentage of the actuarial value of benefit changes to the applicable members' Zing Health Medicare plan, as determined by Zing Health and modified from time to time at Zing Health's sole discretion or as otherwise required by law.

CHRONIC CONDITION SPECIAL NEEDS PLAN (C-SNP) – plans that restrict enrollment to special needs individuals with specific severe or disabling chronic conditions, defined in 42 CFR 422.2.

CLAIM – (i) for non-institutional providers, a paper or electronic instrument submitted to Zing Health in accordance with the agreement that consists of the CMS-1500 data set, or its successor, that has all mandatory entries for a physician licensed according to state statutes or psychologists licensed under state statutes or any appropriate billing instrument that has all mandatory entries for any other non-institutional provider; and (ii) for institutional providers or facilities, a paper or electronic billing instrument submitted to Zing Health in accordance with the agreement that consists of the UB-04 data set, or its successor, with entries stated as mandatory by the National Uniform Billing Committee. Notwithstanding the foregoing, all electronic claims must be submitted by providers and facilities in accordance with HIPAA transaction code set requirements, as may be amended from time to time, and Zing Health's companion guide to HIPAA transactions, as set forth in this manual and required in accordance with HIPAA.

CLEAN CLAIM – a claim submitted by provider or facility that has no defect or impropriety or particular circumstance requiring special treatment that prevents timely payment. In the event Zing Health requires additional substantiating documentation, including medical records or encounter data from a source outside of Zing Health, the claim shall be deemed a non-clean claim.

CO-INSURANCE – upon satisfaction of the applicable deductible, the percentage of the allowance not paid or payable by Zing Health, which percentage is the responsibility of the member, and which is exclusive of all amounts due for deductibles, copayments, benefit reductions, non-covered services and charges in excess of the allowance. The benefit payable by Zing Health on behalf of a member under his/her Zing Health Medicare plan is the applicable percentage of the allowance, subject to all deductibles, copayments, co-insurance, penalties and other charges provided for in the applicable Zing Health Medicare plan.

CONTRACTED PROVIDER – a health care provider including, but not limited to, physicians, physician's assistants, osteopaths, chiropractors, dentists, optometrists, opticians, podiatrists, advanced registered nurse practitioners, midwives and nurse midwives, hospitals and other health care facilities that is under contract, directly or indirectly, with Zing Health to provide covered services to members.

CO-PAYMENTS – charges pursuant to a Zing Health Medicare plan that are required to be paid by a member directly to provider or to facility or a covering physician at the time covered services are rendered, in accordance with the schedule of benefits applicable to the particular Zing Health Medicare plan.

COVERED SERVICES – all physician, medical and hospital services, benefits and supplies, including, without limitation, primary care services, specialist services, emergency services and urgently needed services, that Zing Health is obligated to provide coverage for members under the terms of the applicable Zing Health Medicare plan and this manual.

COVERING PHYSICIAN – a provider who (i) is a duly licensed doctor of medicine or osteopathy under the state laws; (ii) entered into an agreement, either oral or written, with provider to provide covered services to members when provider is not available; and (iii) is a provider or locum tenens provider. A covering physician must meet the "covering physician" requirements set forth in this manual and shall be required by provider to abide by all terms and conditions of the agreement and this manual. A covering physician may include an admitting panel physician or a hospitalist physician.

CREDENTIALING CRITERIA – the protocol for the process performed by Zing Health or its designee to verify that a provider or facility satisfies Zing Health's requirements for participation in its provider network, including, but not limited to licensure, certification, and any other requirements and/or standards adopted by Zing Health regarding providers' and facilities' qualifications. Credentialing criteria shall include protocols for the recredentialing process of providers and facilities from time to time with such frequency as Zing Health may elect.

D

DEDUCTIBLE – the amount of charges for covered servicess applied against the relevant allowance that a member must pay in each calendar year before Zing Health will reimburse or pay for covered services.

DELEGATE – the contractual process that Zing Health may use to outsource an administrative responsibility under its CMS contract. The types of entities and their relationship to Zing Health include:

- **Downstream entity** – any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit or Part D benefit, below the level of the arrangement between an MAO or applicant or a Part D plan sponsor or applicant and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

- **First tier entity** – any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program.

- **Related entity** – any entity that is related to an MAO or Part D sponsor by common ownership or control and
  - Performs some of the MAO or Part D plan sponsor's management functions under contract or delegation;
  - Furnishes services to Medicare enrollees under an oral or written agreement; or
  - Leases real property or sells materials to the MAO or Part D plan sponsor at a cost of more than $2,500 during a contract period.

DUAL ELIGIBILITY CATEGORIES – classification of individuals that meet certain financial criteria and are eligible for Medicaid. The Medicaid eligibility categories include: full Medicaid benefit dual eligible (FBDE), qualified Medicare beneficiary without other Medicaid (QMB only), qualified Medicare beneficiary with full Medicaid (QMB+), specified low-income Medicare beneficiary without other Medicaid (SLMB only), specified low-income Medicare beneficiary with other Medicaid (SLMB+), qualifying individual (QI) and qualified disabled and working individual (QDWI).

DUAL ELIGIBLE SPECIAL NEEDS PLAN (D-SNP) – plans that enroll individuals who are entitled to both Medicare (title XVIII) and medical assistance from a state plan under Medicaid (title XIX).

E

EFFECTIVE DATE – the date that the agreement is deemed effective as set forth in the agreement.

ELIGIBILITY INFORMATION – information provided by Zing Health to providers and facilities regarding the eligibility status of an individual for coverage under a Zing Health Medicare plan.

EMERGENCY MEDICAL CONDITION – (a) a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that a prudent layperson, pursuant to section 4704 of the 1997 Balanced Budget Act, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: (1) Serious jeopardy to the health of a patient, including a pregnant woman or fetus. (2) Serious impairment to bodily functions. (3) Serious dysfunction of any bodily organ or part. (b) With respect to a pregnant woman: (1) That there is inadequate time to effect safe transfer to another hospital prior to delivery. (2) That a transfer may pose a threat to the health and safety of the patient or fetus. (3) That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

EMERGENCY SERVICES – medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable laws, by other appropriate personnel under the supervision of a physician, to determine whether an emergency medical condition exists, and if it does, the care, treatment, or surgery for a member by a physician which is necessary to relieve or eliminate the emergency medical condition, within the service capability of a facility.

ENCOUNTER DATA – documentation provided to Zing Health by providers and facilities on a monthly basis that summarizes all relevant information that pertains to any occasion where a member receives covered services, including all data necessary to characterize the context and purpose of each encounter between a member and provider, facility, physician or other practitioner, such as the member identification number, provider identification number, date of service, applicable CPT4 and ICD10 codes, place of service and provider's usual and customary charge for the service rendered. Encounter data shall comply with applicable Accreditation Organization standards, laws and regulations in effect from time to time, and shall be on such forms and provided with such frequency as Zing Health may require.

F

FRAUD – knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

FULL BENEFIT DUAL-ELIGIBLE (FBDE) – members that are eligible for Medicaid, which may be responsible for payment of the member's Medicare cost sharing. These members are also eligible to receive the full Medicaid benefits.

G

GRIEVANCE – an expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination.

H

HEALTH RISK ASSESSMENT – A tool used to identify the medical, functional, cognitive, psychosocial and mental health needs of each SNP member.

HIPAA – the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended from time to time, and particularly Title II, Subtitle F (Administrative Simplification) thereof (42 U.S.C. §§ 1171 et. seq.) and all applicable regulations, as amended from time to time.

HOSPITAL VENDOR – any and all individuals or entities contracted with facility to provide facility services.

HOSPITALIST PHYSICIAN – physicians contracted, directly or indirectly, with Zing Health who are responsible for certain primary care services which PCP is otherwise obligated to provide under the agreement on behalf of PCP members who present to or are admitted as inpatients to a hospital, as set forth in this manual and in accordance with the agreement.

I

ICP INTERVENTIONS AND GOALS – Setting objectives in measurable terms; identifying the appropriate data source(s) to measure; and the methodology used to analyze the data to determine whether/how the initiative affected the health status of the targeted member.

INDIVIDUALIZED CARE PLAN (ICP) – A member-centric document and process that identifies an individual's current health care status and potential gaps in care with goals and interventions identified that are intended to either improve upon or maintain an individual's medical and functional status, as well as close gaps in care.

INTERDISCIPLINARY CARE TEAM (ICT) – A team consisting of health plan representatives, physicians, providers, therapists, members, caregivers and other community stakeholders working collaboratively, with a common purpose, to set goals, make decisions and share resources and responsibilities associated with improving upon a member's health and functional status.

L

LOCUM TENENS PROVIDER – a licensed physician who provides provider services to members on a temporary basis when neither the provider nor the covering physician is readily available to provide care to members.

M

MEDICAL DIRECTOR – physician(s), or his/her designee(s), who is designated by Zing Health to review the provision of covered services to members and perform certain administrative duties.

MEDICAL INTERVENTION – actions of a provider or facility in the provision of health care services.

MEDICARE – the Medicare Advantage program provided under Title XVIII of the Social Security Act, as amended.

MEMBER – a Medicare eligible beneficiary who is enrolled as a member under a Zing Health Medicare plan.

N

NON-CLEAN CLAIM – a claim that has a defect due to missing key data, such as procedure, diagnosis, or provider information that prohibits the claim from being processed.

NON-CONTRACTED PROVIDER – a health care provider including, but not limited to, physicians, physician's assistants, osteopaths, chiropractors, dentists, optometrists, opticians, podiatrists, advanced registered nurse practitioners, midwives and nurse midwives, hospitals and other health care facilities that is not under contract, directly or indirectly, with Zing Health to provide covered services to members.

P

PHARMACY BENEFIT MANAGER (PBM) – an entity that provides pharmacy benefit management services, which may include contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and prior authorization programs; performing drug utilization review; and operating disease management programs. Some sponsors perform these functions in-house and do not use an outside

PRE-AUTHORIZATION – an authorization that must be obtained from Zing Health, or its designee, prior to the provision of certain covered services, as set forth in this manual and as required by the applicable Zing Health Medicare plan and the agreement.

PRIMARY CARE PHYSICIAN (PCP) – a doctor of medicine or osteopathy who is a family practitioner, general practitioner, internist, or other practitioner as permitted under state law, licensed by the relevant state, and who entered into a written agreement with Zing Health to provide primary care services to members.

PRIMARY CARE SERVICES – the services listed below, which PCP is required to provide in accordance with and subject to the agreement, this manual and the applicable Zing Health Medicare plan:

- Primary care covered services including, but not limited to, all services, tests, supplies and procedures dictated by the need for preventive, diagnostic or therapeutic care for the treatment of a particular injury, illness, condition or disease which does not require the knowledge, skill or expertise of a specialist, including, but not limited to, those which are provided in PCP's office, a member's home, a facility, a nursing home or elsewhere;

- Vision and hearing screening (excluding refraction for vision correction prescription);

- Family planning services including, but not limited to, counseling with respect to birth control and contraception, or assistance to determine the cause(s) of infertility;

- Appropriate referral services to providers, including specialists, for services of a non-primary care nature including, but not limited to, orthopedics, ophthalmology, urology, neurology, gastroenterology, surgery, obstetrics and gynecology, otolaryngology, dermatology, cardiology and psychiatry; and

- Administrative services including, but not limited to, arranging, coordinating, and managing the delivery of covered services that are not primary care services to members and the performance of administrative functions in connection therewith in accordance with the agreement and this manual and as required by the applicable Zing Health Medicare plan.

PROVIDER – a health care provider including, but not limited to, physicians, including primary care physicians and specialists, physician assistants, chiropractors, dentists, optometrists, opticians, podiatrists, advanced registered nurse practitioners, midwives and nurse midwives, and other health care facilities which are under contract, directly or indirectly, with Zing Health to provide covered services to members. The term "provider" shall not include Facilities, unless specifically indicated herein.

PROVIDER SERVICES – those covered services provider typically provides to all their patients, including but not limited to primary care services, as applicable, which provider is required to provide in accordance with and subject to the agreement, this manual and the applicable Zing Health Medicare Plan.

PROVIDER STAFF – all physicians, administrative staff or other health care professionals employed by or associated or contracted with provider, as set forth in the agreement.

Q

QUALIFIED DISABLED & WORKING INDIVIDUALS (QDWI) – Medicaid helps pay Part A premiums.

QUALIFYING INDIVIDUAL (QI) – Medicaid helps pay Part B premiums.

QUALIFIED MEDICARE BENEFICIARY (QMB) – Medicaid helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medi-Cal (Medicaid) benefits (QMB+).)

QUALITY OF CARE GRIEVANCE – A grievance related to whether the quality of covered services provided by a plan or provider meets professionally recognized standards of health care, including whether appropriate health care services have been provided or have been provided in appropriate settings.

R

RECONSIDERATION – under Part C, the first level in the appeals process which involves a review of an adverse organization determination by an MA plan, the evidence and findings upon which it was based, and any other evidence submitted by a party to the organization determination, the MA plan or CMS. Under Part D, the second level in the appeals process which involves a review of an adverse coverage determination by an independent review entity (IRE), the evidence and findings upon which it was based, and any other evidence the enrollee submits or the IRE obtains.

REDETERMINATION – First level in the Part D appeal process in which the plan sponsor reviews an adverse Part D coverage determination, including the findings upon which the decision was based and any other evidence submitted or obtained.

REFERRAL/REFER – recommendation of a member to a provider that may or may not require prior approval by Zing Health, in accordance with this manual and as required by the applicable Zing Health Medicare plan.

REOPENING – A remedial action taken to change a binding determination or decision even though the determination or decision may have been correct at the time it was made based on the evidence of record.

REPRESENTATIVE – Under Part C, as defined in §422.561, an individual appointed by an enrollee or other party, or authorized under state or other applicable law, to act on behalf of an enrollee or other party involved in a grievance, organization determination, or appeal. Under Part D, as defined in §423.560 as "appointed representative", an individual either appointed by an enrollee or authorized under state or other applicable law to act on behalf of the enrollee in filing a grievance, obtaining a coverage determination, or in dealing with any of the levels of the appeals process. For both Part C & Part D, the representative will have all of the rights and responsibilities of an enrollee or other party, as applicable.

RISK MANAGEMENT – the identification, investigation, analysis and evaluation of risk and the solicitation of the most advantageous methods of correcting, reducing or eliminating identifiable risks.

RISK STRATIFICATION – The process or data-driven algorithm used by the health plan to identify new members with higher and more complex heath care needs that are at risk of an adverse health outcome or worsening health status if initial contact does not occur within the CMS-required timeframe.

S

SERVICE AREA – the area consisting of those states and counties for which Zing Health has regulatory approval to provide services pursuant to its license requirements and under its contract with CMS, as amended by Zing Health from time to time in Zing Health's sole discretion.

SICK CARE – non-urgent problems that do not substantially restrict normal activity but could develop complications if left untreated (e.g. chronic disease).

SPECIALIST – a physician licensed to practice medicine by the relevant state (other than a primary care physician) who entered into a written agreement with Zing Health, either directly or indirectly, to provide specialist services to members pursuant to a referral or pre-authorization from a primary care physician.

SPECIALIST SERVICES – those covered services a specialist is contracted to provide, as specifically set forth in their agreement.

SPECIFIED LOW-INCOME MEDICARE BENEFICIARY (SLMB) PROGRAM – Savings program that pays for Part B premium with Medicaid. (Some people with SLMB are also eligible for full Medi-Cal (Medicaid) benefits (SLMB+).)

SUBSCRIBER GROUP – any public or private organization, firm, association, business, employer group or other entity which entered into a Zing Health Medicare Plan for the provision of health care services to its constituents.

U

URGENTLY NEEDED SERVICES/URGENT CARE – covered services for conditions that (i) though not life-threatening, could result in serious injury or disability to the member unless medical attention is received or (ii) substantially restrict a member's activity; and (iii) which are provided (a) when a member is temporarily absent from the service area or; (b) under unusual and extraordinary circumstances, when the member is in the service area but all providers are temporarily unavailable or inaccessible when such covered services are medically necessary (as defined under Medicaid) and immediately required (1) as a result of an unforeseen illness, injury, or condition; and (2) it was not reasonable given the circumstances to obtain the covered services through a provider. Examples include, without limitation, high fever, animal bites, fractures, severe pain, infectious illness, flu, and respiratory ailments.

W

WASTE - the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

WELL CARE – a routine medical visit for one of the following: child health check-up visit, family planning, routine follow up to a previously treated condition or illness, adult physicals and any other routine visit for other than the treatment of an illness.

WELL WOMAN VISIT – an annual medical visit to a gynecologist by a female member for the purpose of assessing her reproductive health.

Z

ZING HEALTH MEDICARE PLAN – an agreement, contract or undertaking pursuant to which Zing Health arranges for the provision of certain health care services to Members in accordance with the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the regulations and guidance promulgated thereunder, as amended from time to time, and Zing Health's contract with

CMS.

Commonly Used Zing Health Acronyms

Acronym	Definition
AAAHC	American Association for Ambulatory Healthcare
ARNP	Advanced Registered Nurse Practitioner
ASC	Ambulatory Surgical Centers
C.F.R.	Code of Federal Regulation
CMS	Centers for Medicare & Medicaid Services
COB	Coordination of Benefits
CPT	Current Procedural Terminology
C-SNP	Chronic Condition Special Needs Plan
DEA	Drug Enforcement Administration
DHHS	Department of Health and Human Services
DME	Durable Medical Equipment
DOH (DH)	Department of Health
DRG	Diagnosis Related Group
D-SNP	Dual Eligible Special Needs Plan
EDI	Electronic Data Interchange
FTE	Full Time Equivalent (Physician)
HCPCS	Healthcare Common Procedure Coding System
HEDIS	Health Plan Employer Data Information Set
HIPAA	Health Insurance Portability and Accountability Act
HRA	Health Risk Assessment
ICD	International Classification of Diseases
ICP	Individualized Care Plan
ICT	Interdisciplinary Care Team
MOC	Model of Care
OIR	Office of Insurance Regulation
OSHA	Occupational Safety and Health Administration
OT	Occupational Therapy

Acronym	Definition
PA	Physician Assistant
PCP	Primary Care Physician
PQI	Potential Quality of Care Issue
PT	Physical Therapy
QDWI	Qualified Disabled Working Individuals
QI	Qualified Individual
QIO	Quality Improvement Organization
QMB	Qualified Medicare Beneficiary
SLMB	Specified Low Income Medicare Beneficiary
SNF	Skilled Nursing Facility
ST	Speech Therapy
UM	Utilization Management
USC	U.S. Code

Appendix 3: Forms and Other Resources

Authorization Approval Form and Instructions: Authorization_Request_Form_Member_Instructions_and_Form_2022.pdf (myzinghealth.com)

Case Management Referral Form: CM_DM_Referral_Form_Member_Instructions_andForm_2022.pdf (myzinghealth.com)

Claim Dispute Form: Provider Claim Dispute Form (myzinghealth.com)

HIPAA Privacy Notice and Forms: Zing Health member documents and links (myzinghealth.com)

Medical Coverage Determination Form: Drug_Coverage_Determination_Request_2022.pdf (myzinghealth.com)

Medication Therapy Management Program: Zing Health (myzinghealth.com)

Part D Prior Authorization Criteria: 2022_Zing_PACr_ENG.pdf (myzinghealth.com)

Part D Step Therapy Criteria: 2022_Zing_STCr_ENG.pdf (myzinghealth.com)

Prescription Drug Transition Policy: Zing Health (myzinghealth.com)

Prior Authorization Grid: Prior Authorization List (myzinghealth.com)

Quick Reference Guide: Provider Quick Reference

Redetermination Form: [Prescription_Redetermination_Request_2022.pdf (myzinghealth.com)]

Transition of Care/Continuity of Care Form: [Transition of Care_Continuity_of_Care_2022.pdf (myzinghealth.com)]

Waiver of Liability (WOL) Form: [WOL_Form.pdf (myzinghealth.com)]