Centivo
Provider Manual

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The way healthcare should be.

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1. Introduction

Welcome to the Centivo Network. We have prepared this Provider Manual to provide you with helpful administrative and other information relating to your important role with the covered Participants. We hope to minimize your administrative interaction and maximize your time with your patients.

This Manual is meant to supplement your Provider Services Agreement; nothing in this manual is intended to alter the terms and conditions of your Provider Services Agreement. The Agreement, along with state or federal law formally guide our relationship. Please note that if a provision in this Manual conflicts with state or federal law or the terms of the Provider Services Agreement, the state or federal law or the Provider Services Agreement takes precedence.

In addition to the obligations specified in your Agreement, this Manual provides information about contractual obligations for Centivo Network Participating Providers. Centivo will provide thirty (30) days prior written notice to Provider. If you are contracted through a medical group or an IPA participation agreement, the medical group or IPA will notify you of changes to the Centivo Participating Provider Manual.

Unless otherwise defined herein, all capitalized terms shall have the same meaning as ascribed to them in the Provider Services Agreement.

2. Centivo Information & Contact Information

Centivo Support is available Monday-Friday 8:00am to 8:00pm Eastern Time or any time at https://provider.centivo.com.

For questions regarding benefits, eligibility, claims status, or claims support:

- Phone: please see the Participant's ID card
- Email: providers@centivo.com
- Provider portal: https://provider.centivo.com

For claims submissions:

- Centivo electronic payer ID: 45564
- Submit all claims to the following address:
  Centivo
  P.O. Box 211681
  Eagan, MN 55121

If you require additional communication or to send form and documents, you may:

- Fax to Centivo Support: 716-219-1946
- Mail to: Centivo Provider Support, 307 Cayuga Road, Suite 170, Buffalo, NY 14225

3. About Centivo

Centivo is an administrator of health plans for self-funded employers committed to promoting the importance of primary care and engaging covered Participants to make well-informed decisions. The Centivo Network is a new type of health plan serving area employers, beginning in January 2020.

The Centivo model emphasizes the partnership between individuals and their Primary Care Team as the proper model to coordinate healthcare needs. Participants are encouraged to choose high-value care, adhering to the guidance from their Primary Care Team and supported through a state-of-the-art digital app and concierge team.

Centivo does not underwrite insurance plans and is not at risk for the payment of claims. Centivo administers its clients' benefit plans in accordance with the employer's applicable Plan Documents. Copies of Plan Documents and less detailed Summaries of Benefits and Coverage are available on the Provider Web Portal.

4. Centivo Plan Design

The Partnership Plan emphasizes the partnership between an individual and their primary care provider to coordinate participants' needs, and participants' out-of-pocket costs are determined by their actions. Participants are required to designate a primary care provider and receive referrals for in-network specialty and ancillary care receive (see details and exceptions in Section 5) to access free care or low/moderate co-pays. Claims for participants who do not designate a primary care provider or who do not get referrals before seeing a specialist will be considered out-of-network and may not be covered.

To ensure that you are referring patients appropriately please use the Provider Referral Portal or call Centivo Support using the number of the Participant's ID card.

5. Referrals for Specialty and Ancillary Care

Centivo Participants must coordinate their care needs with their Primary Care Provider to obtain the best coverage and keep their out-of-pocket costs low. As such, Participants are required to get a referral from their Primary Care Team before going to specialists (except obstetrics/gynecology, behavioral health, or urgent care) or facilities.

Role of the Primary Care Provider:

- If a referral is required for Medically Necessary treatment, submit a referral using the Centivo Referral Portal or by calling Centivo Support.
- Keep a record of any referrals.

Role of the Specialist Provider:

- Ensure a referral is on file before providing care to a Partnership Plan member, either by checking

with the member, Centivo Concierge, or via the Centivo Referral Portal.

Role of the Participant:

- Obtain referral from primary care team.
- In case of emergencies, Participant must contact the PCP within 72 hours (ER / Urgent Care).

Other Referral Guidelines:

- Each referral will be valid for 180 days.
- There is no referral requirement for obstetrics/gynecology and behavioral health providers.
- In the event of emergency or urgent care, Participants have 72 hours after they receive care to contact their Primary Care Team and submit the referral notification.
- Referrals are not required for Laboratory tests, x-rays, or therapies (occupational, physical, or speech)—but a physician must order or prescribe these services.
- A referral is not a substitute for pre-certification (see Section 9).

6. Network Quality Assurance

The following is intended to provide clarification/additional information regarding your Participation Agreement's requirements for quality programs.

Nondiscrimination

You must not discriminate against any patient with respect to the delivery or accessibility of services. Your practice must maintain written policies and procedures related to non-discrimination. This includes discrimination based on:

- Type of health insurance
- Race
- Ethnicity
- National origin
- Religion
- Sex
- Age
- Disability
- Sexual orientation
- Claims experience
- Medical history
- Genetic information
- Type of payment

Quality and Patient Safety Activities

You are expected to support the quality improvement and patient safety activities and programs. Specifically:

- Providing timely access to medical records when requested.

- Providing timely responses to queries and/or completion of improvement action plans related to quality of care investigations.
- Support audits and data gathering, including site visits, medical record standards reviews, and Healthcare Effectiveness Data and Information Set (HEDIS®) record review.
- Allow use of practitioner and provider performance data.

Requirements for Primary Care Physicians

The following is intended to supplement and clarify the requirements for Primary Care Physicians under the Centivo Network program:

The role of a Centivo Network primary care provider is to deliver appropriate preventive and other primary care services within the scope of your practice. These services might include, but are not limited to:

- Accepting all patients who elect them as the Primary Care Team
- Establishing and managing patient-specific care plans.
- Coordinating care among various health care practitioners and facilities.
- Delivering routine preventive care (e.g., wellness visits, immunizations, blood tests).
- Treating patients with routine sick care.

Call coverage/Off-hours access

Centivo Network PCPs are expected to provide coverage for Centivo Participants 24 hours a day, 7 days a week. When a PCP is unavailable to provide services, the PCP must ensure they have coverage from either another participating primary care provider (preferred), or a provider that agrees to accept the same rates and ensure continuity of care. Hospital emergency rooms or urgent care centers are not substitutes for covering participating providers, unless Centivo approves a specific request for an exception by a provider.

All PCPs or their covering physicians must provide telephone access 24 hours a day, seven days a week so that you can appropriately respond to patients and other providers concerning after hours care. The use of recorded phone messages instructing patients to proceed to the emergency room or urgent care during off hours is not an acceptable level of care.

7. Credentialing and Re-Credentialing

Centivo has engaged with RT Welter and Associates (RTW) to conduct the credentialing and re-credentialing process for new and existing networks. When calling the Centivo provider relations department (833-559-7597), selecting questions related to credentialing will connect you to the RTW support team.

Centivo supports both non-delegated and delegated credentialing.

Non-Delegated Credentialing: For non-delegated credentialing, the following elements will be requested, tracked, reviewed and verified.

Initial Application:

- Application request and tracking.
- Application review and follow up.

Primary Source Verification for initial credentialing and re-credentialing process:

- Verification of licensure in the state where the provider has a primary office. The practitioner holds a valid, current license to practice which is verified directly from the state licensing agency to include sanction information where available.
- Verification of clinical privileges. Oral or written confirmation from the institution designated by the healthcare provider as the primary admitting facility (as indicated on the application) or the first one listed on the application. Verification to be completed by attestation.
- Obtain copy of DEA, and when appropriate a CDS certificate, for providers and facilities that can prescribe or dispense controlled substances. The provider's certificate or verification from the NTIS must be effective at the time the credentialing file is finalized.
- Verification of education when not board certified. Must be verified in accordance with NCQA or URAC standards.
- Verification of nationally recognized board certification for practitioners that state they are board certified.
- Document a minimum of five years' work history. This information can be collected on the application or curriculum vitae with dates which include the month and year. Gaps in work history of six (6) months or greater will be identified. Verification of work history is not required from primary sources.
- Verification of malpractice insurance by obtaining face sheets. A copy of the current malpractice coverage that shows the dates and amounts of coverage will be obtained from the provider.
- Verification of malpractice claims history. Can be completed by collecting history of malpractice settlements from the National Practitioner's Data Bank (NPDB) or the insurance carrier when available.
- Verification of Medicare and Medicaid sanctions. Verify the status of the practitioner in regard to Medicare and Medicaid sanctions which can be done by completing a query of the NPDB.
- Final review of provider credentialing file by Centivo Medical Director. Centivo Medical Director will recommend approval, pending, or denial of file.
- Ongoing monitoring of sanctions from Licensing Agency(ies) and DHHS (Medicare and Medicaid).

Delegated Entities Credentialing:

For non-delegated credentialing, the following elements will be requested, tracked, reviewed and verified to determine if the Delegated Entities credentialing and re-credentialing written policies and documented procedures conform to National Committee for Quality Assurance ("NCQA") and/or Utilization Review Accreditation Commission ("URAC") standards; and (b) Delegated Entity has the capacity to perform the specific functions identified here;

- Pre-Delegation Assessment
    - On-site evaluation of the potential delegates ability to perform required PRIOR to signing an agreement

        - Policies & procedures, file review
- Delegation Agreement Monitoring for Compliance
    - Responsibilities of each party/activities being delegated
    - Reporting frequency per Delegated Agreement
    - Performance evaluation process
    - Remedies for non-compliance
    - Right of plan to make final decision
- Annual Assessment
    - Annual reviews are performed to ensure that standards continue to be met
    - Semi Annual review of reports determined by Delegated Entity Agreement
        - Policies and procedures
        - Plans standards and requirements
        - File Review; audit process required
- Monthly sanction monitoring (NCQA/URAC)

8. Provider Additions, Changes, Terminations, and Panel Closure

All provider adds, changes and termination requests must be submitted promptly in writing to ProviderRelations@centivo.com .

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

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

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

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

A new provider may not submit claims for services until approval has been obtained through Centivo Provider Relations.

9. Utilization Management

Participating providers are required to observe the protocols of the Centivo Utilization Management Program, referred to as "UM". UM requirements may vary by Client or program, and may include, but is not limited to, prospective, concurrent, and retrospective review. UM programs may also include disease or condition management (referred to as "DM"), maternity management, and management of behavioral health conditions services.

Centivo may choose to employ Delegated Vendors for the administration of various UM programs. Contact Centivo Support to submit or track UM requests at the number on the Participant's ID card.

For Participants in the Centivo Network, MedWatch has been selected as a Delegated Vendor for UM services.

Standard In/Outpatient Pre-Cert List **

- All inpatient stays for medical and/or psych and substance abuse.
- All services listed below regardless of place of service:
    - 23-hour observation stays
    - Arthroscopy or any joint surgery
    - Biopsies - recommended where potential Cancer diagnosis exists
    - Bladder Repair
    - Cardiac Cath / Angioplasty
    - Deviated Septum / Nasal Surgery
    - EBCT (Electron Beam Tomography)
    - Endoscopic Procedures / Colonoscopy
    - Implants of any type
    - Laminectomy / Spinal Surgery
    - Laparoscopy
    - MRI / CT / Pet Scan - excludes bone density studies
    - Physical/Occupational/Speech Therapy - beyond 12 visits
    - Tonsillectomy over the age of 25
    - Any Drug above $1,500 a dose
    - Chemotherapy
    - Infusions (Infusion Therapy) of any type > $1,500
    - Epidural / facet and trigger point injections
    - Biologic Drugs
    - Dialysis
    - DME over $2,500.00
    - Behavioral Health: Intensive Out-Patient Program, Partial Hospitalization Program
    - Radiation Treatments
    - Skilled Nursing Facility
    - Long Term Acute Care (LTAC)
    - Home Health Care
    - Hospice Care

- Gastric Bypass / Panniculectomy / Abdominoplasty
- Cosmetic Surgery
- On-going Wound Care

**Our pre-cert is updated regularly as new procedures are introduced or abused.

Standard Appeals Process

Dispute Resolution:

1. Requests may be made by phone or letter within 180 days of discharge outlining the reason(s) for the appeal.
2. Please mail a copy of the complete medical record for review, obtained at your expense to the address listed on this letter. This allows us to review the case on all available information. If you are unable to obtain a copy of the medical record, we will review the case on the information previously provided.
3. The appeal process will be completed within 30 days of receipt of the request for appeal unless you are informed in writing to the contrary

Members should refer to their Summary Plan Description for more detail on appeals, grievances, or complaints.

Providers should contact Centivo Support with any questions about Eligibility, Benefits, or Claims Review.

10. Case Management

Plans administered by Centivo include case management services to patients with complex health conditions. The case manager will interact with patients and providers in ensuring that services are delivered effectively subject to the terms of the patient's self-funded Plan. This may include assistance in understanding the applicable health benefits and in navigating resources available to them. The complex case management program is a collaborative process among the Participant, the provider(s) and Centivo, as such, we will periodically report progress to a Participant's primary care physician. The goal of these programs is to achieve better health outcomes while managing health care costs.

Most case management will originate from UM programs and identification through medical and prescription drug claims. If you believe a patient is appropriate for Case Management, please contact the Centivo Support at the number on the Participant's ID card. Following your referral, the Case Manager will contact the patient, family members (if appropriate), and any related providers (if appropriate).

11. Eligibility/Participant ID Cards

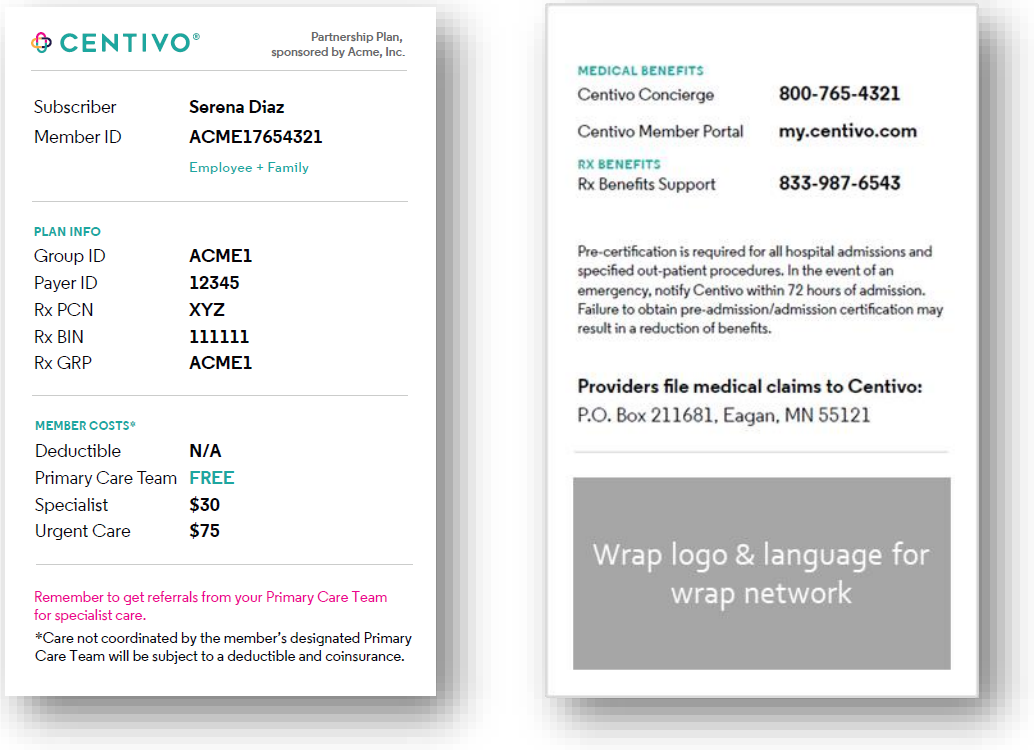
The Member ID and information about verifying eligibility are on the Centivo ID Card. The following are

ways to identify whether a patient is a Centivo Participant:

Digital ID cards: Participants can access and view their digital ID cards after the effective date (listed on the card) using the Centivo app, or the Participant website at my.centivo.com. Patients can easily print replacement ID cards from these portals.

Participant ID cards: Participants should receive an ID card within 10 days of their effective date. At each visit, the office should ask to see the Participant's ID card and collect the appropriate copayment, if applicable. Note: Some covered Participants may only have digital ID cards. These Participants may present their mobile device or a printed copy when seeking health care services.

All Participants enrolled in the Centivo Network receive a Participant ID card. A sample ID card can be found below.



12. Patient Financial Responsibility and Collections

For specialist and other non-primary care practitioners, we anticipate that the vast majority of visits will be referred through the Participant's PCP, thus requiring a straightforward co-pay. However, we recommend that you either:

1. Check to make sure that the Participant has a referral on file by using the Centivo Referral Portal or by calling Centivo Support.
2. Collect the appropriate copay as outlined on the Participant ID card.

Centivo will be closely monitoring activity here and will quickly address any concerning trends through targeted patient education or other means. Contact Centivo Support to confirm benefits or address any questions.

13. Claims Submission

To be reimbursed for services rendered to a Centivo Network Participant, providers must submit a clean claim within the timely filling guidelines. Centivo requests that providers file claims electronically for faster services. When submitting claims, please include all required information. Centivo requires that all claims be submitted on a UB-04 or CMS-1500 claim Form. Instructions for filing using either method are reflected below as well as on the reverse side of the Participant's ID card. When submitting electronic claims, use Centivo's clearinghouse payer ID*: 45564. If you are currently submitting paper claims via mail and would like to submit electronically, please call the Centivo Support and we will assist you.

When Centivo is the primary payor, providers must submit claims for payment within ninety (90) days from the date of service or date of payment received by primary payer unless it is otherwise required by state or federal law or your Provider Services Agreement.

The following information must be included on the claim:

- Current National Provider Identifier (NPI);
- Current Tax Identification Number (TIN);
- Participant's name, address, telephone number, gender, and date of birth;
- Centivo Network Participant ID number;
- Centivo Network Participant group number;
- Current CPT code for each procedure performed and any applicable modifiers;
- CMS coding for place of service and type of service;
- Revenue codes for Departmental revenue, when applicable;
- Diagnosis code number (ICD-10). Indicate appropriate symptoms or diagnoses for tests performed and submit up to four diagnosis codes.
- ICD-10 procedure and DRG codes for all UB-04 claims;
- Referral provider (indicate ordering provider on UB-04);
- Billing provider's name and remit address;
- Date of service;
- Current Coordination of Benefits (COB) information or other insurance information such as motor vehicle, worker's compensation or other third-party liability insurance information.

14. Provider Request for Reconsideration

In the event you disagree with the outcome of a particular claim, a utilization management determination, an erroneous payment adjustment, or other action by Centivo, you may request a reconsideration review. To request a reconsideration, please contact Centivo Support. Note that all claims decisions are governed by the applicable plan document.

15. Pharmacy Management

Centivo will follow the pharmacy benefits set forth in the applicable Health Benefit Plan and plan document. Such benefit plans/plan documents may utilize a prescription drug formulary to help maintain access to quality, affordable prescription drug benefits for your patients. For more information on a Participant's pharmacy benefits, please follow the instruction on the Participant's ID card.

16. Serious Adverse Events

Hospital Acquired Conditions

Participating Providers will not be permitted to receive or retain reimbursement for inpatient or outpatient services related to Never Events. Members will be held harmless for any services related to Never Events

Unless the diagnosis is exempt per the "POA Exempt Diagnosis" list as published by CMS, all participating providers must populate Present on Admission (POA) indicator on all acute care inpatient hospital claims

Nonpayment for Serious Adverse Events

The 14 categories of Hospital Acquired Conditions listed below include the following. For the complete list see the "Centers for Medicare and Medicaid Services (CMS) Hospital-Acquired Conditions" link below.

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Stage III and IV pressure ulcers
- Falls and trauma
    - Fractures
    - Dislocations
    - Intracranial injuries
    - Burn
    - Crushing injuries
    - Other injuries
- Manifestations of poor glycemic control
    - Diabetic ketoacidosis
    - Nonketotic hyperosmolar coma
    - Hypoglycemic coma
    - Secondary diabetes with ketoacidosis
    - Secondary diabetes with hyperosmolarity
- Catheter-associated urinary tract infection (UTI)
- Vascular catheter-associated infection
- Surgical site infection, mediastinitis, following coronary artery bypass graft (CABG)
- Surgical site infection following bariatric surgery for obesity
    - Laparoscopic gastric bypass
    - Gastroenterostomy

    - Laparoscopic gastric restrictive surgery
- Surgical site infection following certain orthopedic procedures
    - Spine
    - Neck
    - Shoulder
    - Elbow
- Surgical site infection following cardiac implantable electronic device (CIED)
- Deep vein thrombosis (DVT)/Pulmonary embolism (PE) following certain orthopedic procedures
    - Total knee replacement
    - Hip replacement
- Iatrogenic pneumothorax with venous catheterization

The 3 wrong surgeries included in the list are:

- Wrong surgical procedure performed
- Surgery performed on a wrong patient
- Surgery performed on a wrong body part

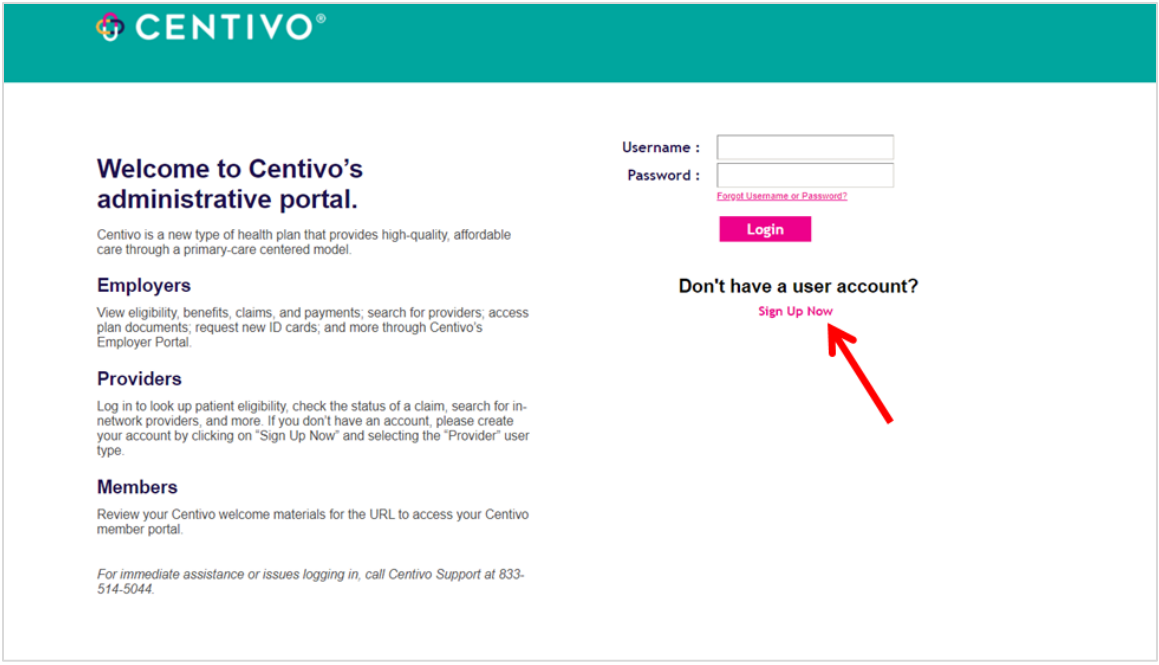
Centers for Medicare and Medicaid Services (CMS). Hospital-Acquired Conditions (Present on Admission Indicator). Retrieved 8/2/10 from: http://www.cms.gov/HospitalAcqCond/

Centers for Medicare and Medicaid Services (CMS). Hospital-Acquired Conditions (Present on Admission Indicator). IPPS FY 2013 Final Rule. Retrieved 1/12/13 from: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html

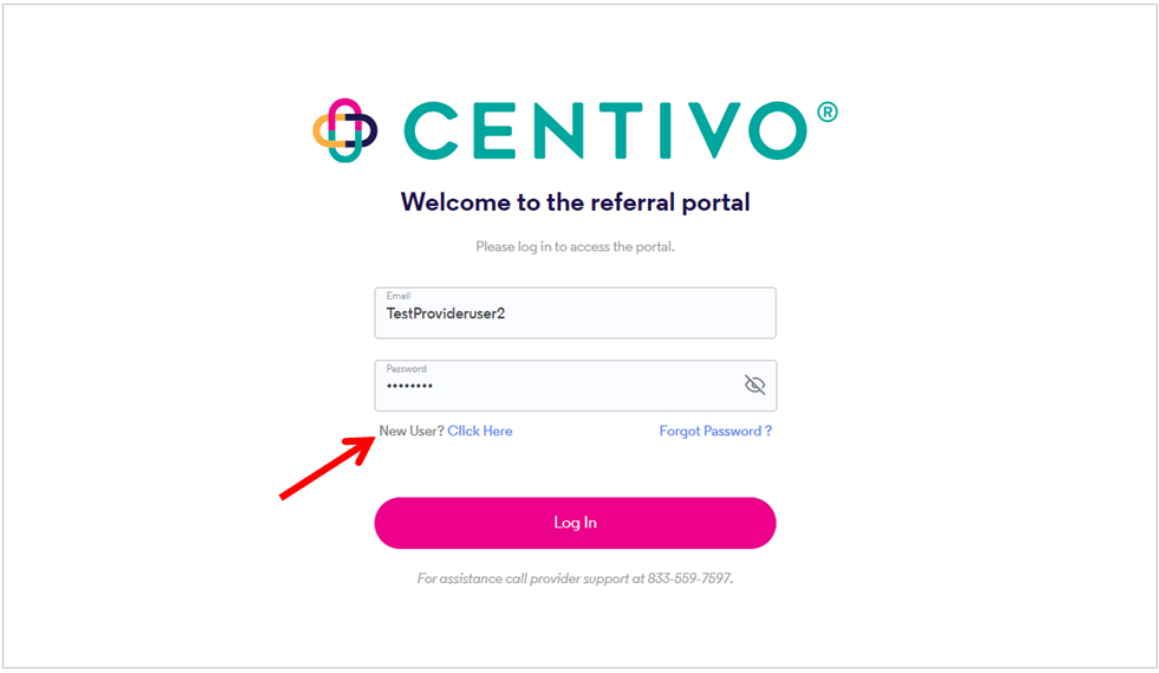
17. Provider Portal Access

Centivo's provider portal is available at https://provider.centivo.com. Use this portal to look up patient eligibility, check the status of a claim, search for in-network providers, and more.

Create your account by clicking on "Sign Up Now" and selecting the "Provider" user type.



Within 2 business days of gaining provider portal access, we will also grant you access to our referral portal at https://referrals.centivo.com.



For assistance, please email providers@centivo.com or call Centivo Support.

EXHIBITS

EXHIBIT A – Important Definitions

The following terms shall have the meanings as ascribed to them or referenced below (such terms shall be equally applicable to both the singular and plural forms of the terms defined):

1. "Client(s)" means any employer group, Plan Administrator, health plan, or insurance company that has an agreement with Centivo.
2. "Claim" means a request for payment for Covered Services rendered to a Participant submitted in accordance with the terms of your Agreement and applicable Health Benefit Plan.
3. "Clean Claim" means a completed UB04 or HCFA/CMS 1500 (or successor form), as appropriate, or other standard billing format containing all information reasonably required by the Client for adjudication, including but not limited to the submitting provider's National Provider Identifier (NPI) number.
4. "Coordination of Benefits" means a method of sequentially assigning responsibility for the payment for health care services rendered to a Participant among two or more insurers.
5. "Covered Services" means those medical and hospital services, for which benefits are available to Participants in accordance with the terms of the applicable Health Benefit Plan.
6. "Delegated Vendor" means any person or organization appointed by Centivo to administer managed care, utilization management, claims processing or other programs for its Health Benefit Plan.
7. "Health Benefit Plan" means the Health Benefit Plan of a Centivo Client which describes the costs, procedures, benefits, conditions, limitations, exclusions and other obligations to which Participants are subject thereunder.
8. "Medical(ly) Necessity(ary)" means those services determined to be (a) preventative, diagnostic, and/or therapeutic in nature, (b) specifically related to the condition which is being treated/evaluated, (c) rendered in the least costly medically appropriate setting (e.g., inpatient, outpatient, office), based on the severity of illness and intensity of service required, and (d) not primarily for the Participant's convenience or that of his or her physician.
9. "Network" means those Participating Providers, preferred provider organizations, specialty networks or other organizations that arrange for the delivery of health care services that contract with Centivo to arrange for the provision of health care services to Participants.
10. "Non-Covered Services" means those medical and hospital services, supplies, products and accommodations provided to Participants that are not designated as benefits to Participants under the terms of the applicable Health Benefit Plan.
11. "Participant" means any person who is eligible to receive benefits under a particular Health Benefit Plan as set forth in the applicable plan document
12. "Participant Responsibility" means deductibles, coinsurances, co-payments or other amounts for which Participants are responsible to Participating Providers under the terms and conditions of the applicable Health Benefit Plan.
13. "Participating Provider" means a health care provider that is considered in-network under the terms of the applicable Health Benefit Plan.