PROVIDER MANUAL

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SECTION 1

PROVIDER MANUAL QUICK REFERENCE

QUICK REFERENCES

provider.eternalhealth.com is the simplest, quickest way to check member eligibility and benefits, submit or check on a prior authorization request, check the status of a claim, find other eternalHealth providers, access documents and forms, and much more. Be sure to have your National Provider Identifier (NPI) handy.

Frequently Used Services	Quick Links	
To submit a claim If you need to make any changes to an original claim, you can resubmit a corrected claim using one of the channels to the right.	interconnect via Change Healthcare: Payer ID#: RP037	via mail: eternalHealth Billing Department **PO Box 1263** **Westborough, MA 01581**
To find an in-network provider	www.eternalhealth.com/for-members/find-a-provider-or-pharmacy/	
To set up electronic payments	Go to www.zelis.com or call **1-877-828-8770** to set up an account. Enter eternalHealth's **Payer ID #RP037**.	
To verify patient eligibility, benefits, and copays	provider.eternalhealth.com	
For all other routine forms and documents	www.eternalhealth.com/for-providers/forms-and-documents/	
For Part D prior authorization criteria	www.eternalhealth.com/for-members/prescription-drugs/#Prior-Authorization	
To submit a Part D prior authorization electronically	go.covermymeds.com/OptumRx	
Part B Prior Authorization List	Part B Prior Auth List	
Part C Prior Authorization List	Part C Prior Auth List	
Prior Authorization Request Form	eternalHealthPrior Authorization Request Form	

If you need additional assistance, please call or fax using the numbers below.

Department	Phone	Fax
Provider Services	1-800-680-9255	1-866-347-8130
Care Management	1-800-787-5076	1-855-708-2735
Expedited Authorization Requests (UM)	1-800-680-9255	1-866-215-4297
Authorization Request (UM)	1-800-680-9255	1-866-337-8686
Pharmacy (OptumRx ®)	1-800-891-6989	1-800-527-0531
Appeals and Grievances	1-800-651-9613	1-888-692-7270
Member Services	1-800-680-4568	1-888-347-8130

SECTION 2

MEMBER ELIGIBILITY AND COVERED BENEFITS

IDENTIFICATION OF MEMBERS AND ELIGIBILITY

Please use the information provided on the member's ID card to confirm the member's current eligibility and benefits through the eternalHealth provider portal at provider.eternalhealth.com.

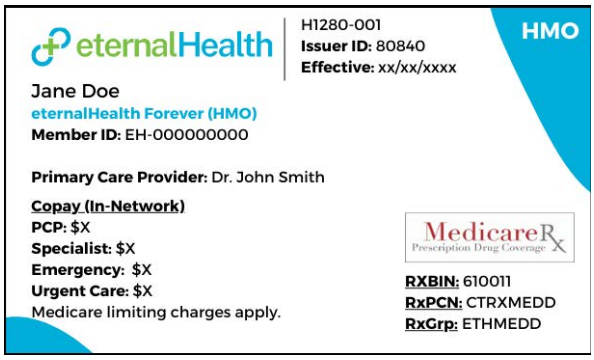
Confirming the member's eligibility and benefits prior to providing care:

- Helps ensure that you submit the claim to the correct payer
- Allows you to collect applicable, accurate copayments
- Determines if a prior authorization or notification is required
- Reduces denials for non-covered specifics

eternalHealth Members will receive their own personal Member identification card that will be physically mailed to their address. Additionally, virtual Membership cards are available to them through the Member portal.

eternalHealth uses unique non-Social Security, number-based identification codes. For Members, this will be a 11-digit alphanumeric Member ID. The syntax of the plan will be: EHXXXXXXXXX.

Example Member Cards:



SERVICE AREA

2024

Suffolk, Worcester, Middlesex, Norfolk, Bristol, and Plymouth Counties of Massachusetts.

Maricopa County of Arizona

REFERRALS AND USE OF NETWORK PROVIDERS

HMO - Members choose a Primary Care Provider (PCP) from our network.

You must direct members to other network providers. Referrals are not required, but we encourage our PCPs to use them whenever referring to other network providers.

The services listed below do not require a pre-authorization:

- Routine health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Flu shots, COVID-19 vaccinations, Hepatitis B vaccinations, and pneumonia vaccinations as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed services from network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible (e.g., when you are temporarily outside of the plan's service area).
- Dialysis services for Chronic Kidney Disease that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area.

PPO – Members do not have to choose a Primary Care Provider (PCP) from our network; however, we strongly encourage that they do.

You should direct members to other network providers, if possible, to help ensure lower cost-sharing and better coordination of care. Referrals are not required, but we encourage our PCPs to use them whenever referring to other network providers.

COVERED BENEFITS

We provide our members with a comprehensive benefit package, including the primary, preventive, and specialty care necessary for good health. Covered services must be medically necessary and appropriate. Claims for services excluded from Original Medicare will not be paid. You can learn more about Medicare excluded services here. To obtain member benefit information please visit **https://www.eternalhealth.com/for-members/forms-and-documents/** and select the plan that you would like more information about.

A member who elects to receive medical care for services not included in the contract, or for services that are determined not medically necessary, will be responsible for payment. In those instances, direct the member to the EOC and document prior approval from the member for such out-of-pocket expenses, or submit a request for organizational determination. All services can be subject to applicable member cost-sharing.

COORDINATION OF BENEFITS (COB)

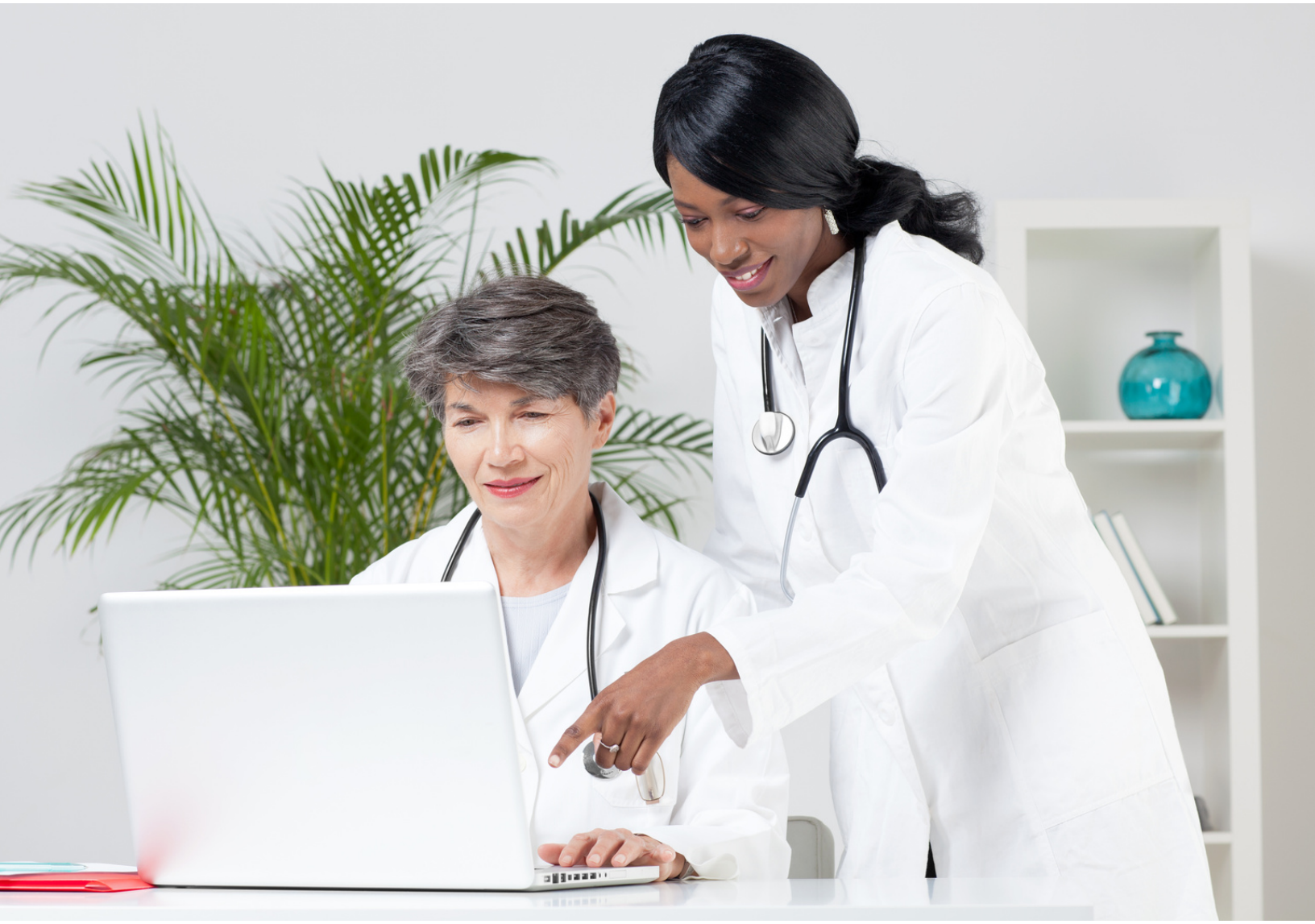
Coordination of benefits (COB) and services is intended to avoid duplication of benefits and at the same time preserve certain rights to coverage under all plans in which the member is covered. COB is an important part of eternalHealth's overall objective of providing healthcare to members on a cost-effective basis. Members cannot be billed for covered services rendered except for any cost-sharing for which the member can be responsible. Your contract with eternalHealth requires you to accept eternalHealth's payment as payment in full.

Coordination of benefits for Medicare Advantage members with Medicaid

No share of cost should be collected at the time of the visit from a member with Medicaid coverage.

SUBROGATION

If there is a third party responsible for the cause of a member's injury or illness, eternalHealth reserves the right to recover benefits previously paid to a provider for related healthcare services. Recoveries can be pursued by eternalHealth or its contracted vendors to the extent permitted under applicable law.



SECTION 3

PROVIDER RESPONSIBILITIES

STANDARDS OF PARTICIPATION

It is important to keep your provider data up to date to ensure accurate claims payment and proper representation in our provider directories. Please let us know if any of the following information about your practice changes:

- Office or billing address information, including telephone number
- Billing information, including National Provider Identifier(s) and Taxpayer Identification Number
- Group affiliation
- eternalHealth participation status
- Medicare participation status
- Sanction information

Acceptance of New Patients

If you decide not to accept additional eternalHealth members, please give us a 60 days notice.

Hospital Privileges

You can submit updates via the provider portal at: provider.eternalhealth.com.

eternalHealth reserves the right to require admission privileges with its network providers. If you or any of your group practice providers lose privileges at any hospital, please notify us no later than 10 business days following the date of the termination.

APPOINTMENTS AND ACCESS STANDARDS

We are dedicated to facilitating quality access to care for our members. To help with this process, we ask that you and your office staff adhere to the following recommendations:

- Provider offices must schedule appointments in a timely and efficient manner. Providers are expected to follow industry, CMS, relevant state, and NCQA health accreditation access standards.

- All network practitioners must be available, either directly or through coverage arrangements, 24 hours a day, 7 days a week, 365 days a year. Availability must be in the form of live voice direct to the Provider or a covering practitioner, or via an answering service that can reach the Provider or covering practitioner. If an answering machine is used, it must provide an option for the Member to directly contact the practitioner or covering practitioner in the case of emergencies. An answering machine cannot refer the member to an emergency room unless it is a life-threatening issue.

- Appointments: You must make every effort to see a member within the following time frames:
  - Emergent: Immediately; member should be directed to call 911 in the event of an emergency or go to the emergency room for treatment
  - Urgent: Within 24 hours
  - Routine/Symptomatic: Within 7 days
  - Wellness/Non-symptomatic: Within 30 days

- Office waiting time: Should not exceed 30 minutes from the time of the scheduled appointment.

- Minimum office hours: You must practice for a minimum of 16 hours a week and must promptly notify eternalHealth of changes in your office hours and locations as soon as this information becomes available, but no later than 3 business days after the change takes effect. The minimum office hour requirement can be reduced under certain circumstances for good cause, with eternalHealth's prior written approval.

- Accessibility: You are expected to meet the federal and state accessibility standards and those defined in the Americans with Disabilities Act of 1990. Healthcare services provided through eternalHealth must be accessible to all members.

eternalHealth tracks and evaluates issues relating to waiting times for appointments, appropriateness of referrals, and other indications of capacity. Providers who fail one or more components of the survey are notified and subject to potential action.

MEMBER REFERRALS

If you are responsible for providing or arranging for a covered service, you agree to direct the member to an appropriate participating provider in eternalHealth's network. You may direct a member to a non-participating provider only when:

- No participating provider is reasonably available to perform the necessary services;
- When member requires emergency services and directing such member to a non-participating provider would expedite diagnosis or treatment;
- eternalHealth and provider mutually agree that the member may be referred to a non-participating provider; or
- A referral to a non-participating provider is reasonably determined by provider to be in the best interest of the member.

Refer to your specific Provider Agreement for additional details.

ACCESS TO MEDICAL RECORDS

eternalHealth may request medical records for audits, quality assurance purposes, as well as to ensure proper billing and claims payment practices. Unless otherwise specified in your Provider Agreement, medical records shall be provided at no cost.

MEDICAL RECORDS STANDARDS

We believe that updated, complete documentation is an essential component to the delivery of quality medical care and collaboration. We reserve the following rights to ensure our member profiles are comprehensive.

Access and Confidentiality

We reserve the right to inspect (at reasonable times) any and all records, specifically any medical records you maintain pertaining to members. This includes, but is not limited to, assessing quality of care, collecting data for Healthcare Effectiveness Data and Information Set (HEDIS®) reporting, collecting data for risk adjustment reporting, coordinating medical care evaluations and audits, determining on a concurrent basis the medical necessity and appropriateness of any care being provided, and ensuring proper billing and claims payment.

Federal and state regulatory bodies can determine other purposes for having access to members' medical records.

For information on member rights as they relate to the above, refer to the Members' Privacy Rights section of this Provider Manual.

Medical Record Documentation

- **Medical information must be legible and follow a logical and consistent format, with page numbers indicated (e.g., "Page 1 of 2") if an encounter spans multiple pages.**

- **The record must contain complete encounter information for each encounter in the chart. This includes:**

    - Member's full name and date of birth
    - Provider's full name and title
    - Facility name
    - Date(s) of service
    - Documentation of all services provided by the physician as well as other nonphysician services (e.g., physical therapy, diagnostic or laboratory services, home healthcare)

- **The record must indicate:**
    - All illnesses and medical conditions
    - Medications list
    - Consultations/referrals
    - Present issue
    - Treatment plan
    - Follow-up plan
    - Preventive screenings and health education offered
    - Documentation on advance directives

- Information should be stored within a secure folder in a safe place.
- No record should be altered, falsified, or destroyed. If a correction is introduced, the individual correcting the record should draw a single line through the item to be corrected, and date and initial the correction.
- All telephone messages and consult discussions must be clearly identified and recorded.
- The medical record system should provide a mechanism to ensure member confidentiality.

Electronic Medical Record (EMR) Integrations

eternalHealth partners directly with EMR and integration vendors to automate the transmission of member charts via a secure and HIPAA-compliant connection.

Integrations automate the transmission of member charts to eternalHealth without any additional effort or disruption to your practice. Under no circumstances does eternalHealth have access to patient data for non-eternalHealth members as a result of this integration. Benefits of participating in an eternalHealth EMR integration include:

- Enhanced care coordination with eternalHealth through incorporation of EMR data into eternalHealth's advanced analytics platform
- Giving time back to your office staff that would have otherwise been spent responding to traditional medical record requests
- Reduced waste and environmental impact of printing charts, made possible through a paperless medical record retrieval
- Automated identification and transmission of member charts to eternalHealth

Although we encourage participating providers to use EMR to help streamline your administrative processes, help protect your patients' information, and result in faster processing, eternalHealth will also accept paper chart submissions and can occasionally request a paper chart to verify the accuracy of EMR data.

NON-ADHERENT MEMBERS

At eternalHealth, we are here to support you. Please contact Provider Services if you have an issue regarding a member's behavior or treatment cooperation and/or completion, or if you have a member who cancels or does not appear for necessary appointments and fails to reschedule.

PROVIDER COLLECTION DATA

Initial Roster and Facility Data Collection

eternalHealth requires a fully complete, accurate, and up-to-date practitioner or facility roster in order to load practitioners, groups, and facilities into our internal systems and provider directory. Inaccurate provider data may result in incorrect claims payment and/or incorrect representation in our provider directories.

Directory Validation

eternalHealth may conduct outreach to every provider in our provider directory to validate demographic and contact information. Outreach is performed on a regular basis by email or phone.

For health systems and large groups, the organization is responsible for the accuracy of the information being sent to eternalHealth and any inaccurate data discovered by eternalHealth will be quickly communicated back to the provider for verification.

Any refusal to share updated provider data with eternalHealth can result in the withholding of payment to the provider for services provided to eternalHealth members.

Updating provider information

Submit updates to eternalHealth by going to the provider portal: provider.eternalhealth.com

CAQH Profile

To help ensure accurate provider directory information, it is important to keep your CAQH profile up to date. While you are required to re-attest every 120 days, it is a good idea to review and attest your data on a monthly basis.

Follow these steps to update and re-attest to your information:

- Log in to CAQH ProView.
- Correct any outdated information, and complete other incomplete questions applicable to your provider type.
- Confirm there are no errors on your profile and attest to its accuracy.

If you have questions, please review the materials provided on the CAQH ProView for Providers and Practice Managers page at caqh.org/solutions/caqh-proview-providers-and-practice-managers.

Additionally, you may contact the CAQH ProView Help Desk for assistance:

- Log in to CAQH ProView and click the Chat icon at the top of the page or call 1-888-599-1771.
- Please have your CAQH ProView Provider ID readily available.

COMPLIANCE WITH FEDERAL LAWS AND DONDISCRIMINATION

The Code of Federal Regulations (42 CFR 422.504) requires that Medicare Advantage Organizations have oversight for contractors, subcontractors, and other entities. The intent of these regulations is to ensure services provided by these parties meet contractual obligations, laws, regulations, and CMS instructions. eternalHealth is held responsible for the compliance of its providers and subcontractors with all contractual, legal, regulatory, and operational obligations.

The contracted provider represents and warrants to eternalHealth that they will not discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, HIV status, source of payment, veteran status, plan membership, or geographic location. Payments received by contracted providers from Medicare Advantage plans for services rendered to plan members include federal funds; therefore you, as a contracted provider, are subject to all laws applicable to recipients of federal funds, including but not limited to: Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, and all other laws that apply to organizations that receive federal funding. In addition, as a contracted provider, you must not discriminate against our members based on their payment status, specifically if they receive assistance from a state Medicaid program.

Treatment of Immediate Relatives or Members of the Household
eternalHealth follows the exclusion of payment guidance for charges imposed by immediate relatives of the patient or members of the patient's household as outlined within Section 130 of the Medicare Benefit Policy Manual. Per this section, providers will not be reimbursed for services provided to those who are immediate relatives or those who share the same household.

Immediate relatives:
- Spouse
- Biological or adoptive parent or child
- Sibling
- Stepparent, stepchild, stepbrother, or stepsister
- In-law
- Grandparent or grandchild
- Spouse of grandparent or grandchild

Members of household:
- Persons sharing a common home with the patient as part of a single-family unit.
- The intent of this exclusion is to bar Medicare Advantage payment for items and services that would ordinarily be furnished free of charge.

SECTION 4

CLAIMS AND BILLING

CLAIMS SUBMISSION

Electronic Submission

We encourage participating providers to use electronic claim submissions whenever possible. Doing so can help streamline your administrative processes, help protect your patients' information, and result in faster claims processing and payment. eternalHealth supports electronic submission via the HIPAA transaction set (837P and 837I) and upholds Medicare guidance requiring electronic claim submission as defined by the American Simplification Compliance Act.

You should submit claims via Change Healthcare with eternalHealth's **Payer ID # RP037**.

Paper submission

eternalHealth also accepts the CMS-1500 and the CMS-1450 paper claim forms.

eternalHealth Billing Department
PO Box 1263
Westborough, MA 01581
Attn: eternalHealth Medicare

Timely filing of claims

You should refer to your Provider Agreement for filing guidelines and documentation requirements. Unless otherwise specified in your Provider Agreement, eternalHealth's standard timely filing limit is 90 days from the claim date of service for in-network providers. As set forth in your Provider Agreement, you cannot bill members for services submitted beyond the timely filing limit. Corrected claims must also be submitted within 90 days from the claim date of service, unless otherwise specified in your Provider Agreement.

Claims processing

We use guidelines established by CMS and internal claims processing policies when determining proper coding. These guidelines and policies dictate claims edits, adjustments to payment, and/or a request for review of medical records that relate to the claim.

You can refer to one of the following CMS guidance documents on electronic and paper claim submissions:

Medicare Billing: 837P and Form CMS-1500
Medicare Billing: 837I and Form CMS-1450

You can check the status of claims you've submitted. Please visit the provider portal at: provider.eternalhealth.com

Clean Claims

Clean Claims should have detailed, accurate, and up-to-date patient data. Any relevant referrals should be included or referenced as proof. All the relevant elements of CMS Form 1500 or UB04 Claims Forms should be submitted, including but not limited to Member identification numbers, NPIs, dates of service, and an accurate and full description of the medical services provided. Additionally, there should be no error in coding the claim for the services provided.

Failure to submit a clean claim can result in a delay of payment and/or rejection of a claim. Common types of errors include incomplete fields, invalid codes, lack of supporting medical records, provider data mismatches, and use of the wrong claim form(s).

Timely Processing of Claims

eternalHealth is required to uphold standard claims timeliness guidelines, which either are stipulated in your Provider Agreement or follow CMS timeliness requirements.

Refer to the CMS guidelines for more information.

Claims Payment

You will be reimbursed according to the compensation provisions of the Compensation Schedule included in your Provider Agreement.

Sequestration

At eternalHealth, we use the same sequestration reductions as those imposed by the Centers for Medicare & Medicaid Services (CMS). All providers are reimbursed using a fee schedule based on the Medicare payment system, percentage of Medicare Advantage premium or Medicare-allowed amount (e.g., resource-based relative value scale [RBRVS], diagnosis-related group [DRG], etc.) and will have the 2% sequestration reduction applied the same way it would be applied by CMS, unless otherwise specified in your Provider Agreement. This reduction applies to all Medicare Advantage plans.

The amount of the sequestration reduction for each affected claim will be identified as “Sequestration” on the Remittance Advice document that providers will receive from eternalHealth.

Claim Corrections

We will deny a claim if it is determined to be incorrect or incomplete due to missing or invalid information. In this event, you can resubmit a corrected claim within the timely filing period.

PROGRAM INTEGRITY

To ensure that claims payments are issued in accordance with CMS guidelines, the integrity of our payment programs is overseen by dedicated staff and can include the use of contracted vendors. All claims can be subject to prospective, concurrent, or retrospective review for both billing and payment accuracy.

Overpayment Recovery

We abide by CMS guidelines for overpayment recoupments, including: provider notification, opportunity for rebuttal, and the possibility of automatic recoupments from future claims payments.

eternalHealth can reopen and revise its initial determination or redetermination on a claim on its own motion:

- Within 1 year from the date of the initial determination or redetermination for any reason; or
- Within 4 years from the date of the initial determination or redetermination for good cause as defined in CMS Medicare Handbook §10.11; or
- At any time if:
  - There exists reliable evidence that the initial determination was procured by fraud or similar fault as defined in the Code of Federal Regulations (42 CFR §405.902); or
  - The initial determination is unfavorable, in whole or in part, to the party there to, but only for the purpose of correcting a clerical error on which that determination was based. Third party payer error does not constitute clerical error or similar fault as defined in the Code of Federal Regulation (42 CFR§ 405.986).

eternalHealth can collect a monetary penalty against a reimbursement request including, but not limited to, an interest charge.

When refunding an overpayment by check, be sure to include all appropriate information to help us identify the overpaid claim:

- Member name and eternalHealth ID
- Date of service
- Billed and paid amounts
- Provider remittance advice that you received for the claim and/or the refund request letter you received from eternalHealth or one of our contracted vendors

If we determine upon investigation that our overpayment was a result of fraud you have committed, we will report the fraud to the appropriate state and federal regulators as required by law. We can then take action to collect an overpayment by assessing it against payment of any future claim submitted by you.

SECTION 5

PAYMENT DISPUTES

PAYMENT DISPUTES

Payments that are made to Provider are based on the terms of the Agreement with PLAN. If Provider disagrees with how a claim was processed, they may file a payment dispute. A payment dispute ("Dispute") is a Provider's written notice to PLAN challenging, appealing or requesting reconsideration of a claim (or bundled claims of substantially similar multiple claims that are individually numbered) that has been denied, adjusted, contested, seeking resolution of a billing determination or other contract dispute (or bundled disputes of substantially similar multiple billing or other contractual disputes that are individually numbered), or disputing a request for reimbursement of an overpayment of a claim.

Disputes should be submitted within **one-hundred and eighty days (180)** of Provider's receipt of the remittance notice ("Dispute Period"). eternalHealth will accept two levels of dispute per claim.

All Disputes must be submitted in writing and must include:

- Claim details
  - Claim number.
  - eternalHealth member ID.
  - Date of service.

- Supporting Documentation:
  - Explanation of Payment.
  - Full explanation for payment adjustment.

- Provider's return address.

PLAN may request other additional documentation to further investigate.

Please submit Disputes to:

eternalHealth
ATTN: Claims
PO Box 1263
Westborough, MA 01581

Provider may also fax disputes to **1 (888) 692-7270**.

A resolution to Disputes will be made and shared in writing, along with an explanation for such resolution "Dispute Resolution", with the Provider within **sixty-five (65)** calendar days of receipt of the Dispute. Please allow the full **sixty-five (65)** calendar days to pass before submitting an additional request. Any additional Disputes arising out of a claim for which there is an open Dispute, unless submitted within the Dispute Period, will be discarded.

If Provider wishes to appeal a Dispute Resolution, this appeal must be submitted in writing. It should include:

- Payment dispute case number.
- Initial claim details.
- Full explanation of reason for appeal.
- Provider's return address.

Please submit appeals to:

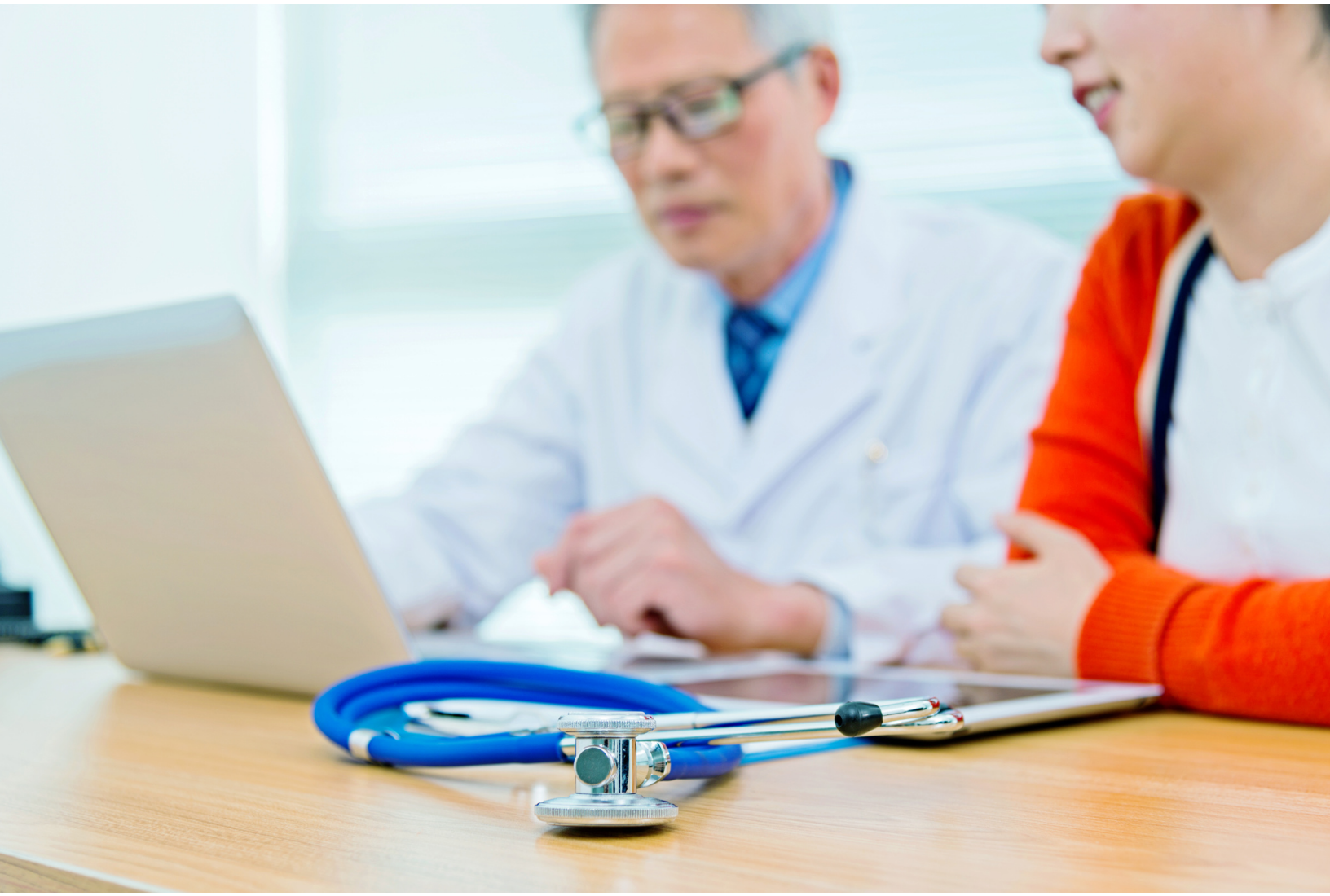
eternalHealth
ATTN: Claims
PO Box 1263
Westborough, MA 01581

Provider may also fax any appeals to **1 (888) 692-7270**.

A resolution to Dispute appeals will be made and shared in writing, along with an explanation for such resolution ("Appeals Dispute Resolution"), with the Provider within **sixty-five (65)** calendar days of receipt of the Dispute appeal.

For more information about the payment disputes process, contact eternalHealth Provider Services at **1 (617) 684-2430**.

Past Due Payments: If the Dispute involves a claim which is determined in whole or in part in favor of the Provider, PLAN will pay any outstanding monies determined to be due, and all interest and penalties required by law, within **fifteen (15)** calendar days of the issuance of the Dispute or Appeals Dispute Resolution.



SECTION 6

FRAUD WASTE AND ABUSE

STATE AND FEDERAL LAWS

Federal and State fraud and abuse laws that apply to you include the False Claims Act, the Anti-Kickback Statute, and the Physician Self-Referral Law (Stark Law). Violations of these laws can result in nonpayment of claims, civil monetary penalties (CMP), exclusion from all federal healthcare programs, and criminal and civil liability.

ETERNALHEALTH'S FRAUD, WASTE, AND ABUSE OBLIGATIONS

As a partner of CMS, we are obligated to monitor for signs of fraud, waste, and abuse; and to ensure well-managed care through a payment integrity review both before and after payment is issued. eternalHealth uses software tools to identify providers and facilities whose billing practices match patterns associated with suspicious conduct.

If a claim, provider, or facility is identified as a behavioral outlier, further investigation is conducted by eternalHealth to determine the reason(s) for the outlier behavior or approximate explanation for an unusual claim, billing, or coding practice. If the investigation results in a determination that the provider's or facility's actions can involve fraud, waste, or abuse, the provider or facility is notified and given an opportunity to respond, and eternalHealth can institute an overpayment recovery process.

Reporting Fraud Waste and Abuse

You are obligated to report suspicious behavior to the OIG by calling 1-800-HHS-TIPS; TTY 1-800-377-4950; oig.hhs.gov/fraud/report-fraud

You can also report suspicious activity by calling eternalHealth's Compliance and Ethics Hotline at 1-857-557-6007 or by email at compliance@eternalHealth.com.

Compliance Training

To ensure that Providers remain compliant with applicable requirements, eternalHealth strongly encourages Providers to provide its workforce Members with compliance, FWA, and HIPAA training. This training may be completed by accessing the General Compliance Training available on the CMS Medicare Learning Network® at cms.gov.

Balance Billing and Inappropriate Billing of Members

If you are a Medicare-participating provider or you contract with eternalHealth, you cannot balance bill or inappropriately bill members. Any such billing is a violation of the Provider Agreement and applicable state laws. Providers who willfully or repeatedly balance bill members will be referred by eternalHealth to the relevant regulatory agency for further action and may have their contract terminated with eternalHealth.

Other inappropriate member billing includes, but may not be limited to:

- The difference between actual charges and the contracted reimbursement amount.
- Services denied due to timely filing requirements.
- Covered Services for which a claim has been returned and denied for lack of information.
- Remaining or denied charges for services where the Provider failed to notify eternalHealth of a service requiring Prior Authorization. Prior Authorizations do not guarantee claim payment.
- Covered Services for which payment was reduced as a result of claim editing as described in this Manual.

SECTION 7

PROVIDER CREDENTIALING AND RIGHTS

Applicants for credentialing have the following rights. Notification that these rights are available is included in the application cover letter, and in the Provider Manual:

Right to be Informed of Their Credentialing Application Status Upon Request

Upon receipt of a written request, the Plan will provide written information to the applicant of the status of the credentialing application within fifteen (15) business days. The information provided will advise any items still needing to be verified, any non-response in obtaining verifications, and any discrepancies in verification information received compared to information provided by the applicant.

Right to Review Information Submitted to Support their Credentialing Application

The applicant may review any documentation submitted by him/her in support of the application, together with any discrepant information received from a professional liability insurance carrier, state licensing agencies and certification boards. The applicant may not review peer review information obtained by the Plan.

Right to Correct Erroneous Information and Receive Notification of the Process and Timeframe

In the event the credentials verification process reveals the information submitted by the applicant varies substantially from the verification information obtained by the Plan, the Plan will notify the applicant. The identified discrepancies are communicated by the Plan to the applicant in writing within fifteen business days. The applicant can submit corrections for the erroneous information to the Plan but must do so within the timeframes and in the format specified in the Plan's letter.

The Plan's notification to the applicant will include:

- The nature of the discrepant information;
- The process for correcting erroneous information;
- The format for submitting corrections;
- The timeframe for submitting the corrections;
- The addressee to whom corrections must be sent;
- The Plan's process for receipt of the corrected information from the applicant;
- The Plan's review process.

The applicant is notified that discrepant information has been identified and is requested to make the necessary corrections to their application information and/or provide a written explanation within thirty calendar days of receipt of request. The correction information is to be returned using one of the following methods: (a) by mail to the Plan Credentialing Department; (b) emailed to the Plan Credentialing Department email; (c) faxed to the Plan Credentialing Department using the fax number provided in the request.

Upon receipt of the correction information by the Plan, the completed credentialing application, which includes the appropriate verifications and correction information provided by the applicant, is then submitted through the Plan's credentialing approval process. Notification of the credentialing decision is provided to the applicant within applicable regulatory or accreditation agency timeframes (Note: NCQA current standards require notification within thirty (30) calendar days).

Confidentiality

The Credentialing Department is responsible for ensuring the confidentiality of all information received and maintained in the credentialing and recredentialing processes. Information derived from peer-review functions is protected from subpoena and discovery by state immunity laws, except as otherwise provided by law. This includes proceedings, reports, and records of a peer review specialty committee.

Nondiscrimination

eternalHealth does not discriminate in the credentialing or recredentialing process on the basis of religion, race, color, national origin, age, gender, sexual orientation, height, weight, familial status, marital status, disability, or any other basis prohibited by law. Additionally, eternalHealth does not discriminate in credentialing and recredentialing based upon the types of procedures or the risks of the population that you serve.

Review of Your Information on File

With the exception of information determined by eternalHealth to be peer-review protected, you have the right to request in writing your file information and to subsequently review and correct any erroneous information obtained by eternalHealth to support its evaluation of your application. Please contact eternalHealth's Provider Relations to request this information.

SECTION 8

PROVIDER TERMINATION

CIRCUMSTANCE FOR TERMINATION

There can be certain circumstances in which eternalHealth decides to terminate its relationship with contracted or participating providers.

An immediate termination can be initiated for the following reasons:

- Suspension, revocation, condition, expiration, or other restriction of your licensure, certification, and/or accreditation to perform services contemplated under your Provider Agreement
- Suspension or bar from participation in federal healthcare programs
- Determination that you engaged in or are engaging in fraud
- Noncompliance with the general and professional liability insurance requirements set forth in your Provider Agreement
- State sanctions, indictment, arrest, conviction, or a felony or any criminal charge
- eternalHealth's reasonable determination that your immediate termination is necessary for the health and safety of members

eternalHealth can also terminate the participation of an individual group provider or can require that an individual group provider cease providing services to members based upon any of the foregoing events, without terminating the Provider Agreement in its entirety.

Certain terminations initiated can also not take effect immediately (terminations for cause, terminations without cause). Refer to your Provider Agreement for details around terminations that cannot take effect immediately and the effective time frames.

In the event of a termination, eternalHealth sends a termination notice to you, your ancillary, or your hospital. eternalHealth can require you, your ancillary, or your hospital to provide continuity of care until a safe transition to another provider has been made.

Your Provider Agreement will not be terminated or refused renewal solely because you have:

- Advocated on behalf of a member
- Filed a complaint against eternalHealth
- Appealed a decision made by eternalHealth

Additionally, you can have termination rights of your own. For details about provider termination rights, please refer to your Provider Agreement.

Appeal Hearing Process

When you, your ancillary, or your hospital requests an appeal of a termination decision, eternalHealth's Credentialing and Termination Committee can form a sub-committee to hear your appeal. The sub-committee consists of no fewer than 3 members. Here are the rules and regulations for holding an appeals process:

- Peers can be providers or healthcare professionals outside of the eternalHealth network of providers
- No individuals involved in the investigation of an appeals case can be part of the appeals hearing committee

- The appeals hearing committee voting can be made in person, via phone, or via email
- The medical director appoints a hearing officer who serves as the presiding officer over the hearing
- The presiding officer should:
  - Determine the order and decorum of the hearing and deliberations
  - Assure that all participants have opportunity to present oral and documented evidence
  - Provide guidance to the appeals hearing committee during the hearing and deliberations
- The hearing officer does not have voting privileges

The notice of the final decision of the appeals hearing committee is delivered by certified mail to you, your ancillary, or your hospital 30 days after close of the hearing. The notice includes the final decision, the basis for that decision (affirm, modify, or withdraw the original proposed action), and the Provider Agreement provisions and facts relied upon by eternalHealth during the hearing.

NONRENEWAL OF CONTRACT

Unless otherwise specified, the Provider Agreement eternalHealth executes with you automatically renews on the one-year anniversary of the effective date on your Provider Agreement, unless terminated in accordance with the provisions stated in it. A nonrenewal of your Provider Agreement constitutes a termination and will be treated as final.

CONTINUITY OF CARE

In the event of a termination, whether initiated by you or by eternalHealth, our goal is to ensure that your patients, our members, continue to receive the care they require until they no longer require it or until a safe transition can be made (unless otherwise specified).

In the event that you voluntarily decide to leave the network, or eternalHealth terminates with/without cause (i.e., a termination that does not fit the criteria of “immediate” as defined above), you must agree to continue to provide covered services until it is safe to discontinue care or other safe alternatives have been confirmed.

YOUR
FOREVER
PARTNER IN
HEALTHCARE