Commercial Provider Manual

Medical and Behavioral Health Provider, Facility, and Ancillary

A Publication of Sentara Health Plans' Network Management Department

This version of the Sentara Health Plans Provider Manual was last updated on May 12, 2026.
Updates to the provider manual may occur due to the introduction of new programs, changes in contractual and regulatory obligations, and updates to existing policies. The most current information is available on the Sentara Health Plans Provider Website.

This version of the Provider Manual supersedes previous versions. The requirements and obligations in this Manual apply to services rendered from May 12, 2026, until Sentara Health Plans publishes an updated version.

Sentara® Health Plans

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Introduction and Welcome

Welcome to Sentara Health Plans. Participating providers are an integral member of our team. Thank you for making it possible for Sentara Health Plans to promote the maintenance of health and the management of illness and disease by providing access to quality healthcare to the communities we serve.

Easily find information in this Provider Manual using the following steps: **Select CTRL+F. Type in the keyword(s). Press Enter.**

This Provider Manual covers policies and procedures for providers caring for members enrolled in Commercial plans administered by Sentara Health Plans.

If a provider is contracted to provide services under Sentara Health Plans Medicaid and/or Dual Special Needs plans, the provider should refer to the Sentara Health Plans Medicaid Program Provider Manual for Medicaid program information and to the Sentara Health Plans Dual Special Needs Provider Manual for specific information about the Dual-Eligible Special Needs plans. Both Provider Manuals are available on the Sentara Health Plans provider website.

Within this manual, providers will find important information to assist with member and product identification, authorizations, claims reimbursement policies/procedures, and provider obligations under the Provider Agreement. Providers will also find useful information such as key contact information and direct web links to policies and forms. Additional information and tools are available at sentarahealthplans.com.

The Provider Manual was developed to assist providers in understanding the administrative requirements associated with managing members' healthcare. The Provider Manual, including all sources that are referenced by and incorporated herein, via weblink or otherwise, is a binding extension of the Provider Agreement and is amended as our operational policies or regulatory requirements change. In addition to the Provider Manual being available online, it is also available in printed form by written request. Many of the policies and procedures that are referenced by or incorporated into this Provider Manual are available on the provider website. Providers are responsible for complying with updates to the provider manual, as they are made available from time to time. Sentara Health Plans notifies providers of updates to this manual via email and website notification 60 days in advance of operational changes that could impact providers doing business with Sentara Health Plans.

If there is a conflict between this Provider Manual and any state law, federal law, or regulatory requirement and this Provider Manual, the law or regulation takes precedence.

Should this Provider Manual conflict with the Provider Agreement, the Provider Agreement takes precedence.

The following terms are used throughout this Provider Manual:

Affiliate means any entity (a) that is owned or controlled, directly or indirectly, through a parent or subsidiary entity, by Sentara Health Plans, or any entity which is controlled by or under common control with Sentara Health Plans, and (b) which Sentara Health Plans has agreed may access services under the Provider Agreement.

Clinical Care Services is a department within Sentara Health Plans comprised of clinicians, physicians, nurses, and non-clinical support staff. This department makes clinical policies, provides case management and utilization review services by assessing proposed treatment plans and make medically necessary coverage decisions using national evidence-based guidelines and internal clinical policies. Coverage decisions are also determined by the member's plan benefit structure.

CMS means the Centers for Medicare and Medicaid Services.

HIPAA Privacy Rule means the requirements at 45 CFR Parts 160 and Subparts A and E of Part 164.

HIPAA Security Rule means the requirements at 45 CFR Part 160 and Subparts A and C of Part 164.

Member means any individual, or eligible dependent of such individual, whether referred to as "insured," "subscriber," "member," "participant," "enrollee," "dependent," or otherwise, who is eligible, as determined by a payer, to receive covered services under a health benefit plan.

Participating Provider, whether referred to as "provider" or otherwise, means a duly licensed physician or other health and/or mental healthcare professional, as designated at the sole discretion of Sentara Health Plans, who has entered into a contract with Sentara Health Plans or any of its Affiliates either as an individual or as a member of a group practice and who has been approved to provide covered services under a health benefit plan(s) in accordance with Sentara Health Plans' credentialing requirements and the requirements of such contract between the provider and Sentara Health Plans (or the Affiliate) at the time such covered services are rendered. Participating providers shall include, but not be limited to, licensed professional counselors, marriage and family counselors, certified behavioral analysts, nurse midwives, nurse practitioners, nurse anesthetists, physician assistants, participating hospitals, and other health and/or mental healthcare professionals, as may be designated by Sentara Health Plans, in its sole discretion, from time to time.

Practitioner means the medical professional that is either employed by or has executed an agreement with Sentara Health Plans, or its subcontractor to render covered services to Sentara Health Plans members.

Provider Agreement means the participating provider agreement, attachments, and any amendments.

Sentara Health Administration, Inc. ("SHA") is a corporation that, among other things, contracts with providers for the provision of healthcare services on behalf of SHA and its

Affiliates. It also contracts to provide, insure, arrange for, and administer the provision of healthcare services.

Table of Contents

Sentara Health Plans Key Contact Information

Provider and Member Services

Provider Services
Phone: **1-800-229-8822**
Fax: **1-757-552-7316**

Behavioral Health Provider Services
Phone: **1-888-946-1168**

Member Services
City/State Phone: **1-800-229-1199 or 757-552-7110**
Cova Phone: **1-866-846-2682 or 757-687-6350**
Feds Phone: **1-800-206-1060 or 757-552-7550**
Large Group Phone: **1-800-741-9910 or 757-552-7325**
Self-funded Phone: **1-800-543-3359 or 757-552-7410**
Small Group Phone: **1-800-275-3755 or 757-552-8850**
City of VA Beach Phone: **1-866-509-7567 or 757-687-6141**
Individual Product Phone: **1-866-514-5916 or 757-552-7274**

Clinical Care Services

Medical Authorizations and Medical Benefit Drugs for Commercial Members
Phone: **1-800-229-5522**

Authorizations Behavioral Health Providers
Phone: **1-800-229-5522**

Nurse Advice Line
Phone: **1-800-394-2237**

Behavioral Health Crisis Line
For a psychological medical emergency, please call:

- **9-8-8, the National Crisis Hotline**
- **1-833-717-2310**

Or go to the nearest emergency room.

Sentara Health Plans Case Management Services (Direct)
Phone: **1-866-503-2730**

Case Management Partners in Pregnancy

Phone: **1-866-239-0618**

Quality Improvement

Phone: **1-844-620-1015**
Fax: **1-804-799-5102**

Pharmacy Services

Specialty Pharmacy (Proprium Pharmacy)

Phone: **1-855-553-3568**
Web: **propriumpharmacy.com/for-prescribers/**

Commercial/Exchange Pharmacy Provider Services

Phone: **1-800-229-8822**

Mail Order Pharmacy (Express Scripts)

Phone: **1-877-728-0179**

Critical Incidents

Email: **CIReporting@sentara.com**
Toll-Free Phone: **1-844-620-1015**
Local Phone: **757-252-8400**
Toll-Free Fax Line: **1-833-229-8932**

Telephone for the Deaf and Disabled (TDD)

Phone (Virginia Relay): **711**

Health and Preventive Services

Phone: **1-833-477-5464**
Email: **wellness@sentara.com**

Fraud and Abuse

Hotline: **1-866-826-5277**
Email: **compliancealert@sentara.com**
U.S. Mail: **Sentara Health Plans**
Program Integrity Department
1330 Sentara Park, Virginia Beach, VA 23464

Network Management

To contact an assigned network educator, please email **contactmyrep@sentara.com**.

Medical Authorizations

Mail: **Clinical Care Services**
PO Box 66189
Virginia Beach, VA 23466

Claim Payment Reconsiderations

Mail:

Medical Claims

PO Box 8203
Kingston, NY 12402-8203

Behavioral Health Claims

PO Box 8204
Kingston, NY 12402-8204

Overpayments

Phone: **1-800-229-8822**
Mail: **Sentara Health Plans Provider Receivables**
PO Box 66189
Virginia Beach, VA 23466

Appeals Department

Commercial Appeals Phone: **1-833-702-0037**
Commercial Appeals Fax: **1-877-240-4214 or 757-233-6354**

Mail: **Sentara Health Plans**
Appeals and Grievances
PO Box 66189
Virginia Beach, VA 23466
Commercial Appeals Email: **commappeals@sentara.com**
Commercial Complaints Email: **commcomplaints@sentara.com**

Product Overview

Sentara Health Plans offers several health plans designed to meet the needs of most large and small employer groups as well as individuals and families. Product offerings and designs are subject to change and often vary by geographic area. Sentara Health Plans is the trade name for Sentara Health Plans issuing health maintenance organization (HMO) and point of service (POS) plans, Sentara Health Insurance Company issuing preferred provider organization (PPO) plans, and Sentara Health Administration, Inc., providing administrative services for self-funded employer group health plans.

Plans Sold on the Health Insurance Marketplace

Sentara Health Plans is a health insurance issuer that is authorized by the Virginia State Corporation Commission, Bureau of Insurance to sell qualified health plans (QHPs) to members in Virginia's Health Benefit Exchange (HBE or Marketplace).

Product Funding Types

When the bottom of the member ID card shows "Administered by Sentara Health Administration, Inc." On the front or back of the card, it is an indicator that the plan is self-funded. These plans may also have employer-specific logos as well as the Sentara Health Plans name. Because medical costs are funded directly by the employer, employer-directed exceptions are common to these plans. Please check benefits on the Availity provider portal or call Sentara Health Plans provider services to obtain plan specifics.

Commercial Product Information

The following tables show general information for commercial plan types currently offered by Sentara Health Plans. For plans with a deductible, the annual deductible does not apply to preventive care. Plan type offerings may vary by geographic location. Specific benefit information is available via the Availity provider portal or by calling provider services.

HMO plan types Underwritten by Sentara Health Plans		
All HMO Plan Types: • No referrals required • PCP selection required • No out-of-network coverage except emergency care or non-emergency ambulance services • Some services require prior authorization		
Product name	**Description**	**Features**

Sentara Vantage	HMO-type plan	• Includes copayments with some services requiring coinsurance • May have deductibles

Sentara Vantage HSA	• High Deductible Health Plan (HDHP) • Includes a Health Savings Account (HSA) (I) with most plans • HSAs administered by HealthEquity • HSAs funded and owned by the employee to help pay patient out-of-pocket expenses • Debit card or remit may indicate HealthEquity	• Includes copayments • May have coinsurance • Annual deductible
Sentara Vantage HRA	• HDHP • A Health Reimbursement Account (HRA) funded by the employer and administered by HealthEquity to help pay patient out-of-pocket expenses	• Includes coinsurance • Some services may require copayments • Annual deductible
PPO plan types Underwritten by Sentara Health Insurance Company		
All PPO Plan Types: • In-network and out-of-network coverage • PCP selection is encouraged but not required • No referrals required • Some services require prior authorization		
Product Name	**Description**	**Features**

Sentara Plus	Standard PPO	• Includes copayments with some services requiring coinsurance • May have deductible

Sentara Plus HRA	• HDHP • A HRA funded and owned by the employer and administered by HealthEquity to help pay patient out-of-pocket expenses	• Includes coinsurance • Some services may require copayments • Annual deductible
Sentara Plus HSA	• HDHP • An HSA (I) with most accounts administered by HealthEquity • Accounts funded and owned by the employee to help pay patient Out-of-pocket expenses • Debit card or remit may indicate HealthEquity	• Includes copayments • May have coinsurance • Annual deductible
POS plan types Underwritten by Sentara Health Plans		
All POS Plan Types: • No referrals required • PCP selection required • Includes an out-of-network benefit • Some services require prior authorization		
Sentara POS	• Operates similar to HMO Plans except includes out-of-network coverage at a reduced benefit level similar to PPO • Offers high deductible options with a HSA (I) or a HRA similar to HMO plans	• Includes copayments with some services requiring coinsurance • May have deductibles

Sentara POS HRA	• HDHP • A HRA funded and owned by the employer and administered by HealthEquity to help pay patient out-of-pocket expenses	• Includes coinsurance • Some services may require copayments • Annual deductible
Sentara POS HSA	• HDHP • An HSA (I) with most accounts administered by HealthEquity	• Includes copayments • May have coinsurance • Annual deductible

	• Accounts funded and owned by the employee to help pay patient out-of-pocket expenses • Debit card or remit may indicate HealthEquity	
Individual and family Underwritten by Sentara Health Plans		

Sentara Individual & Family Health Plans (On-exchange)	• Healthcare purchased directly or through the health insurance marketplace by individuals
	• Plans are HMO:
	  ○ Sentara Gold
	  ○ Sentara Silver
	  ○ Sentara Bronze
	
	Cost Share Reduction Plans also available through the health insurance marketplace
		Refer to the information for the plan purchased.

Sentara Individual & Family Health Plans (Off-exchange)	• Healthcare purchased directly or through Sentara Health Plans
	• Plans are HMO:
	  ○ Sentara Platinum
	  ○ Sentara Gold
	  ○ Sentara Silver
	  ○ Sentara Bronze
		Refer to information for the plan purchased.

Structured networks		
Sentara Tiered Plans	A two-tiered network of doctors and providers for employers that elect a tiered network	Members pay a lower cost share when choosing a provider in Tier 1 for a specific set of benefits.

For plan information regarding Sentara Community Complete, please reference theMedicare Dual-Eligible Special Needs Provider Manual .

Member Identification

Member ID Cards

Members receive identification cards for each enrolled member of the family. The card is for identification purposes only and does not verify eligibility or guarantee payment of services. Members should present their identification card at the time of service.

Access sample member identification cards for Sentara Health Plans here.

Providers can view, download, and print individual member identification cards utilizing Availity's Eligibility and Benefit search.

Eligibility Verification

Since a member's eligibility status may change, member coverage should be verified at the time of service. Providers may access the Availity provider portal or call the Sentara Health Plans interactive voice response (IVR) system 24 hours a day, seven days a week for the most current eligibility in Sentara Health Plans systems. Sentara Health Plans verifies coverage based on the most current data available from the employer/payer. Retroactive changes could alter the member's status; therefore, verification of eligibility **is not** a guarantee of payment.

Joining the Network, Credentialing, and Provider Directory Processes

Join the Network

To participate in the Sentara Health Plans network, providers must have a contract and be credentialed (as applicable) with Sentara Health Plans. To request a contract with Sentara Health Plans, providers must submit a Request for Participation form to the Sentara Health Plans network management contracting team.

To submit a request to be credentialed with Sentara Health Plans, providers must complete a Provider Update Form on the plan website. **Providers must confirm their Council for Affordable Quality Healthcare ("CAQH") application is current and attested before submitting a credentialing request.** The Provider Update Form is also used to add a provider to an existing (or new/pending) Sentara Health Plans contracted practice/organization.

All providers should review the Provider Contracting and Credentialing Guide. Access the complete credentialing program description for Sentara Health Plans here.

Credentialing Overview

The information below is a summary of the standard Sentara Health Plans credentialing process. The goals of the Sentara Health Plans credentialing/recredentialing policy are to ensure quality care and patient safety by utilizing credentialing and recredentialing standards outlined by the National Committee for Quality Assurance (NCQA), CMS, Sentara Health Plans policies and applicable state regulations. Sentara Health Plans will review the education, experience and credentials of all practitioners who care for Sentara Health Plans members at the time of their initial request to participate in the network (credentialing). Sentara Health Plans shall, at a minimum, recredential all providers every 36 months thereafter. Sentara Health Plans may elect to recredential providers after shorter time intervals based on medical director or credentialing committee requests. No provider shall be included in the Sentara Health Plans network without being credentialed. All providers must maintain current recredentialing status and continue to meet all Sentara Health Plans accreditation requirements as well as state and federal regulations between credentialing cycles during ongoing monitoring. No practitioner shall be denied or terminated from network participation based on their age, sex, race, ethnicity, religion, national origin, or disability.

Scope

Practitioners who require credentialing as a condition of participation with Sentara Health Plans are:

- Practitioners who are licensed, certified or registered by the state to practice independently.
- Practitioners who have an independent relationship with Sentara Health Plans. An independent relationship exists when Sentara Health Plans directs its members to see a specific practitioner or group of practitioners, including all practitioners with whom members can select as a PCP. An independent relationship is not synonymous with an independent contract. Sentara Health Plans does not credential some practitioners with whom it holds independent contracts. However, if a practitioner is listed in the Sentara Health Plans network directory, the practitioner must be credentialed.
- Practitioners may seek approval from Sentara Health Plans to participate as a PCP and a specialist, provided they meet Sentara Health Plans' participation criteria for all scopes of practice being requested.
- Practitioners who see members outside the inpatient hospital setting or outside freestanding ambulatory facilities.
- Practitioners who are hospital based but who also see Sentara Health Plans members as a result of an independent relationship with the Sentara Health Plans
- Oral surgeons and dentists who provide care to Sentara Health Plans members under the members' medical benefits.
- Non-physician practitioners who have an independent relationship with Sentara Health Plans and who provide care to members under Sentara Health Plans' medical benefits.
- Telemedicine practitioners.
- Rental network practitioners that are part of Sentara Health Plans primary network and Sentara Health Plans has members who reside in the rental area.
- Rental networks:
    - That are part of the organization's primary network, and the organization has members who reside in the rental network area.
    - Specifically for out-of-area care, and members may see only those practitioners, or are given an incentive to see rental network practitioners.
- PPO network practitioners if information about the network is included in member materials or on a member ID Card that directs members to use the network or there are incentives for members to see the PPO network practitioners.
- Locum Tenens practitioners who work fewer than 60 days or more than 60 calendar days.

Practitioners Who Do Not Need to Be Credentialed

The following types of practitioners need not be credentialed:

- Practitioners who do not have an independent relationship with Sentara Health Plans, and meet any of the following:
- Practitioners who practice exclusively within the inpatient setting, and who provide care for Sentara Health Plans members only as a result of members being directed to the hospital or other inpatient setting

- Practitioners who practice exclusively within free standing facilities and who provide care to Sentara Health Plans members only as a result of members being directed to the facility
- Pharmacists who work in conjunction with a pharmacy benefit management organization to which Sentara Health Plans delegates utilization management functions
- Covering practitioners (e.g., Locum Tenens) who do not have an independent relationship with Sentara Health Plans
- Practitioners who do not provide care for Sentara Health Plans members (e.g., board certified consultants who may provide a professional opinion to the treating practitioner)
- Rental network practitioners who provide out-of-area care only, and members are not required or given an incentive to seek care from them
- Hospital Based Practitioners (including, but not limited to):
  - Anesthesiologists
  - Emergency medicine practitioners
  - Hospitalists / hospital medicine practitioners
  - Pathologists
  - Radiologists
  - Neonatal / perinatal practitioners
  - Critical care medicine practitioners
  - Trauma medicine practitioners
  - Certified registered nurse anesthetists
  - Any other specialty practitioner practicing exclusively in an inpatient setting
- Non-inpatient facilities in which practitioners may practice exclusively and provide care for members only as a result of members being directed to the facility may include, but are not limited to:
  - Mammography centers and free-standing radiology centers
  - Urgent care centers
  - Surgery centers
  - Ambulatory behavioral health facilities
  - Psychiatric and substance use disorder clinics
  - School-based clinics
- School-based practitioners
  - School nurses

Organizational Contracting Approval

Organizations that bill under a Type 2 NPI utilize the organizational credentialing policy and procedure.

Marriage and Family Therapists and Mental Health Counselors

Effective January 1, 2024, CMS recognizes licensed Marriage and Family Therapists (MFT) and licensed Mental Health Counselors (MHC) as a new Medicare provider type. Payment for these services under Part B of the Medicare program began on January 1, 2024. CMS defines MFT services as services furnished by an MFT for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital), which the MFT is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are furnished, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service. CMS defines MHC services as services furnished by a MHC for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital), which the MHC is legally authorized to perform under State law (or the State regulatory mechanism provided by the State law) of the State in which such services are furnished, as would otherwise be covered if furnished by a physician or as incident to a physician's professional service. For more information from CMS, please visit their website. Contact the behavioral health contract manager assigned to the practice to determine if the Provider Agreement needs to be amended.

Long-Term Services and Supports (LTSS) Credentialing

Contracting and credentialing for LTSS are handled by Centipede/HEOPS. Centipede may be contacted by email at joincentipede@heops.com.

Providers already contracted and credentialed with Sentara Health Plans for provision of medical services that also provide LTSS services must also contract with Centipede/HEOPS for provision of LTSS services to members.

Council for Affordable Quality Healthcare (CAQH)

The Sentara Health Plans credentialing process uses the Council for Affordable Quality Healthcare (CAQH) application exclusively for provider credentialing. Providers who do not currently have a CAQH application must complete the CAQH ID Request Form on the Provider Data Portal website listed below.

Contact Information for CAQH

Website:
CAQH proview - Sign In
CAQH Provider Help Desk: **1-888-599-1771** or email providerhelp@proview.caqh.org.

Supporting Documents

In addition to the completed CAQH application, all practitioners must submit the following supporting documents to Sentara Health Plans or CAQH:

- Current state medical licenses
- Drug Enforcement Administration (DEA) certificate (as applicable)
- Current malpractice insurance face sheet indicating the amount of coverage:
    - For the Commonwealth of Virginia, providers must maintain coverage in amounts not less than the medical malpractice cap currently in effect under the Virginia Code (the "Code"). Medical Professional Liability (malpractice) insurance in the amount equal to, not less than, the limitation on recovery for certain medical malpractice actions specified in Section 8.01-581.15 of the Code of Virginia, as such Section may be hereafter amended or superseded (currently $2,700,000 per occurrence) and twice that amount (currently $5,400,000) annual aggregate. These limits change year to year, and it is advised that the provider review the Code annually, upon renewal of their policy, to ensure they have the correct limits applied to their current policy. In states other than Virginia, if the state does not have a requirement for minimum medical malpractice coverage, the provider must maintain coverage in an amount not less than $1 million per occurrence and $3 million in the aggregate per year. Non- prescribing Sentara Health Plans behavioral health providers in Virginia, individual non-physician providers must maintain coverage in an amount not less than $1 million per occurrence and $3 million in the aggregate per year.
- Curriculum vitae (resume) that includes work history for the past five years

Where applicable, practitioners should also submit:

- Letter of explanation for any gaps in malpractice insurance
- Letter of explanation for any gaps in work history of six months or longer in the past five years
- Letter of explanation for practitioners who do not have an active DEA or Controlled Dangerous Substances (CDS)/Controlled Substance Registration (CSR) Certificate, but who should have one based on their practice. Such practitioners must state the reason for not having a DEA or CDS/CSR certificate, and the appropriate covering Practitioner who will agree to write prescriptions for their members, if applicable.
- Evidence of patient coverage or transfer arrangements with another Plan participating Practitioner to manage their Plan membership hospitalizations; or
- Have documented admission arrangements with a hospitalist group to a participating Plan hospital.
- Educational Commission for Foreign Medical Graduates (ECFMG) certificate if foreign medical school graduate with an ECFMG number noted in CAQH.
- Cross coverage forms from covering provider if not within the provider's practice.

- Explanations for malpractice cases.
- Explanations for license sanctions or license limitations.

Practitioners must have acceptable 24-hour coverage which includes arrangements for alternate care of patients when the Practitioner is unavailable through another qualified Practitioner consistent with the Plan's policies and procedures and standards and/or criteria.

Credentialing Process

Sentara Health Plans credentialing specialists review all applications for completeness. Incomplete applications will not be processed, and the provider will be notified within 30 days of receipt of the application. Notice shall be provided by electronic mail unless the provider has selected notification by mail.

Verifications

The Sentara Health Plans credentialing department verifies with the primary source that the provider meets the Sentara Health Plans credentialing requirements. Any verifications performed that have an actual expiration date such as a DEA or license, must be verified within 120 days of the credentialing or recredentialing decision and the expiration dates must still be valid on the date the decision is made.

Providers are required to complete an application for initial credentialing and recredentialing. The applications must contain a current, signed and dated attestation statement as to the correctness and completeness of the application. Sentara Health Plans uses the CAQH Universal Provider Data Source Application found at proview.caqh.org as part of our credentialing and recredentialing processes. Faxed, digital, electronic, scanned or photocopied signatures are acceptable. Signature stamps are not acceptable unless the practitioner is physically impaired, and the disability is documented in the practitioner's file. CAQH has a system that allows providers to update application information electronically. NCQA accepts the last attestation date generated by this system as the date when the provider signed and dated the application to attest to its completeness and correctness.

If the application and attestation must be updated, only the provider may attest to the update; Plan staff may not. If a copy of an application from an external entity to Sentara Health Plans is used, it must include an attestation to the correctness and completeness of the application. NCQA does not consider the associated attestation elements present if the Practitioner did not sign the application within the required time frame.

The following verifications are completed for each participating provider:

- Review of the full application to ensure it is fully completed.

- Verification of current valid state licensure (licenses will be verified for all states where the provider provides care to Sentara Health Plans members).
- Verification of current valid DEA/CDS/CSR (if applicable).
- Verification of education and training (if the provider is an individual practitioner).
- Sentara Health Plans verifies the highest of the following levels of education/training obtained by the practitioner as appropriate:
    - Board certification in their practicing specialty(-ies).
    - Residency in their practicing specialty(-ies).
    - Graduation from medical or professional School.

Sentara Health Plans only recognizes residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) in the United States, the American Osteopathic Association in the United States, the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada.

Note: Verification of Fellowship completion and any future program completion dates do not meet the requirement for verification of education and training.

- Board certification status

Note: Verification of board certification does not apply to Nurse Practitioners, Physician Assistants, or other non-physician health care professionals unless the Plan communicates these board certifications to Plan members. Sentara Health Plans may, at its sole discretion, waive the specialty board certification requirement for applicants who meet a certain criterion, not limited to practicing with a specialty required to fill a geo-access gap in an underserved geographic area.

- Work history (minimum relevant work history of the most recent 5 years)

Note: Provider must explain any gap(s) in work equal to or exceeding six months.

- Current professional liability insurance that meets state limit requirements
- Five Practice-Year malpractice history
- Medicare and/or Medicaid sanction history
- State license sanctions or limitations
- Hospital privileges or acceptable coverage arrangements
- National Provider Identification (NPI)
- Federal sanction
- System for Award Management (SAM)
    - Medicare & Medicaid sanctions
    - Medicare & Medicaid exclusions

Specialty-Specific Credentialing Requirements

In addition to the general credentialing requirements applicable to all providers, additional requirements may apply to certain provider types in accordance with Sentara Health Plans policies. Provider agrees to furnish information and documentation necessary for Sentara Health Plans to perform credentialing and recredentialing in accordance with such requirements.

A provider's credentialing or recredentialing file is deemed complete and ready for medical director or credentialing committee review when a complete application has been received, all supporting documents and/or responses have been received and all verifications, primary source or otherwise, have been confirmed. Sentara Health Plans notifies providers within 30 days of receipt of the provider's credentialing application if such application is incomplete. Completed files are reviewed by the credentialing department to ensure the provider's electronic file in Sentara Health Plans' credentialing system has been fully updated and all required tracking information, application, documents and primary source verifications have been obtained and are stored appropriately. Completed files are then assigned clean" or "issue" status based on the criteria outlined in the credentialing policy and procedure. Sentara Health Plans medical director has the authority to approve clean files. All "Issue" files must be reviewed and determined by the credentialing committee.

Sentara Health Plans does not discriminate, in terms of participation, reimbursement, or otherwise against any health care professional or facility, who is acting within the scope of their license or certification under state law on the basis of the license or certification.

Sentara Health Plans does not make credentialing or recredentialing decisions based on a practitioner's race, ethnic or national identity, gender, age, sexual orientation or the type of procedure(s) or patient (i.e., Medicaid and Medicare), in which the practitioner specializes. This does not preclude Sentara Health Plans from including in its network practitioners or facilities who meet certain demographic or specialty needs, for example, cultural needs of Sentara Health Plans members. Sentara Health Plans does not discriminate against practitioners or facilities that serve high-risk member populations or specialize in conditions that may require costly treatment.

Following credentialing or recredentialing decision determinations issued by the medical director or credentialing committee, a letter is sent to the provider advising them of the decision. Unless specific state notification time frames exist, the NCQA notification time frame of sending the decision notification letter within 30-calendar days of approval or denial determination will be followed. In the event a denial decision is issued, the provider is notified in writing within 30 calendar days of the denial reason and if applicable, offered the right to appeal.

After an application is approved, Sentara Health Plans contacts providers to inform them of the effective participation date. Sentara Health Plans complies with Virginia Code §38.2-3407.10:1 regarding payments to providers during the credentialing process (see below).

Recredentialing

Sentara Health Plans recredentials all providers at least every 36 months. Information and documents are obtained and verified according to the credentialing policy and procedure standards. NCQA counts the 36-month cycle to the month, not to the day. The recredentialing process will also include performance-monitoring information on each provider. This review includes review of adverse data from any of the following plan data areas:

- Member grievances and/or complaints
- Utilization management
- Quality improvement, performance quality measures, quality deficiencies, and/or trend patterns
- Site assessment and/or medical record keeping practice/treatment assessment issues

Confidentiality and Provider Rights

All credentialing information and documents obtained during credentialing, recredentialing and on-going monitoring activities are maintained in a confidential manner. All parties involved in the Sentara Health Plans credentialing process sign a confidentiality agreement on an annual basis. The confidentiality agreement includes all credentialing documents, reports, and communications relating to practitioners. Credentialing applications, data, documents and verifications are only tracked and stored in a secure, electronic credentialing software platform. Sentara Health Plans has documented policies and procedures for managing credentialing system controls and oversight.

Upon receipt of a written request, Sentara Health Plans will provide the applicant with information on the status of their credentialing or recredentialing application. Sentara Health Plans will provide a status update to the applicant within 10 business days of receiving their request. Providers will be advised of the date their application was received, the status of the processing of their application including any missing or outstanding information still needed for their file and the expected timeframe for Medical Director or Credentialing Committee review for participation determination (no peer-review information or details will be disclosed to the provider). Providers are informed of this Right through the Credentialing Program Description which is posted publicly on Sentara Health Plans website. Providers are instructed on the Sentara Health Plans

website to contact the Credentialing Department at shpcreddept@sentara.com to request the status of their application.

An applicant may review any documentation submitted by the applicant in support of their application, together with any information received from outside sources such as malpractice carriers, state licensing agencies, or certification boards. Providers may not review any peer review information obtained by Sentara Health Plans. Providers are informed of this Right through the Credentialing Program Description which is posted publicly on Sentara Health Plans website. Providers may choose to request to review such information, at any time, by sending a written request, to the Credentialing Department online at shpcreddept@Sentara.com or through the United States Postal Service at:

Sentara Health Plans
Attn: Credentialing Department
1330 Sentara Park
Virginia Beach, VA 23464

In the event the credentialing or recredentialing verification process reveals information submitted by the provider that differs from the verification information obtained by Sentara Health Plans, the provider has the right to review information Sentara Health Plans received. Examples of verifications that may produce a variance from information provided by the provider may be licensing actions, malpractice cases and board certification status. The provider is allowed to submit corrections for erroneous information or an explanation for the variation. Providers are informed of this Right through the Credentialing Program Description which is posted publicly on the Sentara Health Plans website.

Sentara Health Plans notifies the provider of any discrepancy it has received during the credentialing and recredentialing process within 30 days of receipt. Sentara Health Plans informs the provider of the discrepancy and requests a written explanation be submitted within 10 days. Providers are provided with a copy of the discrepant information to review. The provider is asked to provide a written explanation of correction within 10 business days of receipt. If a correction is needed to the provider's application, they are asked to make the correction on the application page(s) and to sign/date each correction made to the application. After Sentara Health Plans receives the corrected information, it will continue to process the provider's file and will follow Sentara Health Plans' normal review process for medical director or credentialing committee participation determination. The provider will be notified of the medical director or credentialing committee participation decision within 30 days of the determination date.

Ongoing Monitoring

Sentara Health Plans monitors provider sanctions, grievances/complaints and quality issues between credentialing cycles and will take action(s) against providers when it identifies occurrences of poor quality. Sentara Health Plans acts on important quality and safety issues promptly by reporting such occurrences to the Credentialing Committee or other designated peer-review body. If an occurrence requires urgent attention, the medical director and/or designee will address it immediately, and the Committee and/or the medical director may take any action(s) reasonably necessary to ensure quality. On an ongoing monitoring basis, Sentara Health Plans collects and takes intervention and/or action by:

Collecting and reviewing Medicare and Medicaid sanctions and exclusions

- Sentara Health Plans will review sanction and exclusion information from an NCQA approved source at least monthly or within 30-calendar days of a new alert.

Collecting and reviewing sanctions or limitations on licensure

- Sentara Health Plans will review sanctions and limitations on licensure in all states where the practitioner or facility provides care to Plan members. Licensure sanction and limitation monitoring will be reviewed from a NCQA-approved source at least monthly or within 30 calendar days of a new alert.

Collecting and reviewing grievances/complaints

- Sentara Health Plans investigates all practitioner-specific member complaints upon receipt and evaluates the practitioner’s history of complaints, if applicable. Additionally, evaluation of the provider's history of grievances/complaints will occur at least every six (6) months; if a trend is identified, a level rating will be assigned. The Credentialing Committee or other designated peer-review body will recommend appropriate interventions based on assigned scoring. When the appropriate interventions are determined, the provider will follow the recommendations to address the issues that were identified, including quality and safety concerns.

Collecting and reviewing information from identified adverse events

- Sentara Health Plans monitors adverse events at least monthly to determine if there is evidence of poor quality that could affect the health and safety of the members. Depending on the adverse event, Sentara Health Plans will implement actions and/or interventions based on its policies and procedures when instances of poor quality are identified.

Credentialing for Facility and Ancillary Providers

Providers interested in participating with Sentara Health Plans should complete the “Request for Participation” form located here.

Sentara Health Plans facilities and ancillary providers are required to hold certification and/or licensures appropriate to the services offered. The ancillary credentialing and recredentialing processes will:

- Reassess the credentials of each participating organizational provider at least every 36 months after initial credentialing.
- Confirm that the provider is in good standing with state and federal regulatory bodies.
- Confirm, when applicable based on provider type, that the provider has been reviewed and approved by an acceptable accrediting body.
- Conduct a quality assessment of the organization when organizational providers are not accredited.
- Review a copy of a quality review by the Centers for Medicare and Medicaid (CMS) or applicable State review board in lieu of Sentara Health Plans conducting its own quality assessment if the CMS or state assessment is no more than three (3) years old. If the CMS or State assessment is older than three (3) years, Sentara Health Plans is required to perform its own quality assessment.

Note: Sentara Health Plans is not required to conduct a quality assessment if the organizational provider is located in a rural area, as defined by the U.S. Census Bureau How We Define Rural, and the state or CMS has not conducted a site review.

- Confirm proof of general and professional liability insurance. At least $1 million per occurrence and $3 million in the aggregate is required.
- Validate an active National Provider Identifier (NPI).
- Validate licensure, if applicable.
- Validate the absence of Medicare or Medicaid sanctions and federal exclusions.

Facilities and ancillaries must provide Sentara Health Plans with copies of current accreditation certificates (if applicable), Medicare certification survey results (if applicable), general and professional liability insurance, and state licensures, as applicable to each contracted facility or ancillary. In addition, completion of a Disclosure of Ownership and Control Interest Statement is required.

Any facility or ancillary provider that does not hold the required certification may be credentialed only after the Sentara Health Plans quality improvement department reviews the certification survey letter and copy of CMS-2567 (Statement of Deficiencies and Plan of Correction) issued by the applicable state survey organization.

Disclosure of Ownership and Control and Control Interest Statement

Sentara Health Plans requires all provider-disclosing entities to complete a Disclosure of Ownership and Control Interest Statement at initial contracting/credentialing and at recredentialing as a condition of participation. Ownership means a direct or indirect ownership interest totaling five percent or more. Disclosure as a participating fee-for-service provider for DMAS meets this requirement for Sentara Health Plans.

Notice of Suspension Requirement

Any facility or ancillary provider that has its Medicare certification suspended due to cited deficiencies must notify their Sentara Health Plans contract manager immediately.

Accreditations and Certifications

Accreditations or certifications accepted by Sentara Health Plans are as follows:

Accrediting Body	Acronym	Examples of Organizational Provider Types Accredited
Accreditation Association for Ambulatory Health Care	AAAHC	Hospitals, Surgery Centers, FQHC, Imaging Center, Urgent Care
Accreditation Commission for Health Care, Inc. (formerly HFAP)	ACHC	Hospitals, Surgery Centers, Behavioral Health, Assisted Living
American Academy of Sleep Medicine	AASM	Sleep Laboratory, DME
American Association for Accreditation of Ambulatory Surgery Facilities	AAASF	Surgery Centers, Rural Health Centers, Physical Therapy Centers
American Association for Laboratory Accreditation	A2LA	Laboratory
American Board for Certification in Orthotics and Prosthetics	ABCOP	Orthotics, Prosthetics
American College of Radiology	ACR	Imaging Centers
American Society for Histocompatibility and Immunogenetics	ASHI	Laboratory
American Speech-Language Hearing Association	ASHA	Hearing Center
Association for the advancement of Blood & Biotherapies	AABB	Blood Collection, Transfusion Services
Board for Orthotist/Prosthetist Certification	BOC	DME, Prosthetics, Orthotics, Supplies, Pharmacy, Homecare
Center for Improvement in Healthcare Quality	CIHQ	Hospital, Substance Use Disorder, Free-Standing ER
College of American Pathologists	CAP	Laboratory
Commission for the Accreditation of Birth Centers	CABC	Birth Center
Commission on Accreditation of Ambulance Services	CAAS	Ambulance
Commission on Accreditation of Medical Transport Systems	CAMTS	Air Ambulance
Commission on Accreditation of Rehabilitation Facilities	CARF	Health & Human Service Organizations
Commission on Laboratory Accreditation	COLA	Laboratory
Community Health Accreditation Program	CHAP	Home & Community Based
Council on Accreditation for Children and Family Services, Inc	COA	Health & Human Service Organizations
Det Norske Veritas Healthcare, Inc.	DNV	Hospitals
DME, Prosthetics, Orthotics, Supplies, Pharmacy, Homecare, etc	DMEPOS	DME, Prosthetics, Orthotics, Supplies, Pharmacy, Homecare
Healthcare Organizations (NIAHO)	NIAHO	Hospitals
Healthcare Quality Association on Accreditation	HQAA	DME, Prosthetics, Orthotics, Supplies, Pharmacy, Homecare
National Association of Boards of Pharmacy	NABP	Pharmacy
National Children's Alliance Behavioral Health Center of Excellence	BHCOE	Health & Human Service Organizations
National Committee for Quality Assurance	NCQA	Case Mgt, Specialty Pharmacy, Long Term Services & Supports
National Urgent Care Center Accreditation	NUCCA	Urgent Care Centers
Surgical Review Corporation	SRC	Surgery Centers
The Compliance Team	TCT	DME
The Joint Commission (formerly JCAHO)	TJC	Hospitals, Surgery Center, Nursing Homes, Behavioral Health
Urgent Care Center Accreditation	UCCA	Urgent Care Centers

The only exception made for hospital accreditation is when a facility is newly opened. If the hospital is newly opened, documentation of patient safety plans and records from a state or federal regulatory body that has reviewed the hospital must be forwarded to Sentara Health Plans.

Billing While Credentialing Is Pending

In accordance with Virginia Code § 38.2-3407.10:1, Sentara Health Plans will reimburse providers for services rendered during the period in which their credentialing application is pending, provided that the claims for such services are clean claims and otherwise meet the criteria for reimbursement, within 40 days of the provider being credentialed and contracted with Sentara Health Plans. Reimbursement of clean claims for services rendered during the pending application period is contingent upon approval of the provider's credentialing application by the Sentara Health Plans credentialing committee and execution of a provider agreement. However, no services shall be provided to a Sentara Health Plans member until a completed credentialing application has been received by Sentara Health Plans. Claims for these services must be held until the provider has received notification of credentialing approval and the provider agreement is fully executed. If a Sentara Health Plans provider agreement is not signed and/or the provider does not meet all credentialing requirements, Sentara Health Plans is not required to reimburse claims as a network provider and the provider should not seek any in-network reimbursement for services provided to the member from the time of application to final notice of the credentialing decision.

To submit claims for services rendered during the credentialing process, new provider applicants must provide written or electronic notice to covered members in advance of treatment informing the members that the provider has submitted a credentialing application to Sentara Health Plans and is in the process of obtaining approval. The notice must include the language at Virginia Code § 38.2-3407.10:1(G).

If a payment is made by Sentara Health Plans to a new provider applicant or any entity that employs or engages such new provider applicant under this section for a covered service, the patient shall only be responsible for any coinsurance, copayments, or deductibles permitted under the insurance contract with Sentara Health Plans or participating provider agreement with the physician, mental health professional, or other provider. If the new provider applicant is not credentialed by Sentara Health Plans, the new provider applicant or any entity that employs or engages such physician, mental health professional, or other provider shall not collect any amount from the patient for health care services or mental health services provided from the date the completed credentialing application was submitted to Sentara Health Plans until the applicant received notification from Sentara Health Plans that credentialing was denied.

Disciplinary Action

The Sentara Health Plans credentialing committee is responsible for reviewing potential areas warranting corrective action and recommending disciplinary or corrective action for individual practitioners who fail to comply with their Provider Agreement or with Sentara Health Plans policies and procedures.

Grounds for corrective action include, but are not limited to:

- Quality of care below the applicable standards
- A pattern of over/underutilization of services that is significantly higher/lower than other practitioners in the same specialty
- Failure to comply with utilization management and quality improvement programs
- Violation of the terms of the Provider Agreement
- Disruptive behavior, including but not limited to failure to establish a cooperative working relationship with Sentara Health Plans, making false statements to members or the public that discredit Sentara Health Plans, or abusive or abrasive behavior toward members of Sentara Health Plans or other providers' office staff
- Falsification of information on documents submitted to Sentara Health Plans
- Conviction of a felony
- Licensure sanctions (including probation, suspension, supervision, and monitoring)
- Loss of DEA certification
- Sanction or exclusion from government health programs, including Medicare and Medicaid
- Failure to maintain required malpractice insurance coverage

The Sentara Health Plans credentialing committee and other committees may recommend the following actions as applicable:

- Summary suspension
- Termination of participation
- Probationary participation status
- Mandatory attendance at continuing education courses if the quality of care is deficient but not deficient enough to warrant immediate termination
- Concurrent review by the Sentara Health Plans medical director or designee of the care rendered by the disciplined practitioner
- Other actions as determined by the committee

Summary suspension of the practitioner's clinical privileges may occur without prior investigation or hearing whenever:

- Immediate action is deemed necessary in the interest of patient care or safety or the orderly operation of Sentara Health Plans
- Practitioner is convicted of a felony

The National Practitioner Data Bank (NPDB) and/or the applicable licensing board of state(s) where the practitioner is providing services will be notified in accordance with applicable law.

Provider Data Accuracy

Sentara Health Plans ensures that data received from providers are accurate and complete by:

- Verifying the accuracy and timeliness of reported data
- Screening the data for completeness, logic, and consistency
- Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for quality improvement and care coordination efforts

Updating Provider Information

Keeping Sentara Health Plans informed of provider updates is an important step to ensuring accurate claims payment, correct provider directories, and member satisfaction. It is important that Sentara Health Plans has up-to-date information about each provider's practice and data. Please notify Sentara Health Plans in accordance with the timeframes set forth in the Sentara Health Plans Provider Agreement of any changes related to the practice, provider roster or location/phone number. Sentara Health Plans offers electronic submission for provider update requests. Please use the link below to access, complete, and submit a Provider Update Form. Allow 30 calendar days for the requested provider information to be updated in all Sentara Health Plans systems (60 days for new providers/credentialing requests).

The Provider Update Form is intended for providers who are currently contracted with Sentara Health Plans or are in the contracting process. To access the Provider Update Form, visit this link.

Please note: Tax identification number (TIN), legal business name, product/reimbursement changes, or other changes affecting the Provider Agreement cannot be submitted on the Provider Update Form; these requests should be submitted directly to the appropriate Sentara Health Plans contract manager. Please contact the network contracting team at 1-877-865-9075 for these requests.

Making Sure Providers Appear in the Directory

Sentara Health Plans members rely on Sentara Health Plans and its network providers to maintain complete and accurate information in our provider directories. Keeping Sentara Health Plans informed of provider changes and updates is vital to ensure members have access to the most current provider information at all times.

All Sentara Health Plans providers must give prior notice using the appropriate Update Form for any change of provider information, including but not limited to:

- Provider name, address, and telephone number
- Office hours (as applicable), including whether provider site is open after 5:00 p.m. (Eastern Standard Time) weekdays and on weekends
- Licensing information (e.g., NPI number)
- Specialty/areas of expertise
- Ability to accept new patients
- Group affiliations/hospital affiliations
- Service locations (street address/phone number(s)/indication if on a public transportation route)
- Accommodations for disabilities/Americans with Disabilities Act (ADA) accessibility
- Cultural and linguistic capabilities
- Completion of cultural competence training
- Availability of telehealth services
- Website URL, if applicable
- For behavioral health providers, training in and experience treating trauma, areas of specialty, any specific populations, and substance use

In addition, Sentara Health Plans network providers are required to respond to quarterly requests for attestation of provider directory data.

Member Information

Member Visit/Encounter Procedure

- Members should present their ID card and another form of identity verification (e.g., driver's license).
- The provider's staff should check the card for eligibility and benefits and make a copy of the card for the member's record.
- In an emergency, treatment should proceed without question of eligibility or coverage. Eligibility verification can be obtained as soon as appropriate after initiation of treatment.
- The provider's staff should confirm that an authorization for the services to be provided has been received from Sentara Health Plans, if necessary, under the member's health benefits.
- Provider's staff may access the Availity provider portal anytime or call provider services during business hours for verification if a member's status is in question.

Copayments, Coinsurance, and Deductibles

- Check the member's ID card to determine if there is a copayment due for the specific service rendered. Copayments vary depending on services provided and the member's plan benefits. Some plans do not have copayments. Collect the appropriate copayment from the member.
- The suggested best practice is for providers to submit the claim to Sentara Health Plans first and utilize the Sentara Health Plans remittance to determine the amount due from the member. This process avoids over collecting from members and the additional paperwork and cost of refunding overpayments.
- The member should not pay more than the provider's contracted rate with Sentara Health Plans for the service rendered. If the copayment amount is more than the contracted rate for the service, the member pays the lesser amount of the contracted rate and the copayment amount.
- A copayment should only be collected for services that are reimbursable under the member's plan.
- Members are responsible for the full plan-contracted allowable amount for applicable visits until their deductible is met if their plan has a deductible.
- Once the deductible is met, members who have plans with coinsurance are responsible for the appropriate coinsurance (percentage of the contracted allowable charge for the visit) unless the member's plan has a reimbursement account funded by the employer to help pay out-of-pocket expenses directly to the provider.
- Providers may elect to collect at the time of service when the member has not yet met their deductible. The amount of the deductible and whether the member has met a portion, or all of the deductible, are usually available through the Availity provider portal or by calling Sentara Health Plans provider services. Member responsibility information will be current as of the time of an inquiry, but

if other claims are received and processed before the claim is received and processed, member responsibility could change.

- Providers must reimburse the member any amount collected more than the member's responsibility within 30 days.
- When Sentara Health Plans is the secondary insurance carrier:
  - Do not collect the copayment if the primary payer does not have a deductible.
  - Do not collect the copayment if the member has met the deductible of the primary payer.
  - Collect the copayment if the member has not met the primary payer's deductible.
- Members are notified when they reach their max out-of-pocket (MOOP) and providers should not collect a copayment or coinsurance. It is the responsibility of the provider to refund the member any coinsurance or copayment paid if the member has already met the MOOP. Providers agree to assist Sentara Health Plans to document refunds as part of Sentara Health Plans internal audits, or any audit by a state or federal regulatory body.

Members Rights and Responsibilities

The Member Rights and Responsibilities document assures that all Sentara Health Plans members are treated in a manner consistent with the mission, goals, and objectives of Sentara Health Plans and assures that members are aware of their obligations and responsibilities upon joining Sentara Health Plans and throughout their membership with Sentara Health Plans. Each Sentara Health Plans product has specific Member Rights and Responsibilities and members are mailed information on where to locate their Rights and Responsibilities at the time of enrollment. The Member Rights and Responsibilities are similar for all Sentara Health Plans products but have slight variations based on variations in the product and the members served by that product. The Member Rights and Responsibilities listed here apply to Sentara Health Plans commercial product members (HMO/POS/PPO/Individual).

Interpreter Services

Providers are responsible for the coordination and payment of interpreter services for their patients, if necessary, as directed by the Americans with Disabilities Act (ADA) and the Civil Rights Act of 1964. Providers can contact Sentara Health Plans provider services for assistance in coordinating (but not reimbursement for) interpreter services.

Essential Community Providers

Sentara Health Plans contracts with available essential community providers (ECPs), such as federally qualified health centers, rural health centers, community health centers, and Indian healthcare providers.

Primary Care Provider Panels

PCPs are required to accept an average of 500 members across all Sentara Health Plans products (per their Provider Agreement) with which they participate before closing their panels to new members. In addition, providers are required to accept current patients who convert to Sentara Health Plans coverage even if they have reached the 500-member requirement.

Notification from the provider practice is required for any network panel status change in accordance with the timeframes set forth in the Provider Agreement. All changes must be sent online via the Provider Update Form on the Sentara Health Plans website.

Please allow up to 30 business days for the requested provider information to be updated in all Sentara Health Plans systems. The requestor will receive a confirmation email when the request has been completed. After 30 days, if a confirmation email has not been received and/or the updated information is not reflected on the provider's profile in the Sentara Health Plans directory, please email an inquiry for status to PUStatus@sentara.com.

PCP Panel Status Options:

- Open and accepting new patients
- Not accepting new patients; providers will continue to provide services for established patients, siblings, and spouses switching plans
- Pediatrics provider is not accepting new patients; provider will accept established patients, newborns, and their siblings
- Age restriction
- Covering provider only patients who have seen the provider within the past two years are considered established patients by Sentara Health Plans.

Guidelines for Removing a Member from a PCP Panel

Providers may request that Sentara Health Plans assist a member in the selection of another PCP when the member demonstrates any of the following behaviors:

- Abusive behavior
- Noncompliance with a provider treatment plan
- Failure to establish a provider-patient relationship

Upon notification of these behaviors, member services will make an outreach to the member and assist with selecting a new PCP.

The procedure for removing a member from a provider's panel is as follows:

1. Provider sends a certified letter to Sentara Health Plans notifying the Plan and stating the reason for asking him/her to be repaneled to another provider.
2. Provider sends a letter to the member notifying the member that the provider will no longer be serving as the member's PCP and informing the member that Sentara

Health Plans will work with them to find a new PCP. Provider must send a copy of the letter to their contract manager in the network management department at Sentara Health Plans by mail or fax.

Providers may not seek or request to have a member terminated from Sentara Health Plans or transferred to another provider due to the member's medical condition or due to the amount, variety, or cost of covered services required by the member.

Cultural Competency

Sentara Health Plans embraces and promotes cultural humility as a foundational approach to the delivery of services, fostering respectful, inclusive, and culturally competent care to all members including individuals with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and sex, which includes, but is not limited to, sex characteristics, (including intersex traits), pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes.

Culturally competent care allows healthcare providers to appropriately care for and address healthcare concerns, including the beliefs and value systems of enrollers with diverse cultural and linguistic needs.

Providers are encouraged to:

- Build rapport by providing respectful and culturally appropriate care.
- Assess the members' need for interpreter or translation services and provide appropriate aids and services to meet the members' needs.
- Be mindful of the cultures that may have specific beliefs surrounding health and wellness.
- Ensure that the member understands diagnosis, procedures, and follow-up requirements.
- Offer health education materials in languages that are common to your patient population and/or per member's preferred language.
- Be aware of the tendency to unknowingly stereotype certain cultures.
- Ensure staff receives continued education and training in providing culturally competent and linguistically appropriate care.

Sentara Health Plans requires network and/or affiliated providers to demonstrate cultural competency in all forms of communication and ensure that cultural differences between providers and members do not impede access and quality healthcare.

Quality Improvement

Through its commitment to excellence, Sentara Health Plans has developed an ongoing comprehensive program directed toward improving the quality of care and services, safety, access, transition of care, health disparities, timeliness, and appropriate utilization of services for our members. The Quality Improvement (QI) program is designed to implement, monitor, evaluate, and improve processes within the scope of our health plan to continuously improve the health of our members every day.

Sentara Health Plans' network and/or affiliated providers must comply with the health plan QI program and actively participate in QI initiatives to improve the delivery of quality of care and services, access and availability to care, member experience and satisfaction.

National Committee for Quality Assurance Accreditation

As part of our commitment to quality, Sentara Health Plans voluntarily participates in the accreditation process administered by the NCQA, a private, nonprofit organization dedicated to improving healthcare quality. NCQA accredits and certifies a wide range of healthcare organizations. It also recognizes clinicians and practices in key areas of performance. NCQA is committed to providing healthcare quality information for consumers, purchasers, healthcare providers, and researchers.

HEDIS®[1]

Healthcare Effectiveness Data and Information Set (HEDIS) is the measurement tool used by the nation's health plans to evaluate their performance in terms of clinical quality and customer service. HEDIS is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare healthcare quality.

HEDIS performance measures are a part of the NCQA accreditation process. Some of the major areas of performance measured by HEDIS are:

- Effectiveness of care
- Access/Availability of care
- Experience of care
- Utilization and risk-adjusted utilization
- Health plan descriptive information
- Measures reported using electronic clinical data systems

[1]HEDIS® is a registered trademark of NCQA

Clinical Practice Guidelines

Clinical Practice Guidelines (CPG) are adopted to help practitioners and members make decisions about appropriate healthcare for specific clinical circumstances. Sentara Health Plans adopts and disseminates CPGs relevant to its membership for the

provision of preventative, acute and chronic medical and behavioral health services. All clinical or preventive health practice guidelines that are adopted or developed:

- Are based on valid and reliable clinical evidence-based practices or a consensus of healthcare professionals in the respective field
- Consider the needs of the members
- Are reviewed and updated, at minimum, every two years, or more often, as appropriate
- Are adopted in consultation with contracted health care professionals
- Are disseminated to practitioners and members upon adoption, revision and request
- Are used to provide a basis for utilization decisions, member education, and service coverage
- Do not contradict existing Virginia regulations or requirements as published by the Department of Social Services (DSS), Department of Health (DOH), Department of Health Professions (DHP), Department of Behavioral Health and Development Services (DBHDS), or other state agencies, as applicable

Sentara Health Plans requires that network providers utilize appropriate evidence-based clinical practice guidelines through web technology, use of electronic databases, and manual medical record reviews, as applicable, to evaluate appropriateness of care and documentation. A modified approach to the utilization of clinical practice guidelines and nationally recognized protocols may need to be taken to meet the unique needs of all beneficiaries.

These medical and behavioral health guidelines are based on published national guidelines, literature review, and the expert consensus of clinical practitioners. They reflect current recommendations for screening, diagnostic testing, and treatment. These guidelines are published by Sentara Health Plans as recommendations for the clinical management of specific conditions. Clinical data in a particular case may necessitate or permit deviation from these guidelines and treatment decisions are always to be made by the practitioner based on their best medical judgement considering each patient's clinical situation. The Sentara Health Plans guidelines are not intended as a substitute for clinical judgment. Copies of clinical guidelines are available via mail, email, or fax. To request a printed copy of Sentara Health Plans' CPGs, please contact the quality improvement and member safety team at 757-252-8400, option 1, or toll-free at 1-844-620-1015. CPGs are also available online via the Sentara Health Plans website.

Sentara Health Plans Quality Improvement (QI) Program

The goal of the QI program is to ensure member safety and the delivery of high-quality medical and behavioral healthcare. The QI program concentrates on evaluating both the quality of care offered and the appropriateness of care provided.

With the application of Continuous Quality Improvement (CQI) principles, Sentara Health Plans aims to provide high quality cost-effective care that enables members to remain healthy, manage chronic illnesses and/or disabilities, and maintain or improve

members' quality of life. Improvement of health status can be demonstrated by measurable health outcomes. Sentara Health Plans is committed to improving the communities where our members live through participation in public health initiatives on the national, state, and local levels and the achievement of public health goals.

This continuous assessment uses quality improvement methodologies such as Six Sigma, Define-Measure-Analyze-Improve-Control (DMAIC), Root Cause Analysis (RCA), and Plan, Do, Study, Act (PDSA). The QI program is a population-based plan that acts as a road map in addressing common physical and behavioral health conditions identified within our population.

The QI program activities include:

- Identifying performance goals
- Establishing internal and external benchmarks
- Collecting data and establishing baseline measurements
- Analyzing outcomes for barrier identification for performance improvement
- Developing and implementing written remedial/corrective action, as needed

The scope of the QI program is integrated within clinical and nonclinical services provided for the Sentara Health Plans members. The program is designed to monitor, evaluate, and continuously improve the care and services delivered by contracted practitioners and affiliated providers across the full spectrum of services and sites of care. The program encompasses services rendered in ambulatory, inpatient, and transitional settings and is designed to resolve identified areas of concern on an individual and system-wide basis.

The QI program reflects the population served in terms of factors including, but not limited to, age groups, disease categories, special risk statuses, and diversity. The QI program includes monitoring community-focused programs, practitioner availability and accessibility, coordination and continuity of care, and other programs or standards impacting health outcomes and quality of life.

The QI Program provides the structure, framework, and governance used to guide the formal and informal processes for evaluating and improving quality focusing on the following aspects:

- Appropriateness of health care services
- Effectiveness of care and care outcomes for the populations served
- Responsible cost and utilization management
- Member experience of care
- Provider experience of service and support

The QI program uses the Institute for Healthcare Improvement (IHI) Quintuple Aim, DMAS Quality Strategy, CMS guidelines, state and federal mandates, Bureau of Insurance (BOI), and NCQA Standards as guiding principles to shape the QI program efforts and provide the highest quality of care to better serve Sentara Health Plans' members and the community. The scope of the QI program includes oversight of all

aspects of clinical and administrative services provided to Sentara Health Plans members, including:

- Program design and structure
- Quality improvement activities that comply with CMS, NCQA, DMAS, and other regulatory entities, including contractual and regulatory reporting requirements
- Care Management (to include Complex Case Management, Behavioral Health, Care Transitions, and End of Life Planning) and Chronic Care Management programs that are member-centric and address the healthcare needs of members with complex medical, physical, and mental health conditions, assessments of drug utilization for appropriateness and cost-effectiveness
- Utilization Management focuses on providing the appropriate level of service to members
- Complaints/grievances and appeals
- High-quality customer service standards and processes
- Benchmarks for preventive, chronic, and quality of care measures
- Credentialing and re-credentialing of physicians, practitioners, and facilities
- Compliance with NCQA accreditation standards
- Audits and evaluations of clinical services and processes
- Development and implementation of clinical standards and guidelines
- Measuring effectiveness
- Evidenced-based care delivery
- Potential quality of care and safety concerns

Each year, Sentara Health Plans develops a QI Program Description, Quality Annual Evaluation, and Work Plan that outlines efforts to improve clinical care and service to members. Providers may request a copy of the current QI Program Description and Annual Evaluation by calling the network management department. Information related to QI initiatives is also available on the provider website and in provider newsletters.

The Sentara Health Plans QI Program Description, Annual Evaluation, and Work Plan is a comprehensive set of documents that serves our culturally diverse membership. It describes, in plain language, the QI program's governance, scope, goals, measurable objectives, structure, responsibilities, annual work plan, and annual evaluation.

The primary objective of the QI program is to continuously improve the quality of care provided to enhance the members' overall health status. Improvement in health status is measured through HEDIS performance measure data, internal quality studies, and health outcomes data with defined areas of focus. Sentara Health Plans have defined objectives to support each goal in the pursuit of improved outcomes.

The following are identified functions of the QI program:

- Provide an annual Quality Program Description, Quality Annual Evaluation, and Quality Work Plan
- Coordinate the collection, analysis, and reporting of data used in monitoring and evaluating care and service, including quality, utilization, member service,

credentialing, and other related functions managed at the plan level or delegated to vendor organizations
- Identify and develop opportunities and interventions to improve care and services
- Identify and address instances of substandard quality of care concerns
- Monitor, track, and trend the implementation and outcomes of quality interventions
- Evaluate the effectiveness of improving care and services
- Oversee organizational compliance with regulatory and accreditation standards
- Improve health outcomes for all members by incorporating health promotion programs and preventive medicine services into primary care practices
- Report on relationships between QI department staff and the QI Committee and subcommittee structure
- Provide resources and analytical support
- Collaborate interdepartmentally for QI-related activities
- Outline efforts to monitor and improve behavioral healthcare and the role of designated behavioral healthcare practitioners in the QI program
- Define the role of the designated physician within the QI program, which includes participating in or advising the Quality Improvement Committee (QIC) or a subcommittee that reports to the QIC
- Define the role, function, and reporting relationships of the QI Committee and subcommittees, including committees associated with oversight of delegated activities (e.g., clinical subcommittees, ad hoc task forces, or multidisciplinary work groups or subcommittees)
- Describe practitioner participation in the QI Committee and how participating practitioners are representative of the specialties in the organization's network (including those involved in QI subcommittees)
- Outline Sentara Health Plans' approach to addressing the cultural and linguistic needs of its membership
- Provide guidance on how to report critical incidents (including quality of care, quality of service, and sentinel events)
- Provide training materials for providers and organization employees on cultural competency, bias, and/or diversity and inclusion
- Coordinate performance measure monitoring for improvement and sustainability
- Utilize performance measure data for continuous quality improvement (CQI) activities

Goals of the Quality Improvement Program

One of the primary goals of Sentara Health Plans' QI Program is to achieve a 5-star rating from NCQA and CMS, respectively, by ensuring the delivery of high-quality culturally competent healthcare, particularly to members with identified healthcare disparities. Our care service delivery modalities emphasize primary medical and specialty healthcare services, behavioral health, long-term services and supports, care coordination, and pharmaceutical services. The QI Program concentrates on evaluating

both the quality of care offered and the appropriateness of care provided. This approach allows Sentara Health Plans to:

- Reduce healthcare disparities in clinical areas
- Improve cultural competency in materials and communications
- Improve network adequacy to meet the needs of underserved groups
- Improve other areas of needs that the organization deems appropriate
- Include a dynamic Work Plan that reflects ongoing progress on QI activities throughout the year
- Plan QI activities and objectives for improving quality and safety of clinical care, quality of service, and member experience
- Monitor previously identified issues
- Evaluate effectiveness of the QI Program's Annual Evaluation by analyzing performance measure outcomes
- Continuously meet regulatory and accreditation requirements
- Create a system of improved health outcomes for the populations served
- Improve the overall quality of life of members through the continuous enhancement of comprehensive health management programs, including Performance Improvement Projects (pips) and other Quality Improvement projects
- Make care safer by reducing variation in practice and enhancing communication across the continuum
- Strengthening member and caregiver engagement in achieving improved health outcomes
- Ensure culturally competent care delivery through practitioner cultural education including the provision of information, training, and tools to support culturally competent communication

For hard copies or information about the QI Program at Sentara Health Plans, please contact the quality improvement and member safety team at 757-252-8400, option 1 or toll-free at 1-844-620- 1015, option 1.

NCQA's website, ncqa.org, contains information to help consumers, employers, and others make more informed health decisions.

Critical Incident Reporting

A critical incident is defined as any actual, or alleged, event or situation that threatens or impacts the physical, psychological, emotional health, safety, or well-being of the member. Critical incidents are categorized as either quality of care incidents, sentinel events, or other critical incidents as defined below:

- Quality-of-care incident is any incident that calls into question the competence or professional conduct of a healthcare provider while providing medical services and has adversely affected, or could adversely affect, the health or welfare of a member. These are incidents of a less critical nature than those defined as sentinel events.

- Sentinel event is a patient safety event involving a sentinel death (not primarily related to the natural course of the illness or underlying condition for which the member was being treated or monitored by a medical professional at the time of the incident) or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function that leads to permanent or severe temporary harm. The phrase “or the risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. All sentinel events are critical incidents.
- Another critical incident is an event or situation that creates a significant risk to the physical or mental health, safety, or well-being of a member not resulting from a quality-of- care incident and less severe than a sentinel event.

Providers must report critical incidents that occur during:

- The provision of services to members in nursing facilities, inpatient behavioral health or HCBS settings, hospital, PCP, specialist, transportation, or other healthcare setting
- Participation in or receipt of mental health services, ARTS, or waiver services in any setting (e.g., adult day care center, a member’s home, or any other community-based setting)

Examples of Reportable Critical Incidents:

- Abuse
- Attempted suicide
- Deviation from standards of care
- Exploitation, financial or otherwise
- Medical error
- Medication discrepancy
- Missing person
- Neglect
- Sentinel death
- Serious injury (including falls that require medical evaluation)
- Theft
- Other

Serious Reportable Events

Serious reportable events (SRE) are events that are clearly identifiable and measurable, usually preventable, and are serious in their consequences, such as resulting in death or loss of a body part, injury more than transient loss of a body function, or assault. These are severely significant adverse events that should never occur.

Examples of SREs include, but are not limited to, the following:

- Death (patient suicide, attempted suicide, homicide, and/or self-harm while in a healthcare setting)

- Falls (resulting in death or serious injury while being cared for in a healthcare setting)
- Pressure ulcers that are unstageable or stage III or IV acquired post-admission/presentation to a healthcare setting
- Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting
- Restraint use (physical restraints or bedrails) that results in death, requires hospitalization, or results in loss of function
- Patient death or serious injury associated with patient elopement (disappearance) while being cared for in a healthcare setting
- Abuse/assault on a patient or staff member on healthcare facility grounds

Abuse, Neglect, or Exploitation

Mandated reporters are identified in the Code of Virginia as having a legal responsibility to report suspected abuse, neglect, and exploitation. As defined by the Code of Virginia § 63.2-1606, the mandated reporter is:

- Any person licensed, certified, or registered by health regulatory boards listed in Code of Virginia § 54.1-2503, except for persons licensed by the Board of Veterinary Medicine
- Any mental health services provider as defined in § 54.1 -2400.1
- Any emergency medical services personnel certified by the Board of Health pursuant to § 32.1-111.5, unless such provider immediately reports the suspected abuse, neglect or exploitation directly to the attending physician at the hospital to which the adult is transported, who shall make such report forthwith
- Any guardian or conservator of an adult
- Any person employed by, or contracted with, a public or private agency or facility and working with adults in an administrative, supportive, or direct care capacity

Procedures/Guidelines

Sentara Health Plans requires all network and affiliated providers to report critical incidents within 24 hours of discovery via the approved Provider Critical Incident Report Form found under “Forms” on the Sentara Health Plans website. An initial report of an incident may be submitted verbally within 24 hours but must be followed up with a written report within 48 hours.

If the critical incident includes notifying Adult Protective Services (APS) or Child Protective Services (CPS), the following numbers may be used:

APS: 1-888-832-3858
CPS: 1-800-552-7096

Notify Sentara Health Plans of a critical incident either by phone, fax, or email within 24 hours of knowledge of the incident. Sentara Health Plans contact information to report a

critical incident is located on the Provider Critical Incident Report Form found under "Forms" or the "**Sentara Health Plans Key Contact Information**" at the top of this document.

Provider Office Quality of Care/Service Site Visit

A Provider Office Site Visit will be conducted by the quality department secondary to a Quality of Care (QOC)/Quality of Service (QOS) event and/or member grievance, or complaint, related to a QOC/QOS event. An office site visit may be conducted as a result of one or more quality concerns including, but not limited to, the following:

- Critical incidents (QOC/QOS/Sentinel Event)
- Member complaints/grievances related to:
  - Quality of care/quality of service
  - Provider office physical accessibility
  - Provider office physical appearance
  - Provider office adequacy of waiting and examining room space
  - Provider office adequacy OP of medical/treatment record-keeping
  - Provider office equipment accessibility
- Reported member safety concerns from Sentara Health Plans employees

A provider office visit will be conducted as expeditiously as the quality event, or complaint, necessitates, but no later than 30 days of the identified quality concern. All network providers must comply with Sentara Health Plans quality department's quality initiatives to investigate such concerns and must meet a predetermined minimum performance compliance threshold set forth by Sentara Health Plans. If issues are found during the site visit, Sentara Health Plans in its sole discretion may initiate a Corrective and Preventive Action (CAPA) Plan. If the quality concern(s) remains unresolved after the specified timeframe, a referral will be made to the appropriate department and/or committee for review.

Failure To Comply with Review Programs

Failure to comply with utilization management and quality improvement programs could be grounds for corrective action in addition to requirements for repayment of identified overpayments and/or being removed from the network. The failure of the provider to follow the policies and procedures of the Sentara Health Plans credential verification, quality assurance, risk, or utilization management programs regulations can lead to exclusion from federal funding, including payments from Medicare and Medicaid, as well as criminal and civil liability.

Health and Preventive Services

Member Services

Preventive health services for members include specific interventions to increase preventive health practices and to decrease identified health risks.

The patient identification manager (PIM) reminder system is a computer-based direct mail program designed to reach members and providers monthly to promote health. These initiatives support HEDIS improvement requirements. Mailings and communications may include:

- **Birthday Cards** – Plan members receive a birthday card during their birth month from Sentara Health Plans.
- **Healthy Pregnancy Mailings** - Once the health plan learns of a member's pregnancy, the member receives two letters from the health plan. Our messages include pregnancy resources and tips for mothers-to-be.

Health and preventive services by Sentara Health Plans offer health improvement programs, which include health risk identification and risk reduction strategies. Members may complete an online personal health assessment (PHA) and generate an immediate detailed report with specific risk-reduction strategy recommendations. A shorter report that the member can take to their healthcare provider is also available. Diabetic, asthmatic, those with cardiovascular disease, and pregnant health plan members are referred to Clinical Care Services.

Health Risk Reduction Programs

Several health risk reduction programs are available free of charge to health plan members on a regular basis throughout the year. A current list of programs is available to members on the member website.

Digital Lunch-and-Learn Webinars/Podcasts

As part of our ongoing effort to address relevant and timely risk-reduction education, our team of health educators host free, monthly webinars on a range of well-being topics. Available here, this series is open to all members. Past webinars are archived for viewing anytime. Topics include Tobacco Use and Cholesterol and Blood Pressure; Probiotics and Gut Health; Planting Your Money Tree; The Importance of Water Intake; Becoming Mindful, Not Mind Full; and Sleep Deprivation and Heart Health.

Individual Self-Paced Programs

Our unique, self-paced, and award-winning individual wellness programs are offered at no cost to all Sentara Health Plans members. Members can visit the Prevention and Wellness page to download programs on-demand or place an order for materials to be delivered via U.S. mail. The programs use a variety of media to engage the member in

learning about the risks and benefits of their behavior and offer tools for the member to take charge and make healthy changes including:

- Healthy Heart Yoga: Yoga programs include stretching and strengthening exercises to help improve flexibility, strength, and cardiovascular health. Chair yoga is also available.
- Eating for Life: This award-winning educational program helps participants develop healthy eating and exercise habits.
- Guided Meditation – A Journey Toward Health: This program invites listeners to experience a calm, peaceful retreat from everyday stressors.
- Qigong: This program helps your body to relax mentally and physically. The movements of this ancient practice enhance blood flow, release muscle tension, and improve balance.
- Stay Smokeless for Life: This education and support program helps people who want to quit using tobacco.
- Moveabout: This program focuses on increasing regular activity. It includes information to incorporate movement into daily activities.
- Healthy Habits, Healthy You: This educational program offers helpful ways to prevent Type 2 diabetes and heart disease by making healthy food choices, managing body weight, exercising, and finding ways to relax and get more sleep.

Health Education and Coaching Services

MyLife MyPlan Connection (powered in partnership with WebMD)

Through a partnership with WebMD® Health Services, Sentara Health Plans offers members flexible programs, expert guidance, and inspiration to take charge of their health—whether they are continuing healthy behaviors or making a change to improve their health. Sentarahealthplans.com and the Sentara Health Plans mobile app provide direct connection to each member's personalized WebMD Health Services online portal, streamlining how members can access the tools and education they need to sustain healthy behaviors. It all begins when the member completes a personal health assessment, which creates the foundation for their health record and coaching program. The online portal also offers a comprehensive activities tool known as Daily Habits. The Daily Habits tool delivers a personalized, interactive, and motivational experience to help members take action and sustain healthy behaviors in a fun way.

Personal Health Assessments (PHA)

The PHA is an advanced health profiling/risk assessment tool that scores an individual's health status, calculates risk levels, and provides recommendations for health improvement and behavior change. It takes approximately 12 minutes and is conveniently available for desktops, laptop, tablet, and mobile. Features include simple language for easy reading, gaming technology to drive engagement, and helpful "coach-like" notes.

The assessment analyzes different health risk factors that affect an individual's health and well-being. These factors fall into personal health status and lifestyle choices and habits. Based on an individual's responses, they receive a personalized score on 11 modifiable risk factors and the likelihood they will develop certain medical conditions.

A results summary screen with the participant's score, personalized steps to improve health, and risk and condition reports are the first thing the member sees upon completing their health assessment. Program recommendations include other wellness services such as telephonic or digital health coaching or referral to one of our disease management programs. The objective is to guide individuals to the appropriate programs and resources and serve as the foundation for overarching health and benefits management strategy. All reports are available for printing, including a physician-specific report that the member can take to their annual physician visit.

Member Dashboard with Personalized Risk Education

Members' wellness portal dashboards feature a dynamic display highlighting articles, resources, and personalized recommendations based on the information provided by the member. For example, if a member has identified a goal or issue related to stress, they will see content related to stress management, or if they indicated a high BMI on their health assessment, they would see content related to losing weight.

Fitness Device Integration

Our wellness portal offers the ability to integrate a variety of biometric device brands, including (but not limited to) Adidas, Fitbit, Garmin, iHealth, Jawbone, Life Fitness, Medisana, Microsoft, Misfit, Moveable, Nokia, Polar, Suunto, Sync, Telcare, TomTom, Under Armour, Withings, and YOO. The portal also offers integration with many fitness apps such as Adidas, Daily Mile, Garmin, iHealth, Jawbone, MapMyFitness, Moves, Nokia Healthmate, Runkeeper, Strava, Suunto, and Withings. When a device is linked to the WebMD portal, the information collected on the device flows seamlessly into various programs in the well-being platform.

Diabetes Prevention Program

Self-funded groups have the option to include the Diabetes Prevention Program, which is powered by WebMD Health Services, for a per-member fee.

Available to Sentara Health Plans members, our health coaching model is a participant-centered, whole-person approach to behavior change. The program was developed to improve member health using motivational interviewing and solution-focused goal setting. By setting reasonable, attainable goals, the program helps participants take a systematic approach to increasing and incorporating healthy behaviors into members' daily lives.

Available at various levels—as determined by the outcome of the member's health assessment—our health coaching covers low, moderate, and high-risk individuals and also has options for more intensive tobacco cessation and weight management coaching modules.

CoachConnect is an email-based communication tool that allows members to communicate at a time convenient to them. Telephonic health coaching provides an additional avenue for members to engage in coaching services for our fully insured groups.

The program is fully integrated with Sentara Health Plans. Self-reported data and claims data combine for better targeting, permitting outreach and interactions that are well coordinated and "member-centric" rather than "disease-centric." This resource promotes total population health management since members have access to health coaches and receive a personalized wellness plan.

In partnership with Omada Health, Sentara Health Plans offers members who qualify a digital, lifestyle-change program focused on reducing the risk of obesity-related chronic disease. This program combines the latest technology with ongoing support so participants can make changes to improve their health. The program includes a wireless smart scale, weekly online lessons, professional health coaching, and small online peer groups that offer real-time support. Members can determine if they qualify for the program by visiting Omada and completing the online screening tool.

Resources

Sentara Health Plans offers several resource libraries that host up-to-date information to help answer members' health and medication questions. With thousands of articles and helpful tools, such as health education videos, recipes, and quizzes, members can easily find trusted answers through our wellness portal.

Communications

Health and Preventive Services contributes news and current preventive health initiatives to the Sentara Health Plans provider newsletter and other Sentara Health Plans publications.

Healthcare Services

Healthcare service teams (case management services) are composed of professional clinical staff, behavioral health clinicians, and nonclinical staff. These teams are integrated around populations of members in specified managed care products. This allows for a complete plan of care for the patient encompassing case management, behavioral health, and disease management services.

Types of issues that may be referred to healthcare services:

- Members with complex medical issues who utilize multiple services
- Members who are nonadherent with treatment plans
- Members who frequently utilize services without consulting a PCP or specialist
- Members who frequently utilize the ER
- Members who could benefit from chronic condition management of heart failure, metabolic cardiovascular disease, transplant, behavioral health conditions, asthma, chronic obstructive pulmonary disease (COPD), or obesity
- Neonatal care for premature and medically complex newborns
- Members who could benefit from condition management during pregnancy, postpartum and need assistance with navigating infertility

Requests for healthcare services (written or verbal) may be initiated by:

- Provider
- Member
- Sentara Health Plans
- Authorized representative via the Release of Information (ROI) Form.

To refer members for healthcare services, providers may call provider services and be referred to the appropriate team.

Direct phone numbers for case/care management services are listed in the "**Sentara Health Plans Key Contact Information**" section of this manual.

Members are assigned to the healthcare services teams based on their individual medical/behavioral needs and the type of group coverage. The following levels of service are assigned along with goals and outcomes:

- Care coordination
- Case management
- Complex case management: coordination of care and services provided to members who have experienced a critical event or diagnosis that requires extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services

Clinical Care Services

Medical and Behavioral Health Services Access

For all members, the following apply:

- PCP referral is not required for members to access medical and behavioral health services from in-network specialists.
- Providers may not refer HMO members to out-of-network providers unless authorized by Sentara Health Plans.
- Providers must obtain prior authorization from Sentara Health Plans prior to recommending the member obtain care out-of-network.
- HMO plans may not pay if the services are provided to the members by a nonparticipating provider, except when authorized by Sentara Health Plans.
- Providers must receive prior authorization before services are rendered for any services requiring prior authorization.

PCPs or specialists **may not** authorize noncovered benefits or out-of-network services unless it is medically necessary and has received prior authorization by Sentara Health Plans.

Exceptions for prior authorization apply for emergencies and network accessibility.

Provider-to-Provider Communication

To ensure continuity of care, the specialist is required to report medical findings to the PCP. The written report must include:

- Diagnosis
- Treatment plan
- Answers to specific questions as the reason for the referral

Second Opinion

Sentara Health Plans covers a second opinion, from a Participating Provider, for treatment options to determine if the service is medically necessary or to explore available treatment options. Members have the option of consulting with an out-of-network provider:

1. Using their out-of-network benefit; or
2. At their own expense; or
3. If authorized by the plan
    - HMO plans do not cover services provided by a nonparticipating provider unless authorized by Sentara Health Plans.

Medical Clinical Care Services: Authorization

Prior Authorization via the Sentara Health Plans Provider Portal

The preferred method to obtain prior authorization, until this functionality is transitioned to Availity, is through the Sentara Health Plans provider portal.

Prior Authorization Forms

All prior authorization forms are available on the provider website here. The fax number varies based on the service requested and the member's Sentara Health Plans product type. To ensure a provider's request is not delayed, providers should use the fax number listed on the authorization form for the specific requested service for Commercial programs.

Providers are encouraged to use the Sentara Health Plans provider portal whenever possible to expedite the prior authorization process.

Clinical Care Service Availability

Clinical care service personnel are available between 8 a.m. and 5 p.m., Monday through Friday, Eastern Time. Confidential voicemail is available between the hours of 5 p.m. and 8 a.m., Monday through Friday, and 24 hours on weekends and holidays.

The Nurse Advice Line Program is also available 24 hours a day, seven (7) days a week.

Prior Authorization Procedures and Requirements

Prior authorization means an evaluation process that assesses the medical necessity of proposed treatment and checks to see that the treatment is being provided at the appropriate level of care.

Some services require prior authorization before the services are given. Physicians or other providers are responsible for getting prior authorization when required. When prior authorization is required for a service, but not obtained, any denial of benefits will not be the responsibility of the member.

Prior authorizations are approved or denied based on current medical practice and guidelines. Decisions are not based on incentives, bonus structures, or intended to result in underutilization of services. Prior authorization is certification by Sentara Health Plans of Medical Necessity and not a guarantee of payment by Sentara Health Plans. Payment by Sentara Health Plans for Covered Services is contingent on the member being eligible for Covered Services on the date the Covered Service is received by the member.

Except in the case of emergency treatment, prior authorization will be required for:

- All inpatient hospitalizations
- All partial hospitalizations (mental health or substance abuse)
- Select outpatient surgeries/short stays/observations, and IV therapy and drug infusions
- All skilled nursing facility admissions
- All acute rehabilitation
- All Intensive outpatient programs

All out-of-area services or referrals to nonparticipating providers (prior to scheduling) for members that do not have an out-of-network benefit included in their plan.

Providers are encouraged to check the Prior Authorization List (PAL) by procedure code before rendering services for commercial plans. The PAL can be found here. There may be variation among requirements for commercial employer groups. For questions, please contact 1-800-229- 8822.

Secondary Payer - Prior Authorizations

Sentara Health Plans does not require prior authorization when acting as the secondary payer except in the following situations:

- The primary payer does not cover the service and Sentara Health Plans does cover it; or,
- The member has exhausted their benefits under the primary payer, and the service is a benefit under Sentara Health Plans.

In either of these circumstances, Sentara Health Plans becomes the primary payer and prior authorization is required, if it is required for the specific service type.

Commercial plans require prior authorization for transplants even as the secondary payer. Please also see Organ Transplants for additional information.

Inpatient Admissions

Inpatient admissions should be completed online via the Sentara Health Plans provider portal.

To authorize admissions for:

- **Scheduled inpatient admissions:** Complete the online request in the Sentara Health Plans provider portal.
- **Emergent inpatient admission for a member who is currently hospitalized:** Complete the online request form via the Sentara Health Plans provider portal and indicate that it is an urgent request.
- **Emergent inpatient admission for a member who has not been admitted:** Complete the online request form via the Sentara Health Plans provider portal and indicate that it is an urgent request.

The provider or office staff should provide the following information when prior authorizing services:

- Attending physician's name
- Patient's name, date of birth, and member ID number
- Name of rendering facility, agency, or provider
- Date of service
- Diagnosis by name and code
- Service by name and procedure code(s)
- Treatment plan and prior treatment rendered
- Summary of test results (if applicable)

Pre-Service Claims Decisions

A pre-service claim means any claim for a benefit under Sentara Health Plans for which Sentara Health Plans requires approval before the member obtains medical care.

Sentara Health Plans makes decisions on pre-service claims within 15 calendar days from receipt of request for the service. Sentara Health Plans may extend this period for another 15 calendar days if it is determined more time is needed because of matters beyond Sentara Health Plans' control. If Sentara Health Plans extends the period, the member/provider will be notified before the end of the initial 15 calendar day period. If Sentara Health Plans makes an extension because there is not enough information to make a decision, Sentara Health Plans will notify the member/provider of the specific information missing and the timeframe within which the information must be provided. Sentara Health Plans will then make a decision within two (2) business days of receiving all the required medical information needed to process the claim.

When Sentara Health Plans has made a decision, the member/treating physician will receive written notice.

Expedited Decisions for Urgent Care Claims

Sentara Health Plans will consider a request for medical care or treatment to be an urgent request if using normal prior authorization standards would:

- Seriously jeopardize the member's life of health; or
- Seriously jeopardize the ability of the member to regain maximum function; or
- In the opinion of a physician with knowledge of the member's medical condition, subject the member to severe pain that cannot be adequately managed without the requested care or treatment.

Sentara Health Plans will notify the member/provider of a decision on an urgent request no later than 72 hours from receipt of the request for service. If Sentara Health Plans requires additional information to make a decision, notification will be sent to the Provider within 24 hours of receipt of the request. Sentara Health Plans will include the specific information that is missing and the applicable timeframes within which to respond to Sentara Health Plans. For requests for prescriptions for the relief of cancer

pain Sentara Health Plans will notify the Member/Provider of the decision within 24 hours of receipt of the request.

Concurrent Review

Concurrent Review means ongoing medical necessity review of a member's care during Hospital and other inpatient Facility, Skilled Nursing Facility, residential Treatment, and Partial Hospitalization confinements. Sentara Health Plans may also do Concurrent Review for Home health, therapy (PT/OT/Speech), and rehabilitation services treatment plans. If Sentara Health Plans decides to reduce or end coverage of a particular service, Sentara Health Plans will notify the Member/Provider before the coverage is reduced and early enough to allow for an appeal of the decision. Sentara Health Plans providers must follow certain procedures to make sure that if a previously authorized course of treatment or Hospital stay needs to be extended, the extension is requested in time to minimize disruption of needed services. Sentara Health Plans will notify the member of a coverage decision within 72 hours of receipt of the request. Notification will include information on how to appeal an adverse benefit determination prior to services being discontinued. Requests for extensions of therapy or rehabilitative treatment plans must be made seven (7) days prior to the end of the authorized timeframe to avoid disruption of care or services.

Sentara Health Plans Oncology Program

The Sentara Health Plans oncology program promotes evidence-based, high-value care for members receiving chemotherapy drug regimens and/or radiation therapy for the treatment of cancer. The program also includes genetic and molecular testing for the diagnosis and management of cancers.

Providers are required to prior authorize cancer radiation therapy, medical oncology and genetic/molecular testing services.

The oncology program applies to all fully insured members. Self-insured commercial groups may elect to join the program at the time of their benefit renewal. Medical oncology providers should obtain authorization for services on all Sentara Health Plans commercial members. If a self-insured member has not yet been enrolled in the program, a message indicating the member's enrollment status will be transmitted at the time of authorization entry.

The oncology program also provides cancer specific case management at no cost to members. As part of this program, the members have access to:

1. 24/7 access to oncology nurses via video, chat, and phone
2. Cancer-specific mental health therapists available by appointment
3. Personalized nutrition support from registered dietitians specializing in cancer care
4. An extensive library of clinically approved articles, videos, and virtual events

Genetic Testing

Providers must obtain prior authorization from Sentara Health Plans prior to the member receiving services for all genetic testing except Noninvasive Prenatal Testing (NIPT). Testing must be performed at participating specialty laboratories.

Behavioral Health Prior Authorization Requirement

Routine Outpatient Services

Prior authorization is not required before routine behavioral health outpatient services are rendered by participating providers.

Clinical Care Policies/Criteria

Clinical decisions are based on evidence-based guidelines, appropriateness of care, service, and coverage. Sentara Health Plans does not reward denials or provide any financial incentives to achieve underutilization.

Clinical care policies are used to determine medical necessity. Clinical Care Services develops policies using the following:

- Federal Statutes and Regulations
- State Statutes and Regulations
- Milliman Care Guidelines (MCG)
- Authoritative Association Guidelines, Specialty and Sub-Specialty Association and Peer Review Literature
- Specialty advisors

The medical directors of Sentara Health Plans review Clinical Care Services' policies. Approved policies are distributed to all appropriate departments. All policies are available to providers upon request and available here. To request copies of coverage policies and criteria, please call Clinical Care Services.

Post-Service/Retrospective Review

Any service (regardless of whether the service was prior authorized) may be retrospectively reviewed. Pre-service reviews and decisions will be completed within 30 business days; post-claim reviews will be completed within 60 business days of receipt of all requested information.

Partners in Pregnancy

The Partners in Pregnancy program is available to commercial members enrolled in any Sentara Health Plans products. Partners in Pregnancy program referrals come from provider offices and member self-referrals, as well as administrative data, to ensure as many members can be reached as possible.

Once a referral has been received, the team reaches out to the member by phone to explain the program. When a member elects to participate in the program, a comprehensive assessment, including an obstetrical assessment, is completed to tailor the program to suit the member's individual needs. Risk stratification is conducted using the assessments to allow members to be assigned to the appropriate Partners in Pregnancy team member. Members are stratified based on risk level and willingness to participate in the program. Members may have a combination of team members based on needs. The team contacts members at regular intervals during their pregnancy to provide prenatal education and mental health screenings and to answer questions regarding benefits and other available services. The team also includes a medical social worker who can assist with community resources such as housing, food, etc.

The Partners in Pregnancy team can communicate a member's or case manager's concern to a designated person within the provider office to expedite coordination of care. After one year postpartum, members who require additional assistance will be referred to other appropriate Sentara Health Plans case management teams for further assistance. The number for Partners in Pregnancy is listed in the "**Sentara Health Plans Key Contact Information**" section at the top of this manualt.

Patient Access Guidelines

For maternity care, appointments to provide initial prenatal care will be made as follows:

- Within seven calendar days of the request for pregnant enrollees in their first trimester
- Within seven calendar days of the request for pregnant enrollees in their second trimester
- Within three business days of the request for pregnant enrollees in their third trimester or for high-risk pregnancies
- Immediately if an emergency exists.

Home Health Post-Delivery Services

Home health services are available, with prior authorization, to assess and treat both the mother and child after discharge.

High-Risk Pregnancies

All high-risk pregnancies should be managed by a contracted maternal and fetal medicine specialist (MFM). If providers need assistance identifying a contracted MFM specialist, please contact the Partners in Pregnancy case manager.

Dependent Obstetrics (OB) Coverage

Please call provider services to confirm OB coverage for dependents.

Gynecological Care

Annual Gynecological Exams

Annual obstetrics and gynecology (OB/GYN) exams are covered every year, allowing a 45-day grace period for scheduling appointments. This exam includes routine healthcare services rendered during or because of the annual visit. It includes:

- Physical and pelvic exam
- Hematocrit or hemoglobin test
- Pap smear
- Urinalysis
- Wet prep
- Depo-Provera
- Pregnancy testing if medically indicated
- Cholesterol screening
- Mammograms per United States Preventive Services Task Force (USPSTF) guidelines

Vasectomies and Tubal Ligations

Most plans require copayments for vasectomies and tubal ligations. Call provider services for more plan-specific information. Not all plans cover these services.

Infertility Treatment

Some members do not have infertility benefits in their core coverage. In addition, fertility drugs, in vitro fertilization, services associated with the storage/freezing of sperm, or charges for donor sperm are not covered under most plans. Please call provider services to verify coverage.

Termination of Pregnancy/Abortions

Members may have benefits for elective abortions in the first 12 weeks of pregnancy. If the PCP or OB/GYN does not wish to refer the member, the member may obtain an authorization by calling the prior-authorization number on the member ID card. Please call the Clinical Care Services medical phone number for a list of providers contracted to provide this service.

24/7 Nurse Advice Line Program

The 24/7 Nurse Advice Line provides an avenue of care for members who need advice after their provider's office is closed. Registered nurses are available to provide direction and education for patients whose needs range from a sore throat to surgery questions. These nurses follow a set of protocols written and approved by physicians in providing educational information.

The nurse will give advice based on approved protocols for self-care or where to seek care based on assessment questions. They may recommend follow-up with a PCP or may refer patients to a facility for evaluation and treatment of symptoms. Members are informed that the nurse does not have access to medical records and does not diagnose medical conditions, order lab work, write prescriptions, order home health services, or initiate hospital admissions. Any time the Nurse Advice Line is contacted, please have the following information readily available:

- The member ID number of the person who is ill or has been injured - this number is on the front of the member ID card
- Detailed information regarding illness or injury
- Any other relevant medical information about the patient, such as other medical conditions or prescriptions

Benefits

Providers benefit from the program in several ways:

- The member receives advice to meet appropriate healthcare needs.
- The program reduces the number of after-hours nonemergency calls providers receive.
- The nurse will contact a provider if the situation requires it.

Information

Information about the program and how to use it is available from provider services for offices to distribute to patients.

Telephone Number and Hours

Members may be directed to their member ID cards or the member website for telephone contact numbers. The program is available 24 hours a day, seven (7) days a week.

MD Live®

When the member's treating provider's office is closed and the after-hours nurse recommends seeking care before the provider's office reopens, Sentara Health Plans fully insured members and some self-funded groups have access to board-certified physicians through MD Live 24 hours a day, seven (7) days a week by calling **1-866-648-3638** or online.

Members with this benefit can access MD Live through online video, phone, or by secure email for a specific listing of complaints. Sentara Health Plans member ID numbers are required for members to register for MD Live.

Additional Ancillary Services

Prior authorization requirements differ between plans and benefits may change over time. Prior authorization requirements and plan benefits should be verified by contacting Sentara Health Plans Provider Services using the number on the back of the member's ID card, or by using our online portal.

Durable Medical Equipment (DME)

DME includes equipment or items, which can be purchased or rented, which are able to withstand repeated use, which are medically necessary, and which are typically used in the home. Some supply items that fall under the DME category are covered services and typically require prior authorization. Most products have a calendar year benefit maximum. Contact provider services for specific member benefit information. Utilization management (UM) will assign authorizations for DME services that require authorization.

Authorizations are issued for medical necessity but do not guarantee payment.

DME Equipment Rental and Purchase Policy

The following applies to commercial plans:

- Clinical Care Services will determine if equipment being rented should be converted to purchase within the first three months of rental.
- Should accumulated rental payments exceed 110% of the purchased price of the equipment, Sentara Health Plans considers the equipment purchased, and all rental payments are stopped.
- If equipment is being rented and is subsequently purchased, all accumulated rental payments are offset against the purchase price; only the difference is paid, and the equipment is considered purchased.
- All equipment rentals must be billed in monthly increments (except codes E0935 RR – CPM Machine and E0202 RR – phototherapy blanket rented daily). The appropriate date range and a quantity of one (one month's rental) should be indicated on the claim form.
- Sentara Health Plans follows CMS units of measure for all rentals.

Equipment Rental Payment When a Member Becomes Disenrolled

If Sentara Health Plans determines that a member became disenrolled during the period covered in the date range, Sentara Health Plans will process the claim as indicated below:

- The line item billed will be changed to indicate the dates the member was covered by Sentara Health Plans.
- A quantity of one will be shown for the covered days, and the full month's rent will be paid.
- A second line item will be added indicating the dates the member was not covered by Sentara Health Plans.

- A quantity of zero will be shown for the noncovered days and an adjustment code, D28, indicated with a comment: “Member disenrolled on XX date, full month rental payment made.”

DME Copayments/Coinsurance

Copayments vary by product and employer. Please contact provider services for details.

DME Service/Maintenance of Purchased Items

Service/maintenance of purchased items requires prior authorization.

Commercial Lines of Business:

- Providers must bill with the appropriate HCPCS code for the purchased item and append the “MS” modifier.
- Sentara Health Plans allows for reimbursement of maintenance/service once every six months for parts and labor items that are no longer under warranty.

DME Miscellaneous Codes

Digital hearing aids, custom and power wheelchairs, and wheelchair accessories with no established allowance will be reimbursed based on invoice. An invoice must be submitted with the claim for the equipment to be reimbursed.

Employee Assistance Program (EAP) Services

All eligible behavioral health providers who participate with Sentara Health Plans commercial products (fully insured, self-insured, commercial, HMO, POS, and PPO) are contractually obligated to provide services for the employee assistance program (EAP), per Exhibit E-1 of the Sentara Health Plans Behavioral Health Provider Agreement, unless there is a qualified approved written exception.

A provider’s assessment and referral of EAP services include:

- Diagnostic assessment
- Intervention and/or short-term counseling
- Referral to appropriate local resources

Providers will receive EAP referrals from employees of Sentara Health Plans. Appointments should be offered within 48 hours of the referral with a face-to-face assessment at that time unless a later date is requested. Sentara Health Plans EAP will send a detailed provider packet via secure email or fax that includes all forms required for case documentation and reimbursement.

Medical Transportation Services/Ambulance

Non-Emergent Transport

- Members are eligible for nonemergent transport through their health plan benefits.
- Members can call their care coordinator to set up transportation or call the number on the back of their health insurance card for prior authorization.

Ambulance transportation by stretcher and wheelchair transportation services that are not emergency services must be prior authorized by Sentara Health Plans. Sentara Health Plans will not cover transportation that is not required by the person's physical or mental condition. Transportation from hospital to hospital may be covered if medically necessary and prior authorized by Sentara Health Plans.

Emergency Transport

- In an emergency, Sentara Health Plans will cover ambulance services from the home or the place of injury or medical emergency to the nearest hospital where appropriate treatment can be provided. Medical Necessity does not apply.
- Ambulance/stretcher transportation from facility to facility must receive prior authorization through the health plan.
- Members are responsible for copayments each way for ambulance services. This applies to both emergent and nonemergency services.

Air Ambulance Services

Please note the following about air transportation benefits under Sentara Health Plans:

- For covered emergency or nonemergency air ambulance services from out-of-network providers, members are responsible for in-network copayments, coinsurance, and deductibles listed on Sentara Health Plans' Schedule of Benefits. Member cost sharing will be applied to in-network maximum out-of-pocket amounts listed on Sentara Health Plans' Schedule of Benefits. Members are protected from balance billing for air ambulance services received from out-of-network providers.
- Benefits are available for air emergency transportation when using a ground ambulance would endanger the member's health and the medical condition requires more urgent transportation to an acute care hospital than a ground ambulance can provide.
- Benefits include air transportation to the closest hospital that can treat the member.
- Transportation or transfer by air ambulance from one hospital to another hospital is only a covered service when the member's condition requires certain specialized medical services that are not available at the hospital that first treats the member and using a ground ambulance would endanger the member's health.
- Transportation or transfer by air is not a covered service just because the member, the member's family, or provider prefer the member receive treatment by a specific provider or at a specific hospital.
- Air ambulances are not covered for transportation to other facilities such as a skilled nursing facility, a doctor's office, or a member's home.

Vision Coverage

Preventive Vision Coverage

For most benefit plans, members receive preventive vision benefits through the Sentara Health Plans' vision vendor. Preventive vision services are not reimbursed under Sentara Health Plans and should be obtained by members through the vision vendor (or if applicable, other employer- specific) vision benefits.

Diabetic Dilated Eye Exam Exception

For members with diabetes, regardless of the benefit plan, dilated retinal eye exams are covered every 12 months without a referral. These screening exams may be obtained through the vision vendor or participating ophthalmologists or optometrists.

Vision Materials Supplement

Groups electing the vision materials supplement coverage have a benefit for expanded optical care service. The member may be responsible for a plan-specific copayment for the materials in addition to the exam copayment.

Pharmacy Services

Pharmacists as Providers

In accordance with the provisions of § 54.1-3303, Virginia law allows pharmacists to initiate treatment with, dispense, or administer certain drugs and devices to commercial plan members 18 years of age or older with whom the pharmacist has a bona fide pharmacist-patient relationship in accordance with a statewide protocol developed by the Virginia Board of Pharmacy in collaboration with the Board of Medicine and the Department of Health and set forth in regulations of the Board.

Pharmacists who initiate treatment with, dispense, or administer a drug or device in accordance with state law shall counsel members regarding the benefits of establishing a relationship with a primary health care provider.

To provide medical services, pharmacists must meet Sentara Health Plans contracting and credentialing requirements. Pharmacists acting as providers are also responsible for adhering to the State Board of Pharmacy protocols. This includes obtaining the appropriate training and maintenance of records. Pharmacists can find additional information on the contracting, credentialing, and billing processes by visiting the Sentara Health Plans provider website, which can be found here.

Pharmacy Program

Sentara Health Plans manages the pharmacy program by evaluating the safety, efficacy, and cost-effectiveness of drugs. A Pharmacy and Therapeutics (P&T) Committee, consisting of pharmacists and physicians representing different specialties, review the clinical appropriateness of drugs for inclusion in the formulary. The P&T Committee also reviews and approves the clinical criteria for drugs with utilization management programs such as prior authorization (PA), step therapy (ST), and quantity limits (QL). A team of pharmacists at Sentara Health Plans is responsible for drug coverage and formulary management decisions with the guidance provided by the P&T Committee.

Sentara Health Plans formularies are developed with the inclusion of key agents within selected therapeutic classes. These agents offer comparable safety and efficacy yet are more cost- effective than similar agents. Sentara Health Plans formularies are available here. Notification of changes to the formulary appears in the Sentara Health Plans provider newsletter, with a link to the formulary changes on the provider website.

Members may enroll in plans that do not include a pharmacy benefit. The member’s ID card will identify pharmacy benefits under the “Rx” section, which will include their cost share for covered drugs.

Sentara Health Plans Formularies

Sentara Health Plans offers the following prescription programs for commercial members:

- Sentara Open Formulary for self-funded, Business***EDGE***®, and large group plans
- Sentara Standard Formulary for self-funded and large group plans
- Sentara Standard Formulary for small group plans
- Sentara Individual & Family Health Plans Formulary
- Virginia Commonwealth University Health System Authority Formulary

Sentara Health Plans Open Formulary covers many medications unless they are benefit exclusions. This allows for the accessibility of multiple medications within a class and permits members and providers to determine the medication that is best for the individual member.

Sentara Health Plans standard and small group plans formularies cover select medications within each therapeutic drug category that have been reviewed by the P&T Committee. In addition, the small group plans formulary meets the Virginia Bureau of Insurance benchmark. Members and providers may request an exception for a drug that is not included on the formulary.

Our formularies require generic drug prescription usage whenever possible. These drugs are listed with the generic name on the formularies. If a member requests a brand-name drug when a generic drug is available, the member may be responsible for additional charges.

Tier Formulary Copayment Structure

All covered drugs, including specialty drugs, are placed in one of four tiers for commercial formularies. Copayments are dependent on both the member's pharmacy benefit structure and the tier in which the prescription drug falls. It is important for the members and providers to work together to determine which drug is appropriate.

- **Preferred Generic (Tier 1):** Medications on this tier have the lowest member cost sharing amount and include commonly prescribed generic drugs. Brand drugs may be included in Tier 1 if Sentara Health Plans recognizes that the drugs show documented long-term decreases in illness.
- **Preferred Brand and Nonpreferred Generic (Tier 2):** Includes brand-name drugs and some generic drugs with higher costs than Tier 1 generics, which are considered by Sentara Health Plans to be standard therapy.
- **Nonpreferred Brand (Tier 3):** Includes brand name drugs not included by Sentara Health Plans on Tier 1 and Tier 2.
- **Specialty (Tier 4):** Includes those drugs classified by Sentara Health Plans as specialty drugs. Tier 4 also includes covered compound prescription medications. For more information, reference the specialty drug section below.

Utilization Management Program

Sentara Health Plans' clinical staff, along with the P&T Committee, may require utilization management edits prior to coverage or reimbursement for the drug. These edits include prior authorization, step therapy, and/or quantity limits. The formulary, which is available on the provider website, will indicate if a covered drug has any restrictions, or providers can refer to the online drug search tool that is available on the Sentara Health Plans website.

- **Step therapy** is a process to ensure that Sentara Health Plans preferred medications are used as the first course of treatment. If the preferred medication is not clinically effective or if the member has side effects, another medication may be used as the second course of treatment. Sentara Health Plans utilizes claim history for approval of second-course treatments at the point-of-sale. Step therapy protocols are based on current medical findings, FDA-approved drug labeling, and drug costs.
- **Quantity limits** restrict the quantity of a drug that is covered within a given time. This helps ensure the safety of Sentara Health Plans members by preventing high and/or inappropriate doses of medication at the point of sale. The quantity limits placed on medications are based on recognized standards of care, such as FDA recommendations for use, and may be periodically updated.
- **Prior authorization** requires prescribing physicians to send clinical documentation to support the safety, efficacy and clinical appropriateness of the requested medication. Prior authorizations are required for selected medications that have specific indications for use, are high in cost, or have increased safety concerns.

A **request** for approval of a drug with utilization management edit(s) may be obtained by filling out the specific prior-authorization form for the medication. These forms may be completed by an office staff member acting as a representative of the prescriber but must contain the prescriber's signature. For copies of the forms, go to the provider section of the provider website or call pharmacy authorizations at Clinical Care Services.

An exception request can be made by the provider, on behalf of the member, by either:

- Calling the pharmacy provider services
- Faxing an exception request form along with clinical evidence to pharmacy provider services
- Electronically submitting a request through the prescriber's electronic health record system (EMR) or by utilizing the electronic portal: Surescripts Prior Auth Portal

Formulary prior authorization responses are generally received within two business days of Sentara Health Plans receiving the completed form and information from the provider.

Mail Order Prescription Drug Program

Commercial and FAMIS members (excluding Medicaid plan members) have the option of filling certain medications from a mail-order pharmacy. Members may purchase a 35- to 90-day supply of drugs from Express Scripts mail services.

Exceptions to the 90-day supply allowance are specialty medications and opioid pain management medications, which are limited to a 30-day supply.

Members can register for Express Scripts by signing into the member portal.

Physicians can submit the prescription electronically to Express Scripts or contact Express Scripts via phone.

For contact information on the mail order program, please reference the "**Sentara Health Plans Key Contact Information**" section at the beginning of this document.

Diabetic Supplies

Diabetic testing supplies may be covered under the member's pharmacy benefit. This allows members to buy their diabetic supplies from a local, in-network retail pharmacy or through an in- network mail-order pharmacy.

Members should contact their member services department for more information about their diabetic testing supply coverage.

Injectable and Infusion Medications Administered in the Physician's Office

Sentara Health Plans has an agreement with Proprium Pharmacy to fill and deliver injectable and infusion medication orders for administration in the physician's office. Proprium Pharmacy is a mail-order specialty pharmacy that provides certain prescription medications and immunizations directly to physician offices.

A 20% coinsurance may apply to certain drugs requiring prior authorization. The prior authorization requirements also apply when using Proprium Pharmacy. Medications that are administered in the physician's office that require prior authorization are listed on the Sentara Health Plans injectable and infusion medication list on the provider website.

Proprium Pharmacy bills Sentara Health Plans directly for the medication. The physician's office should only bill for the administration of the medication and should not collect copayments or coinsurance associated with the medications from patients. **Proprium Pharmacy will bill the member for the coinsurance or copayment amount.** Proprium Pharmacy may be reached by calling **1-855-553-3568**. Specialty resources are available to providers on the provider website.

Providers may also bill Sentara Health Plans for prior authorized injectable and infusion medications obtained from other sources by submitting the appropriate J-code. When billing Sentara Health Plans directly for the cost of the medication, providers will be responsible for collecting any coinsurance amount due from the member when the remittance is received.

Limited Distribution Drugs

Manufacturers are increasingly limiting the distribution of specialty drugs to certain pharmacies. Proprium Pharmacy has access to most specialty medications. However, in the event Proprium does not have access to a medication, it will transfer the prescription to a pharmacy that can provide the medication and will contact the member to notify them of where the prescription has been transferred.

Specialty Drugs

Specialty drugs have unique uses and are generally prescribed for people with complex or ongoing medical conditions. Specialty drugs generally require unique dosing, administration, and additional education and support from a healthcare professional. Specialty drugs include the following:

- Medications that treat certain patient populations, including those with rare diseases
- Medications that require close medical and pharmacy management and monitoring
- Medications that require special handling and/or storage
- Medications derived from biotechnology and/or blood derived (biologic medication that is derived from blood or blood components) drugs
- Medications that can be delivered via injection, infusion, inhalation, or oral administration
- Medications subject to restricted distribution by the FDA
- Medications that require special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy

Specialty drugs are available through the specialty mail-order pharmacy, Proprium Pharmacy. Please reference the "**Sentara Health Plans Key Contact Information**" section for Proprium Pharmacy contact information.

Pharmacy Coverage Exclusions

The following is a list of products or categories that are not covered for reimbursement under the member pharmacy benefit contract. **Benefits for self-funded plans may vary, and coverage should be verified for self-funded plans** here. This list is subject to periodic review by Sentara Health Plans and therefore may not be a complete listing of products.

Prescriptions for the following are **excluded** from coverage:

- Medications that do not meet Sentara Health Plans' criteria for medical necessity are excluded from coverage.
- Medications with no approved United States Food and Drug Administration ("FDA") indications are excluded from Coverage.
- Ancillary charges which result from a request for a brand name outpatient prescription drug when a Generic Drug is available are excluded from Coverage and do not count toward any Plan Maximum Out-of-Pocket Limit.
- All compounded prescriptions require prior authorization and must contain at least one prescription ingredient. Compound prescription medications with ingredients not requiring a Physician's authorization by state or federal law are excluded from Coverage.
- Non-durable disposable medical supplies and items such as bandages, cotton swabs, hypodermic needles, and durable medical equipment not listed as Covered are excluded from Coverage.
- Immunization agents other than those Covered by the formulary, biological sera, blood, or blood products are excluded from Coverage.
- Injectables (other than self-administered injectables and insulin) are excluded from Coverage, unless authorized by Sentara Health Plans.
- Medication taken by, or administered to, the Member in a Physician's office is excluded from Coverage unless Covered under Sentara Health Plans "Medication Administered by a Medical Provider" benefits section in the Evidence of Coverage Section "What is Covered".
- Medication taken or administered, in whole or in part, while a member is a patient in a licensed Hospital is excluded from Coverage.
- Medications for cosmetic purposes only, including but not limited to, Retin-A for aging, are excluded from Coverage.
- Medications for experimental indications and/or dosage regimens determined by Sentara Health Plans to be experimental are excluded from Coverage.
- Therapeutic devices or appliances, including but not limited to, support stockings and other medical/non-medical items or substances, regardless of their intended use are excluded from Coverage.
- Drug charges exceeding the cost for the same drug in a conventional packaging (i.e., convenience packages, unit doses, blister packs, etc.) Are excluded from Coverage.
- Drugs with a therapeutic over the counter (OTC) equivalent are excluded from Coverage unless authorized by Sentara Health Plans.
- Certain off-label drug usage is excluded from Coverage unless the use has been approved by Sentara Health Plans.
- Compound drugs are excluded from Coverage when alternative products are commercially available.
- Cosmetic health and beauty aids are excluded from Coverage.
- Drugs purchased from Non-Plan Providers over the internet are excluded from Coverage.

- Drugs purchased through a foreign pharmacy are excluded from Coverage unless approved by Sentara Health Plans for an Emergency while traveling out of the country.
- Nutritional and/or Dietary Supplements, except as required by law, are not Covered Services. Nutritional formulas and dietary supplements that are available over the counter and do not require a written prescription are not Covered Services. This exclusion does not apply to Plan Covered Services under the "Medically Necessary Formula and Enteral Nutrition Products" benefits section in the Evidence of Coverage section "What is Covered". Dietary supplements, including but not limited to, medical food, food or formula products, or other nutritional or electrolyte supplements are excluded from Coverage under the pharmacy benefit. Drugs not meeting the minimum levels of evidence based on one or more of the following standard reference compendia are not Covered Services:
    - American Hospital Formulary Service Drug Information.
    - National Comprehensive Cancer Network's Drugs & Biologics Compendium; or
    - Elsevier Gold Standard's Clinical Pharmacology.
- Minerals, topical and oral fluoride treatments, and vitamins are excluded from Coverage unless determined to be Medically Necessary to treat a specifically diagnosed Illness or when included under Affordable Care Act (ACA) Recommended Preventive Care.
- Pharmaceuticals approved by the United States Food and Drug Administration (FDA) as a medical device are excluded from Coverage unless authorized by Sentara Health Plans.
- Raw powders or chemical ingredients are excluded from Coverage unless approved by Sentara Health Plans or submitted as part of a compounded prescription.
- Sexual dysfunction drugs to treat sexual or erectile problems are excluded from Coverage.
- Travel-related medications, including preventive medication for the purpose of travel to other countries, are excluded from Coverage.
- Infertility drugs are excluded from Coverage unless listed as a Covered Service under a Plan rider.
- Prescription or over-the-counter appetite suppressants and any other prescription or over-the-counter medication for weight loss are excluded from Coverage unless listed as a Covered Service under a Plan rider.
- Digital Therapeutics, including digital devices, software and applications are excluded from Coverage.
- Refills one year after date of original prescription.
- Administration charges for the administration of any drug except for approved Covered immunization.
- Delivery charges for delivery of prescription drugs.

Additional Pharmacy Policies

- Members may have transition-of-care benefits for certain medications when they are newly enrolled. Transition of care information is available to members by calling member services.
- Benefits will not be denied for any drug prescribed, on an inpatient or outpatient basis, to treat a covered indication so long as the drug has been approved by the Food and Drug Administration (FDA) for at least one indication, and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.
- Benefits will not be denied for any drug, prescribed on an inpatient or outpatient basis, approved by the FDA for use in the treatment of cancer on the basis that the drug has not been approved by the FDA for the treatment of the specific type of cancer for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendia.
- Benefits will not be denied for any drug, prescribed on an inpatient or outpatient basis, approved by the FDA for use in the treatment of cancer pain because the dosage is more than the recommended dosage of the pain-relieving agent if the prescription has been prescribed for a person with intractable cancer pain.
- At its sole discretion, the Sentara Health Plans Pharmacy and Therapeutics Committee determines which tier a covered drug is placed in. The Pharmacy and Therapeutics Committee is composed of physicians and pharmacists. The committee reviews the medical literature and then evaluates whether to add or remove a drug from the preferred drug list. Efficacy, safety, cost, and overall disease cost are factors taken into consideration. The Pharmacy and Therapeutics Committee may approve the addition of utilization management edits (e.g., prior authorization, step-edits, quantity limits) for selected medications.
- Amounts the member pays for any outpatient prescription drug after a benefit limit has been reached, or for any outpatient prescription drug that is excluded from coverage, will not count toward any plan maximum out-of-pocket amount.
- Prescriptions may be filled at a Sentara Health Plans pharmacy or a nonparticipating pharmacy that has agreed to accept as payment in full reimbursement from Sentara Health Plans at the same level as Sentara Health Plans gives to participating pharmacies.
- Sentara Health Plans may approve coverage of limited quantities of an over-the-counter (“OTC”) drug. A member must have a physician’s prescription for the drug, and the drug must be included on the member’s Sentara Health Plans formulary.
- Insulin and syringes and needles used to administer insulin are covered. Diabetic supplies and equipment and in-person outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and noninsulin-using diabetes if prescribed by a healthcare professional legally

authorized to prescribe such items, other than those listed as covered under the prescription drug rider are covered under Sentara Health Plans' medical benefit. Any plan maximum benefit does not apply to physician-prescribed diabetic supplies covered under the medical benefit.

- Intrauterine devices (IUDs), implants, and cervical caps and their insertion are covered under Sentara Health Plans' medical benefits.
- Written outpatient drug prescriptions must be executed on tamper-resistant prescription pads.

Laboratory Services

Contracted lab providers may only perform laboratory services. Any entity providing laboratory services must have the appropriate Clinical Laboratory Improvement Amendments (CLIA) certificate.

In-Office Lab

Sentara Health Plans reimburses providers for certain specific lab tests performed in the provider's office. The current list of services that will be reimbursed by Sentara Health Plans when testing is performed in the provider's office can be located here.

In addition to the in-office lab list, a limited number of specialty-specific lab tests may be performed in certain specialty offices. Assigned network educators will provide details based on specialty. These specialties include:

- Dermatology
- Infectious disease
- Ophthalmology
- Urology
- Endocrinology
- Nephrology
- Reproductive medicine
- Hematology/Oncology
- OB/GYN
- Rheumatology

The in-office lab list is applicable to medical providers only and does not apply to behavioral health providers.

All other testing must be performed by a participating reference lab. Sentara Health Plans will reimburse providers for the draw fee. Charges from providers for lab tests other than the ones listed above will be denied as a non-allowable lab charge, and the member may not be held responsible.

Sentara Health Plans does not provide additional reimbursement to participating reference labs for the draw/collection.

Certain highly specialized lab tests may be available only from a few labs. Some exceptions apply to providers located in specific geographic areas. Please contact the appropriate network educator for guidance in these cases.

In-Office Laboratory Services Reimbursement

- The office may bill one venipuncture fee per patient.
- Samples obtained by swab or cup are part of the office visit.
- Sentara Health Plans will not reimburse CPT code 99000 as a handling or draw fee.
- Sentara Health Plans will not reimburse CPT codes billed individually when they are considered part of a bundled CPT code.

Reference Lab Providers

Any lab test not included on the “in-office lab” list must be sent to a participating reference lab. Participating reference laboratory providers are listed on the provider website under the provider search option.

Laboratory Services Reporting

Sentara Health Plans reference lab providers are required to provide an electronic report each month. This report includes actual test values for selected tests used by Sentara Health Plans in HEDIS reporting and in disease management. Laboratory provider service standards and reporting requirements are listed in the Reference Laboratory Provider Agreement.

Laboratory Draw Sites

Providers have the option of sending the patient with orders to a participating reference laboratory draw site. Members and providers may locate the nearest participating laboratory draw site by using the provider search option on the provider website or by calling provider services.

Since locations and providers are subject to frequent additions and changes, the most reliable locator for current information is on the provider website.

Preoperative Lab and X-ray

Members scheduled for surgery at a participating hospital may obtain services through a participating reference lab or may be sent directly to the admitting participating hospital with a prescription for preoperative testing.

If surgery is scheduled with fewer than three days’ notice, the lab testing should be performed by the admitting hospital.

Toxicology Lab Services and Medication Compliance Testing

Toxicology lab services are available for all Sentara Health Plans service areas. In-depth medication compliance services, including pain management and substance use testing, are available for Sentara Health Plans medical and behavioral health providers for all Sentara Health Plans products.

Billing And Payments

Contracted Amounts/Billing Covered Persons

By entering into a provider agreement, the provider has agreed to accept payment directly from Sentara Health Plans. This constitutes payment in full for the covered services the provider renders to members, except for copayments, coinsurance, deductibles, and any other monies listed in the "patient responsibility" portion of the remittance advice. The provider may not bill members for covered services rendered or balance bill members for the difference between the actual charge and the contracted amount. In cases where the copayment is greater than the allowed amount for services rendered, only the allowed amount for the services should be collected. Should the provider collect more than the allowed amount, the provider will be expected to refund the member the difference between the two amounts within 30 business days after receipt of the excess amount, unless a shorter timeframe is required by law.

Balance Billing (Protection from Surprise Medical Bills "No Surprises Act")

- The following services from in-network or out-of-network providers are covered under in- network benefits; and members are protected from balance billing:
- Emergency services at a hospital or freestanding emergency facility. This also includes post-stabilization services, including any additional covered services furnished by an out-of-network provider or emergency facility (regardless of the department of the hospital in which the items and services are furnished) after a member is stabilized as part of outpatient observation, or as part of an inpatient or outpatient stay with respect to the visit in which emergency services are furnished.
- Air ambulance services provided by an out-of-network provider.
- Nonemergency services provided by an out-of-network provider at an in-network facility if the nonemergency services involve otherwise covered surgical or ancillary services, or other covered services provided by an out-of-network provider.

For the services above, members are responsible for in-network copayments, coinsurance, and deductibles which will be applied to in-network maximum out-of-pocket amounts.

Provider remits should indicate whether a particular service is protected from balance billing and indicate how a provider may initiate formal negotiation and independent dispute resolution processes over reimbursement amounts for these services.

Additional Provider Responsibilities Under "No Surprises Act" Regulations

In addition to prohibitions against balance billing listed above, Title I (No Surprises Act) of Division BB of the Consolidated Appropriations Act, 2021 (CAA) amended Title XXVII

of the Public Health Service Act (PHSA) and includes the following requirements for providers and facilities:

- Provision of good faith estimate in advance of scheduled services, or upon request for uninsured or self-pay individuals (PHSA 2799B-6; 45 CFR § 149.610). The estimate must include expected charges for the items or services that are reasonably expected to be provided in conjunction with the primary item or service, including items or services that may be provided by other providers and facilities.
- Ensure continuity of care when a provider's network status changes.
- A provider or facility must disclose to any member to whom the provider or facility furnishes information regarding federal and state (if applicable) balance billing protections and how to report violations. Providers or facilities must post this information prominently at the location of the facility, post it on a public website (if applicable) and provide it to the participant, beneficiary, or enrollee. Providers must provide this notice no later than the date and time on which the provider requests payment from the participant, beneficiary, or enrollee. If the provider doesn't request payment from the individual, the notice must be provided no later than the date on which the provider submits a claim for payment to Sentara Health Plans.
- Must submit provider directory information to Sentara Health Plans that includes, at a minimum:
    - At the beginning of the network agreement with Sentara Health Plans
    - At the time of termination of a network agreement with Sentara Health Plans
    - When there are material changes to the content of the provider directory information of the provider or facility
    - Upon request by Sentara Health Plans
    - At any other time determined appropriate by the provider, facility, or HHS

Providers will reimburse members who relied on an incorrect provider directory and paid a provider bill in excess of the in-network cost sharing amount.

Hold Harmless Policy

For all Sentara Health Plans products, if Sentara Health Plans denies a claim for service due to failure of the contracted providers to follow any rule or procedure or based on retrospective review that the service was not medically necessary, the provider must hold the member harmless and not bill the member.

Appropriate Service and Coverage

Sentara Health Plans has mechanisms in place to detect and correct potential under and overutilization of services. As such:

- Utilization management ("UM") decision-making is based only on appropriateness of care and service.
- Sentara Health Plans does not compensate providers or other individuals conducting utilization reviews for denials of coverage or services.

- Financial incentives for UM decision-makers do not encourage denials of coverage or service.

Medical Necessity

Coverage decisions are based upon medical necessity. For commercial plans, Sentara Health Plans uses Sentara Health Plans Medical Coverage Policies and MCG (formerly known as Milliman Care Guidelines) in making medical necessity determinations.

Sentara Health Plans may deny claims for services deemed medically unnecessary. If the provider does not agree with Sentara Health Plans' determination, the provider may submit medical documentation (chart copies, treatment sheets, consultation reports, etc.) with a request for claim reconsideration to Sentara Health Plans.

Members may not be billed for services determined to be not medically necessary by Sentara Health Plans, unless:

- The member has been informed prior to receiving the services that those services may not be covered under the member's benefit plan.
- The member has agreed in writing to pay for the services at the time or before services are rendered.
- A patient should be billed directly if it cannot be proven that a patient is a member at the time of service. If it is later determined that the patient was indeed a member on the date of service, providers must refund the member any payments he/she made **more than** applicable copayments, coinsurance, or deductibles and file a claim for the service rendered.

Payment Policies

Sentara Health Plans payment policies are accessible through the Availity provider portal under the resources tab in Payer Spaces. The policies explain acceptable billing and coding practices to equip providers with information for accurate claims submission. To qualify for reimbursement, claims must meet criteria in these policies and procedures. Sentara Health Plans will inform providers as new policies are published. To access the policies, providers must have an active Availity Essentials provider portal account.

Corrected Claim Submission of a Previously Billed Claim

UB-04 Claims

- Bill type is a key indicator to determine whether a claim has been previously submitted and processed.
- The first digit of the bill type indicates the type of facility.
- The second digit indicates the type of care provided.
- The third digit indicates the frequency of the bill.
- Billing type is important for interim billing or a replacement/resubmission bill.

- "Resubmission" should be indicated in block 80 or any other unoccupied block of the UB- 04.

CMS-1500 Claims

- Claims submitted for correction require a "7" in box 22.
- Claims that need to be voided require an "8" in box 22.
- Enter the original claim number of the claim being replaced on the right side of item 22.

Inpatient Billing Information

Clinical Care Services will assign an authorization number based on medical necessity. The authorization number should be included in the UB claim.

Copayments, deductibles, or coinsurance may apply to inpatient admissions. Inpatient claim coding must follow most current coding based on the date of discharge. If codes become effective on a date after the member's admission date but before the member's discharge date, Sentara Health Plans recognizes and processes claims with codes that were valid on the member's date of discharge. If the Facility/Ancillary Provider Participation Agreement terms change during the member's inpatient stay, and payment is based on the Hospital Agreement in effect at the date of discharge. If the members' benefits change during an inpatient stay, payment is based upon the benefit in effect on the date of discharge. If a member's coverage ends during the stay, coverage ends on the date of discharge.

An inpatient stay must be billed with different "from" and "through" dates. The date of discharge does not count as a full-confinement day since the member is normally discharged before noon and therefore, there is no reimbursement.

Pre-Admission Testing

Pre-admission testing may occur prior to the ambulatory surgery or inpatient stay. The testing may include chest X-rays, EKG, urinalysis, CBC, etc. The tests should be performed at the same facility at which the ambulatory surgery or inpatient stay is ordered. The tests should be billed on the inpatient or ambulatory surgery claim. The admission date for ambulatory surgery must be the actual date of surgery and not the date of the pre-admission testing.

Sentara Health Plans will only pay separately for pre-admission testing if the surgery/ confinement is postponed or canceled. If the pre-admission testing is billed separately from the ambulatory surgery or inpatient stay and the surgery was not postponed or canceled, the pre- admission testing will be denied "Provider billing error, provider responsible" (D95).

Readmissions

Members readmitted to the hospital for the same or similar diagnosis will be considered as one admission for billing and payment purposes according to the terms of the Facility/Ancillary Provider Participation. This protects the members from having to pay multiple cost-share amounts for related readmissions within a short period of time.

Never Events and Provider-Preventable Condition Claims

Sentara Health Plans requires providers to code claims consistent with CMS “Present on Admission” guidelines and follows CMS “Never Events” guidelines.

A “never event” is a clearly identifiable, serious, and preventable adverse event that affects the safety or medical condition of a member and includes provider-preventable conditions. Healthcare services furnished by the hospital that result in the occurrence and/or from the occurrence of a “never event” are considered noncovered services.

When an inpatient claim is denied as a “never event,” all provider claims associated with that “never event” will be denied. In accordance with CMS guidelines, any provider in the operating room when the error occurs who could bill individually for their services is not eligible for payment. All related services provided during the same hospitalization in which the error occurred are not covered. The hospital providing the repair will be paid. All “never event” claims are reviewed by a Sentara Health Plans medical director.

Furloughs

Furloughs (revenue code 018X) occur when a member is admitted for an inpatient stay, discharged for no more than ten days, and then readmitted under the same authorization. Examples include situations in which surgery could not be scheduled immediately, a specific surgical team was not available, or further treatment is indicated following diagnostic tests but cannot begin immediately.

Interim Billing

Interim bills are a series of claims filed by a facility to the same payer for the same confinement or course of treatment for a patient who is expected to remain in the facility for an extended period of time. The interim billing process only affects admissions in a general acute care hospital and therefore Specialized Care Hospitals, Inpatient Rehabs, and Inpatient Psych stays are excluded.

Newborn Claims

Claims for newborn members may be sent utilizing the subscriber’s member ID number, the newborn’s date of birth, and the newborn’s name in field two of the CMS-1500 form. Coverage for a newborn child or adopted newborn child of a member will begin at birth if the newborn is added to the plan within 31 days of birth. Sentara Health Plans does not differentiate between sick and non-sick newborns or whether the care is rendered in an

inpatient facility or provider's office. Claims for infants outside of 31 days from the date of birth will be suspended for review of newborn eligibility and will be processed according to the enrollment status of the newborn.

Normal newborn charges (charges outside of labor and delivery) for care rendered in the hospital (while the mother is confined) will be paid whether the newborn is enrolled in Sentara Health Plans or not. One claim should be submitted for the mother, and a second claim should be submitted for the newborn.

If the newborn must stay in the hospital after the mother has been discharged (boarder baby), the newborn must be enrolled and must have an inpatient prior authorization under the newborn's own member ID number for the charges to be covered. The "boarder baby's" date of admission should be the same the mother's date of discharge.

Organ Transplants

Sentara Health Plans contracts directly with Optum Health Care Solutions for organ transplantation services. A limited number of direct contracts with local and regional transplant providers are used as part of the Optum Managed Transplant Program. **Prior authorization is required for transplant services, even if Sentara Health Plans is the secondary payer.** Prior authorization should be obtained at the time the member is identified and referred for organ transplant evaluation for all plans.

Skilled Nursing Facility Services

Placement in a Skilled Nursing Facility (SNF) requires prior authorization. Clinical Care Services nurses work with hospital and nursing facility staff to assist in making the necessary arrangements for Skilled Nursing Facility admission. Utilization Review (UR) Nurses review SNF services concurrently and review the facility continued stay for medical necessity in collaboration with Plan Medical Directors. UR Nurses will assist in the member's transition to home or to a lower level of care. Skilled Nursing Facility benefits are limited and vary by plan. If the member exhausts their SNF benefit limit, continued stay requests are not covered. Custodial care is not a Covered Benefit.

Inpatient Denials/Adverse Decisions

If the attending physician continues to hospitalize a member who does not meet the medical necessity criteria, or there are hospital-related delays (such as scheduling), all claims for the hospital from that day forward will be denied for payment. The claim will be denied, "services not prior authorized, Provider responsible (D26)". The member cannot be billed.

If the member remains hospitalized because a test ordered by the attending physician is not performed due to hospital-related problems (such as scheduling and pretesting errors), then all claims from that day forward for the hospital will be denied. The claim

will be denied, “Services not prior authorized, provider responsible (D26).” The member cannot be billed.

If a family member insists on continued hospitalization (even though both the attending physician and Sentara Health Plans agree that the hospitalization is no longer medically necessary), the claims related to the additional days will be denied. The claims will be denied “continued stay not authorized, Member responsible (D75)”.

For all medically unnecessary dates of service, both the provider and member will receive a letter of denial of payment from Sentara Health Plans. The letter will note which dates of service are denied, which claims are affected (hospital and/or attending physician), and the party having responsibility for the charges.

Facility Outpatient Services

Members may receive certain outpatient services (i.e., diagnostic tests, chemotherapy, radiation therapy, dialysis, physical therapy, nutritional counseling, etc.) Per their benefit plan. Providers must use UB bill type 131 for outpatient services.

Outpatient facility services typically have a member cost share associated with them. Sentara Health Plans assigns certain revenue codes to specific plan benefits. For example, revenue codes 0450-0459 are mapped to Emergency Department services and further drive the determination of the member’s cost share. The default outpatient benefit is “outpatient diagnostic.” Member cost share may be waived if the member is subsequently admitted.

If no dollar amount is billed on the claim, Sentara Health Plans automatically assigns zero dollars as the billed amount. If the quantity is not reported, Sentara Health Plans automatically denies the claim and requests additional information from the provider.

Emergency Department Services

Emergency services are those healthcare services that are rendered after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in:

- Serious jeopardy to the mental or physical health of the individual
- Danger of serious impairment of the individual's bodily functions
- Serious dysfunction of any of the individual's bodily functions in the case of a pregnant woman, serious jeopardy to the health of the fetus there are no follow-up days associated with an emergency room visit. Emergency room providers must direct the member to the appropriate provider for follow-up care.

A member liability amount may apply under the member’s benefit plan. If the member is directly admitted to the same hospital where the ER service was performed, the

emergency room facility charges should be added to the inpatient or ambulatory surgery bill submitted by the facility. The member is only responsible for the inpatient or Ambulatory Surgical Center (ASC) copayment, coinsurance, or deductible, as applicable. If the member is not directly admitted to the same hospital, the Emergency Department charges are paid separately from the inpatient charges. In this situation, the member may visit the Emergency Department, return home, and be admitted later in the day (normally within 24 hours).

Member Cost Share

Providers should expect payment of member copayments at the time of service. If the copayment is more than the charges for the service rendered, the allowed charge amount should be billed to the member instead of the full copayment.

The Sentara Health Plans remittance advice will indicate the “patient responsibility” amount. After receipt of the remittance, the provider will be able to calculate and bill the member for the amount due for any coinsurance or deductible.

Coordination of Benefits (COB)

Group health plans coordinate benefits with various other payers on either a primary or secondary basis to avoid duplication of coverage among payers that have partial liability for the same bill. Work-related claims and similar liability insurance claims are not covered by group health plans. Access detailed Sentara Health Plans Coordination of Benefits Policies here.

Overpayments and Recoveries

As part of the Sentara Health Plans audit process, Sentara Health Plans and its subcontractors may use statistical sampling and extrapolation of claims in determining the amount of an overpayment made to a provider.

In most cases, when a provider is paid in error, Sentara Health Plans automatically executes a retraction with 30 days advance notice to the provider stating the reason for the retraction. Sentara Health Plans follows the Ethics and Fairness in Carrier Business Practices Act (Va. Code § 38.2-3407.15) for Commercial recoveries. The lookback period for Commercial is generally one year from the date the overpayment was received. The 12-month lookback does not apply if either of the following are true: (i) the original claim was submitted fraudulently or (ii) the original claim payment was incorrect because the provider was already paid for the health care services identified on the claim or the health care services identified on the claim were not delivered by the provider.

Sentara Health Plans follows the Fair Business Practices Act for Commercial recoveries. The Fair Business Practices Act in Virginia establishes minimum fair business standards for health insurance carriers in the state. These standards include

timely payment of claims, handling of additional documentation requests electronically, and specific guidance in provider contracts regarding required documentation for claims payment. As part of this Act and required by state law, Sentara Health Plans is required to gather accurate contact information for our network providers in order to communicate electronically. Sentara Health Plans has established a form to easily update your information. Please visit this link to update your information.

If retraction is not possible and the provider would prefer to send a refund, please send a copy of the remit, the reason the claim was paid in error, and the payment check within 35 days to the Sentara Health Plans provider receivables address in the "**Sentara Health Plans Key Contact Information**" section of this manual. If the remittance is not available, please send a check with the member's name, member ID number, the reason the claim was paid in error, and the date of service to the provider receivables address. Please be sure to make the check payable to the company that sent the provider the check.

Reimbursement

Sentara Health Plans follows American Medical Association (AMA) coding guidelines (e.g., Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) definitions) and health plan policy, as well as Medicare policies and procedures, to include the most current Correct Coding Initiative (CCI) edits when making claims payment determinations with respect to the following:

- Bundling/Unbundling
- Anesthesia included in surgical procedure
- Separate procedure definitions
- Most extensive procedure
- Sequential procedures
- Mutually exclusive procedures
- Misuse of component codes with comprehensive codes
- Standard preparation/monitoring services
- Standards of medical/surgical practice
- Laboratory panels

The above list is not meant to be all-inclusive but represents major categories of edits where Sentara Health Plans routinely uses Medicare rules as its basis. Sentara Health Plans may utilize proprietarily purchased software products that incorporate similar coding and compliance rules into Sentara Health Plans' claims processing edits.

Provider Fee Schedule

Provider compensation arrangements and rates are detailed in the Provider Agreement. Information and current policies for developing fee tables and gap-filling fees for existing codes or assigning fees to new codes may be obtained by contacting the appropriate contract manager.

Claims

General Information and Filing Requirements - Rendering and/or Billing Provider

- The preferred method for claim submission to Sentara Health Plans is electronic claim submission. Claims can be submitted through Availity or any clearinghouse that can connect through Availity.
- All claims must be submitted within the guidelines of the product (see the "timely filing" section in this manual), or they will be denied as a late claim submission.
- Claims must be submitted by participating providers
- Submit paper claims on the standard CMS-1500 form for professional providers or UB-04 form for facilities.
- All claims must be "Clean Claims."
- To process a claim, Sentara Health Plans must have on file a valid W-9 for the provider TIN. Claims submitted without a W-9 may be administratively denied by Sentara Health Plans. Sentara Health Plans may require that any claim submitted without a valid W-9 on file be resubmitted to be processed.

National Provider Identifier (NPI)

All claims submitted to Sentara Health Plans must include individual and group practice NPI numbers and taxonomy codes. Claims received without an NPI number and taxonomy code are not Clean Claims and will be rejected or denied.

Completing the CMS-1500 Claim Form

To expedite payment and avoid resubmission of claims, it is important to fill out the CMS-1500 claim form as completely and accurately as possible. Submit claims containing all the data elements and industry-standard coding conventions. The National Uniform Claims Committee (NUCC) provides standard instructions for completing the CSM-1500 form on their website at nucc.org.

The CMS-1500 claim form version 02-12 is required by Sentara Health Plans.

Listed below are some of the fields that cause most payment delays:

- Complete all patient-identifying information in boxes 1–13. The **member's ID** and **group number** should be placed in boxes **1a and 11**. Paper claims will be accepted when billed under the member's Sentara Health Plans member ID or the Social Security number.
- The member's name submitted on the claim must match the member's name in box 12.
- Either the patient's signature or the words "signature on file" are required.
- **ICD-10** diagnosis codes are required on all claims, or the claim will be denied for an invalid diagnosis code and must be resubmitted for correction within 365 days from the last date of service.

- For unlisted or miscellaneous procedure codes (codes ending in 99), an English description of services or a complete list of supplies must be provided.

A Clean Claim, as defined in the Provider Agreement, will generally be processed and paid by Sentara Health Plans within 30 days of its receipt. Processing delays may occur for claims that require coordination of benefits, code review, or medical review.

Paper Claims

All paper claims should be sent to the claim address on the member's ID card. Handwritten claims are not accepted by Sentara Health Plans.

Common Reasons for Claim Rejection

- There are errors in the member's name.
- Hyphenated last names are submitted incorrectly.
- The birth date submitted doesn't match the birth date associated with the member ID number.

Remittance Advice

A remit is an explanation of reimbursement. The remittance advice details claim adjudication. Providers registered with the Availity provider portal may download their remittance advice by clicking on Claims & Payments and selecting Remittance Viewer.

Negative Provider Status

This term is used for information purposes for claims that are paid to providers with negative balances. Providers can enter a negative status when retractions are greater than positive payments. Retractions are done to correct overpayments. An example of a common overpayment issue is if Sentara Health Plans paid a claim as the member's primary carrier but should have paid as secondary. Reversing the claim to pay as secondary could create a negative balance if the dollar amount for other claims being paid would not cover the reversal. The provider would then be in a negative provider status and receive no additional payments until new claims are approved for payment or a refund is received by Sentara Health Plans. Sentara Health Plans will provide written notice to a provider at least 30 days in advance of reversing any claim. Such notice will specify the claim(s) to be reversed and explain why the claim(s) is being reversed.

Interim Reports

When providers enter a negative provider status, they begin receiving a negative provider interim statement rather than a check and a remit. The negative vendor interim statement reports all claims received and processed to that provider's account for that month. It is to be used for information purposes only and should not be used for posting. When enough claims have been received to balance out the negative amount, or the

provider refund check has been received, the provider will receive a remit. Claim payments will resume.

Pending Claims

If a claim needs to be reviewed by claims processing or clinical staff, it will be assigned a “suspend” code. The “suspend” code states the reason for the suspension.

If a claim has not been paid or denied and is not pending for any reason, please call provider services for information. If the claim is confirmed as not received, a second request must be submitted. These claims are subject to the timely filing policy.

Timely Filing Policy

All claims are to be submitted within one year (365 days) of the date of service. This includes first time submission claims and claims that have been previously paid or denied (reconsideration).

Sentara Health Plans allows 18 months from the date of service to coordinate benefits.

Duplicate Claims and Corrections

Duplicate claim submission is one of the biggest obstacles encountered during the claims process. If a provider is unsure if a claim has been filed, they should view claim status on the Availity provider portal or call provider services to inquire on the status of the claim. Sentara Health Plans checks for duplicate claims by comparing the member number, vendor identification number, date of service, procedure code, and total charges of the current claim to claims that are stored in the member’s history. Some service lines may be paid, and other service lines denied as duplicates, or the entire claim may be denied as a duplicate.

A “new claim” is a first submission by the provider. It has not been previously billed or processed and does not reference another claim.

A “re-billed" or "corrected claim" is a claim being resubmitted by the provider to correct or change a previous submission for the same patient, date of service, and/or procedures.

Electronic corrections are accepted in an electronic claim file through a clearinghouse or software vendor. Claims sent through a clearinghouse or software vendor must have a seven- frequency code in the CLM05-3 segment of the 2300 loop of the 5010 A1 837 professional guides. If a claim is resubmitted without the resubmit code, the claim will be denied as duplicate. Providers should contact their software vendor or clearinghouse with questions about how to send this code.

Changes in Insurance Information (Claim Submission)

If a provider receives corrected insurance information from the member and provides supporting documentation (for example, original dated registration, new registration, etc.) The provider may submit a claim to Sentara Health Plans within 90 days of receipt of the new information.

Retroactive Disenrollment

Sentara Health Plans will use reasonable efforts to determine in a timely manner that a member has been disenrolled. Should an employer group retroactively disenroll one of its members, Sentara Health Plans may retract claim payments for that member made for dates of service falling after the effective date of the member's disenrollment. The provider will be given 30 days' notice prior to the retraction of any claim.

Individual and Family Qualified (QHP) Sold on the Virginia Health Insurance Marketplace Grace Period Mandate

Sentara Health Plans must provide a grace period of three consecutive months if an enrollee receiving advance payments of the premium tax credit (APTC) has previously paid at least one full month's premium during the benefit year.

In accordance with the mandate, Sentara Health Plans will process claims for service rendered during the first month of the grace period. Claim payment for services received during the second and third month of the grace period will be suspended until the premium is paid in full or the grace period ends, and the member's enrollment is terminated for nonpayment.

If the member fails to pay the full premium balance before the end of the grace period, the member will be disenrolled as of the last day of the first month of the grace period. At that time, all claims for services during the second and third months will be denied, and the members will be responsible for the payment of these services in full. Sentara Health Plans will not retract claim payments from services rendered during the first month of the grace period.

Providers will receive notification when claims are suspended for nonpayment of premium during the second and third months of the grace period and will be informed of a grace period status. Eligibility status is also available 24 hours a day through the Availity provider portal located here.

Workers' Compensation

Any claim with an injury diagnosis code for a patient over the age of 16 will be reviewed. Sentara Health Plans communicates with the member to determine if the injury is work-related. Sentara Health Plans will automatically send a letter to the member requesting information about the injury. The member has 20 days to respond to the request for information.

If a claim is paid under a Sentara Health Plans benefit plan prior to determining that it is a workers' compensation claim, Sentara Health Plans will reverse the payment. The claim should be submitted through the member's employer's workers' compensation plan.

Provider Dispute Resolution

Subject to the exceptions noted below, any dispute initiated by the provider arising out of or relating in any manner to the Provider Agreement, whether sounding in tort, contract, or under statute (a "Provider Dispute") shall first be addressed by exhausting all Policies and Procedures applicable to the Provider Dispute before a provider may seek to resolve the Provider Dispute in any other forum or manner. Policies and Procedures shall include the following: Program Integrity Audit, Reconsideration and Appeals Policy; Provider Appeals Procedure; Credentialing/Recredentialing Appeals Process; and Appeals of an Adverse Benefit Determination Policy. If the Provider Dispute is of a type not subject to the Policies and Procedures, the provider and Sentara Health Plans shall engage in good faith negotiations between their designated representatives (such representatives shall be authorized to resolve the dispute). The provider must initiate negotiations upon written request to SHP (the "Meeting Request Notice") delivered in accordance with the notice requirements in the Provider Agreement within ninety (90) days of the date on which the provider first had, or reasonably should have had, knowledge of the event(s) giving rise to the Provider Dispute. The negotiations shall commence within thirty (30) calendar days after Sentara Health Plans receives the Meeting Request Notice, and the provider may not seek to resolve a Provider Dispute in any other forum or manner unless the Provider Dispute is not resolved within ninety (90) days after Sentara Health Plans' receipt of the Meeting Request Notice. This section shall not apply to, with respect to fully-insured payers, disputes arising as a result of SHP's violation of Va. Code § 38.2-3407.15 or SHP's breach of any provision(s) of this Agreement that is required under Va. Code § 38.2-3407.15. Sentara Health Plans' and providers' rights to terminate a Provider Agreement pursuant to applicable requirements in the Provider Agreement are not subject to the requirements and processes in this section.

Electronic Claims and Electronic Funds Transfer

Electronic Funds Transfer (EFT)

EFT is safe, secure, efficient, and less expensive than paper check payments. Funds are typically deposited 48 hours after payments are processed. Clean claims are processed and paid for by Sentara Health Plans within an average of seven days when submitted electronically and when payment is made through EFT. For commercial claims, EFT and ERA will be issued through Zelis Payments Network. This will require a Zelis account.

Current Zelis Users

Providers who are enrolled with Zelis should work directly with Zelis to ensure eras are routed correctly to avoid payment delays.

New Zelis Users – How to Register:

If a provider is not enrolled in the Zelis Payments Network, the provider must complete an enrollment option to continue receiving electronic payments or payment will be issued by check and sent via U.S. mail. Alternative payment options are also available, including the Automated Clearing House Network (ACH), virtual credit card, and paper check. If providers have any questions or want to change their payment method, they should call 1-855- 496-1571 or visit zelis.com/providers/provider-enrollment/.

Sentara Health Plans ePayment Center

To enroll in the Sentara Health Plans ePayment center, please call 1-855-774-4392, send an email to help@epayment.center, or visit sentarahealthplans.com.

Filing Claims Electronically

Providers that submit claims to Sentara Health Plans' electronic claims program enjoy several benefits: documentation of claims transmission, faster reimbursement, reduced claim suspensions, and lower administrative costs.

- Claims can be submitted through Availity or any clearinghouse that can connect through Availity.
- The Sentara Health Plans payer ID number is **54154**.
- Providers who can receive data files in the HIPAA compliant ANSI 835 format may elect to receive EFT/ERA from Zelis or Sentara Health Plans ePayment Center. The 835 transaction contains remittance information as well as the electronic funds transfer.

Inquiries about direct claims submission or EFT/ERA transactions may be submitted by email to EFT_ERA_Inquiry@sentara.com.

- All claims must be submitted within the timely filing policy provisions stated in the Provider Agreement or as dictated by plan policy. Please see the "**Timely Filing Policy**" section in the "**Claims**" chapter of this manual.

- Claims submitted electronically will be accepted when billed under the member's Sentara Health Plans member ID. Providers should first review their clearinghouse requirements for submission of member identification to confirm that their clearinghouse will accept claims using their chosen option for submission.
- Claims submitted must have charge amounts. Claims for zero charge amounts will be rejected.
- Claims submitted electronically are generally processed within 24 hours of receipt.

Required Claims Information

All information noted in the "**Claims**" chapter of this manual is applicable to claims filed electronically.

Birth Date

Claims submitted with incorrect birth dates (the birth date submitted does not match the birth date associated with the member ID number submitted) will be denied (in the QNXT claims system) or rejected (in the CSC claims system).

Corrected Claim Submissions

Sentara Health Plans accepts the following corrections electronically:

- Patient payment
- Service periods/dates
- Procedure/service codes
- Charges
- Units/visits/studies/procedures
- Hospitalization dates
- Name or ID number of the referring provider
- Provider ID
- Wrong member ID number or birth date

Coordination of Benefits Claim Submissions

Sentara Health Plans accepts secondary and subsequent claims electronically. Providers' clearinghouses or software vendors are the best resource for providers to determine how to submit the necessary data. Please provide:

- Full claim allowed amount
- Patient responsibility at the claim level
- Any additional line information that is available

Status Reports

Provider sites receive "status" or "response" reports that will give the total number of claims transmitted and whether they were accepted or rejected.

Support for Electronic Claims Filing

Providers should contact their current EDI vendor for:

- Problems with transmission
- Level one or level two errors

Contact provider services for:

- Consistent rejections of claims, although information is correct
- Status of claims received electronically
- Questions concerning the adjudication or payment of claims sent electronically

Information For Specific Claim Types (A-Z)

After-Office Hours Codes

- After-office hours codes can only be billed when the services extend beyond the **posted** hours.
- Two codes are used for billing after-hours care: the appropriate office visit code and the appropriate after-hours code.
- Specialists are not reimbursed for after-hours codes.

Allergy Claims

The office visit copayment applies to allergy injections. The date of each injection must be indicated on the claim. Since allergy benefits vary, please confirm eligibility and specific allergy benefits and authorization requirements by calling provider services and choosing option 2.

Code 99211

CPT code 99211 is used for an evaluation and management visit that may not require the presence of a physician. Presenting problems are usually minimal, and time spent performing or supervising services is typically five minutes or less. An appropriate use of this code would include a blood pressure check performed by a nurse where medications were maintained or changed at the time of the visit. This service includes an exam and decision making.

Code 99211 should **not** be used if **only** the following services are being performed on the date of service:

- Administration of injections (vitamin B-12, Depo-Provera, etc.)
- Administration of medication for an established course of therapy following a protocol that does not require physician input for dosing (chemotherapy, PUVA) when no other services are performed
- Routine in-person prescription renewal and telephone prescription renewal
- Venipuncture (use code 36415 when no other service is performed)
- Allergy injections

Fluoroscopic Guidance and Contrast

Sentara Health Plans allows the reimbursement of fluoroscopic guidance and, in general, follows CCI guidelines on payment of this procedure.

Sentara Health Plan allows the reimbursement of contrast materials under specific circumstances in accordance with CMS guidelines.

Incident–to Guidelines

Per the CMS National Coverage Provision for Incident-to-Services, when nonphysician practitioners (NPPs) render services that are incident to a physician services, they may bill under the physician when the service meets all of these requirements:

- An integral part of the physician's professional service
- Commonly rendered without charge or included in the physician's bill
- Of the type that is commonly furnished in physician offices or clinics
- Furnished by the physician or auxiliary personnel under the physician's direct supervision

CMS defines incident-to-services as those performed by an NPP who is under the supervision of a physician and who is employed by or contracted with the physician or the legal entity that employs or contracts with the physician.

There must have been a direct, professional service furnished by the physician to initiate the course of treatment of which the service being performed by the nonphysician is an incidental part, which means that the physician must see the patient first to initiate the plan of care for the patient. The NPP would follow the physician's plan of care for subsequent services. The physician must perform the initial service for the diagnosis and must remain actively involved during treatment. The physician must perform subsequent services that reflect his or her continued active involvement in the patient's care.

All nurse practitioners and physician assistants must be licensed independently and credentialed by Sentara Health Plans. They may not utilize incident-to-billing.

Example: If a patient informs the NPP of a new problem while being seen in a subsequent visit for an established problem with an established plan of care, the visit cannot be billed incident-to because the physician has not seen the patient to establish a new plan of care for the new problem. If the NPP is credentialed with Sentara Health Plans and the services are within the NPP's scope of practice, then the NPP should bill the appropriate level of new or established E/M service provided under his or her own provider number.

Per CMS guidelines, "Direct supervision in the office setting means the physician must be present in the office suite and immediately available to provide aid and direction throughout the time the service is performed. Direct supervision does not mean that the physician must be present in the same room with his or her aide."

The only time an NPP can bill a service under a physician is when a physician is in the office and directly available to help. The physician being available by phone is not appropriate and does not constitute direct supervision. *More information is available fromCMS* located here.

Behavioral Health Resident in Training & Supervisees

Residents in Counseling and Supervisees in Social Work practice under the license of their clinical supervisor. They can work with all populations for which their supervisor is credentialed. The supervisor shall assume full responsibility for the clinical activities of the board-approved resident, regardless of if the supervisor is onsite or offsite, specified within the supervisory contract (application) for the duration of the residency.

During Resident or Supervisee sessions, the provider is expected to meet all the requirements of their licensing agency and any educational facility that is providing oversight for the residency program, including documentation, supervising provider participation, and review of notes, etc.

Billing for these services must be submitted with the supervising provider's individual NPI listed as the rendering provider.

Subrogation

Subrogation laws vary by state, and some states' laws do not permit subrogation for certain products. Sentara Health Plans follow the applicable state law.

Appeals of Adverse Benefit Determinations

This section and process described herein apply to Sentara Health Plans fully insured and self-funded individual and group health plans including HMO, POS, and PPO major medical plans. This Appeals process applies before a claim is submitted for payment. Once a claim is processed, a provider should follow the Provider Reconsideration Process outlined below.

Sentara Health Plans has a full and fair internal and external appeal process to review Adverse Benefit Determinations.

An Adverse Benefit Determination is a pre-claim decision made by Sentara Health Plans not to pre- authorize a covered service, or not to cover or reimburse a service because:

- A member is not eligible for benefits under the plan
- The service, either pre-service or post-service, does not meet requirements for:
    - Medical necessity
    - Appropriateness
    - Health care setting
    - Level of care
    - Effectiveness or
- The service is experimental or investigational

Members or their designated agents (which can include a provider) have 180 days from notice of an Adverse Benefit Determination to request an appeal. If a provider is submitting an appeal on behalf of a member, Sentara Health Plans may ask the member to sign a form authorizing the provider to act on their behalf. The internal appeal process must be exhausted prior to filing an independent external appeal. Except for urgent situations, all appeals must be submitted in writing.

When Sentara Health Plans reviews an appeal, Sentara Health Plans will look at all comments, documents, records, and other information submitted to Sentara Health Plans. Appeals involving a medical judgment, including whether a particular treatment, drug, or other service is experimental, investigational, or not Medically Necessary, will be reviewed by a clinical peer reviewer who did not participate in the first coverage decision. When Sentara Health Plans completes the appeal, Sentara Health Plans will send written notification of its decision to the member and the member's authorized representatives. If Sentara Health Plans upholds the initial decision, the notice will include:

1. The specific reason for the decision; and
2. The specific plan provisions Sentara Health Plans based the decision on; and
3. Information on any independent external appeal rights.

Pre-Service Appeals

A pre-service appeal deals with a benefit or service that requires prior authorization before a member receives care. For pre-service appeals, Sentara Health Plans will make a decision and notify the provider and members and their authorized representatives within 30 calendar days of receipt of written request for the appeal.

Post-Service Appeals

A post-service appeal deals with services that have already been rendered (but before the claim is submitted). An example would be a claim for payment for a diagnostic test or other services the member has already had done. Sentara Health Plans will make a decision and notify the member and the member's authorized representatives within 60 calendar days of receipt of written request for the appeal.

Appeals of Concurrent Review Decisions

An appeal of a concurrent review decision occurs where Sentara Health Plans is reducing or ending authorization of payment for a service previously approved. It can also be a request to extend the course of treatment. An example would be a review on the third day of an inpatient hospital stay approved for five days to determine if the full five days is appropriate. Another example would be a request for additional outpatient therapy visits. For appeals of concurrent review decisions, Sentara Health Plans will make a decision and notify the provider and members as soon as possible and prior to the benefit being reduced or terminated.

Expedited Appeals for Urgent Claims

An urgent situation exists when the requested medical care or treatment is urgent and using the normal appeal process would:

- Seriously jeopardize a member's life or health, or
- Seriously jeopardize a member's ability to regain maximum function; or
- In the opinion of a physician with knowledge of the member's medical condition, subject the member to severe pain that cannot be adequately managed without the care or treatment.

An expedited appeal can be requested by telephone, fax, or letter. Please make sure to explicitly state "expedited appeal" in the request to initiate this process.

Sentara Health Plans will make a decision on an expedited appeal and notify the provider as soon as possible, but no later than:

- Not later than 72 hours from the receipt of the request.
- Expedited appeals relating to a prescription to alleviate cancer pain will be decided not more than 24 hours from receipt of the request.

Adverse Determinations Involving the Treatment of Cancer

Expedited appeals relating to a prescription to alleviate cancer pain shall be decided no more than 24 hours from receipt of the request and conducted by telephone.

How to Begin an Internal Appeal:

1. Request forms to start a written appeal by downloading and completing the forms at sentarahealthplans.com and:
   a) Sending a fax to 1-877-240-4214 or
   b) Sending a letter by mail to:
      Sentara Health Plans Appeals and Grievances
      PO Box 66189
      Virginia Beach, VA 23466
2. For an urgent care appeal, please make sure to explicitly state "expedited appeal" in the request to initiate this process.
3. Completed forms can be returned to Sentara Health Plans. Remember to include all the following with the appeal forms:
   a) Member information, including name, address, telephone number, member ID, and group number
   b) The date of service and place of service
   c) The name of the treating physician or other service provider
   d) The charge related to the service, and
   e) Any new additional written comments, documents, records, or other information Sentara Health Plans should consider

Claim Reconsiderations

A *reconsideration*—distinct from a claim correction and distinct from an appeal of an Adverse Benefit Determination—is a written request submitted by the provider seeking a review of how a claim was adjudicated. It is important to note that a reconsideration does not involve any changes to the original claim.

The reconsideration filing deadline is 365 days from the last date of service.

The Provider Reconsideration Form is available on the Sentara Health Plans provider website found here or by calling provider services.

Mail the completed Provider Reconsideration Form and, if necessary, any attached documentation to the claim reconsideration address found at the top of the Provider Reconsideration Form.

Providers will receive written letters indicating that the original claim decision will be upheld when reconsiderations are submitted without complete information. If the provider is not satisfied with the initial reconsideration outcome, a second-level reconsideration may be requested based on the uphold reason within 60 days from the date on the first-level reconsideration decision.

Late Claim Reconsiderations

Requests for waivers to the timely filing requirements due to an exceptional circumstance must be made in writing and should be submitted to the Sentara Health Plans claims department. Extensions will only be granted upon a showing of good cause.

Reconsideration requests must be submitted via mail to the following addresses:

Medical Claims: PO Box 8203, Kingston, NY 12402-8203
Behavioral Health Claims: PO Box 8204, Kingston, NY 12402-8204

Medical Records

Practitioners and providers delivering services to Sentara Health Plans members are expected to maintain and appropriately share member health records in accordance with established professional standards.

Practitioners are required to maintain comprehensive and accurate medical records documenting the care and services provided to Sentara Health Plans members. All communications and records related to a member's healthcare must be treated with strict confidentiality. Unless otherwise authorized by law, records may not be released without the member's written consent, or, in the case of a minor, the consent of their legal guardian (unless the records relate to services for which the minor has consented for themselves in accordance with Virginia law).

Members are not required to complete an additional medical release form for Sentara Health Plans to obtain records. Sentara Health Plans may request member records for quality assurance purposes in accordance with state and federal regulations and accreditation standards.

Medical records are essential tools for preserving the continuity, accuracy, and integrity of clinical information. As the primary source of data related to patient care, medical records support not only the treating provider, but also other healthcare professionals involved in coordinating and delivering comprehensive care.

Confidentiality

All medical records are classified as Protected Health Information (PHI) under HIPAA regulations. Any personal information about a member received by the provider from Sentara Health Plans must be treated as confidential and securely maintained within the United States.

Confidentiality of medical records must be upheld through the following practices:

- Secure Storage: Medical records must be stored in a secure manner, whether in a confidential filing system or electronically, with appropriate safeguards to ensure that only authorized personnel have access.
- Confidentiality Training: Staff must receive periodic training on the confidentiality of member information, including Sentara Health Plans medical record documentation standards, and additional training as needed.

All provider staff are required to comply with the HIPAA Privacy and Security Rules.

Providers rendering substance use disorder treatment services that are subject to 42 CFR Part 2 must comply with the confidentiality provisions set forth in Part 2.

Medical Record Documentation Standards

Medical records may be audited in accordance with Sentara Health Plans' physical and behavioral health treatment record documentation guidelines which reflect accepted standards for medical record documentation.

Each medical record must include, at a minimum, the following elements:

- Comprehensive history and physical, including the history of present illness and relevant psychiatric history
- Documentation of allergies and adverse reactions to medications
- Problem list
- Medications management and reconciliation
- Clinical findings and evaluations documented for each visit
- Preventive services and risk screenings
- Diagnoses, including documentation for behavioral health
- Substance use assessment
- Mental status examination
- Treatment planning
- Evidence of continuity of care, including:
    - Documentation of collaboration with the member's primary care provider (PCP) regarding medications and treatment, or documentation of the member's refusal to consent
    - Upon obtaining consent for the release of information, the BH provider must notify the member's PCP when the member presents for an initial behavioral health evaluation and for ongoing treatment. This includes communication about significant changes in the member's condition, medication adjustments, and termination of treatment. This applies to all specialty providers.

Medical records must be organized and securely stored in a non-public area that allows for efficient retrieval. Providers are responsible for maintaining well-structured records for all members receiving care and services, ensuring they are readily accessible for review or audit by Sentara Health Plans and designated state, federal, and accrediting entities. Records must be comprehensive and contain sufficient detail to support seamless transfer procedures, promoting continuity of care when members are treated by multiple providers. Patient information should be arranged in a consistent, logical format, either chronological or reverse chronological order, to facilitate clarity and ease of use.

Requests for Medical Records

Sentara Health Plans requires participating providers to make medical records available to the health plan, members, and/or their authorized representatives no later than 10 business days after receiving a request.

Fees for Medical Records:

Participating providers **shall not** charge Sentara Health Plans or its members for copies of medical records or for the completion of related forms.

Medical Record Retention and Continuity of Care

Participating providers must retain medical records for Sentara Health Plans members for a minimum of 10 years from the last date of service, or longer if required by applicable Virginia state agency and federal regulations. PCPs are responsible for obtaining and integrating medical records from both participating and nonparticipating providers to whom they refer members, ensuring continuity and coordination of care.

Medical Record Review and Corrective Action

Providers who do not meet Sentara Health Plans' medical record documentation standards will be required to develop and implement a corrective action plan within a specified timeframe. Each identified deficiency will be monitored at least every six months following the initial review until compliance is achieved. If deficiencies remain unresolved after six months, the matter will be escalated to the Senior Medical Director and/or Credentialing Committee for further review and potential sanctions.

Practice Closure or Sale

Subject to applicable laws, if a provider practice or facility is sold or closed, the provider must notify patients and Sentara Health Plans in writing, indicating the change and the location where patients' medical records will be maintained and stored. Providers must also offer patients the opportunity to obtain copies of their records. In the event of closure, medical records must be retained in accordance with applicable state and federal law.

Monitoring the Quality of Care

Sentara Health Plans collaborates with contracted network and affiliated providers to inspect, audit, review, and obtain copies of medical records related to covered services rendered under the Provider Agreement. These reviews may be conducted for purposes including, but not limited to, benefit determinations, payment decisions, member grievances, quality of care (QOC) reviews, sentinel events, member surveys, internal reports, credentialing monitoring, and other quality improvement initiatives.

To support these activities, Sentara Health Plans and its authorized representatives may request documentation, primarily patient medical records. Providers are expected to submit this information electronically if using an electronic health record (EHR) system, or as paper copies, when applicable.

Sentara Health Plans will oversee and review the quality of care administered to members. Providers are encouraged to maintain best practices when documenting a member's medical records.

Medical Record Maintenance Standards

Participating providers must maintain office policies and procedures for medical record documentation that align with the National Committee for Quality Assurance (NCQA) standards or applicable law. At a minimum, records must be:

- Accurate and legible
- Securely stored to prevent loss, destruction, or unauthorized access (e.g., in restricted, non-public areas)
- Organized and accessible for review by the health plan and/or state or federal regulatory entities or external quality review organizations (EQRO)
- Available to Sentara Health Plans' staff, as appropriate, to support quality and utilization management activities
- Comprehensive with sufficient detail to ensure continuity of care when multiple providers are involved

Medical Record Coordination and Continuity of Care Standards

To promote effective communication, coordination, and continuity of care, the following standards must be met:

- A current, legible problem list must be maintained and updated as appropriate. If no significant issues are present, this must be noted (e.g., well-child/adult preventive care visit).
- Allergies and adverse reactions must be clearly documented. If none exist, this must be noted (e.g., sticker or stamp noting allergies or no known allergies (NKA) is acceptable).
- Past medical history must be easily identifiable for all patients, especially patients seen three or more times, and include family history, serious accidents, operations, and illnesses. For children and adolescents (17 years and younger), this includes prenatal care, birth history, surgical history, immunizations, and childhood illnesses.
- Medication records must include drug names, dosages, frequencies, and dates of prescriptions or refills.
- Each page of the medical record must include the patient's name or ID number, and all entries must be dated.
- Working diagnoses and treatment plans must align with clinical findings.
- Consultation reports must be present, with documentation of PCP review and follow-up and a follow-up phone call must be noted in the PCP's progress note. Electronic consults must show evidence of PCP acknowledgment. Any further follow-up needed or altered treatment plans should be noted in progress notes.
- Continuity and coordination of care must be documented across all providers involved in the member's care, including PCP and specialty providers, hospitals, home health, skilled nursing facilities, and free-standing surgical centers, etc.

- Advance care planning and advance directives discussions must be documented for all adult patients and emancipated minors. If the patient does have an Advance Directive, it should be noted, and a copy should be present in the medical record.
- Confidentiality must be maintained in accordance with HIPAA and other applicable laws. Records must be stored in secure, non-public areas and accessible only to authorized personnel, health plan staff, state/federal regulatory entities, and anyone else authorized to access such records under HIPAA and state law.
- Substance use assessments (smoking, alcohol, drugs etc.) Must be documented for patients aged 12 and older, with referrals to behavioral health specialists noted as appropriate.
- Preventive screenings must be offered and documented in accordance with Sentara Health Plans' Preventive Health Guidelines and American Academy of Pediatrics and Bright Futures, as applicable, and documented in the progress notes and/or appropriate screening tool.

Advance Directives

Sentara Health Plans provides members with information regarding Advance Directives, including living wills, healthcare power of attorney designations, and organ donation and anatomical gift preferences. This is done in compliance with the Patient Self-Determination Act and applicable state laws, which require healthcare providers to inform adult patients of their rights to accept or refuse medical treatment and to create advance directives concerning their care.

Access Advance Care Planning information for Virginia and North Carolina providers from the Sentara Center for Healthcare Ethics is located here.

Additional Guidance

Providers are encouraged to consult their malpractice insurance carrier for any additional requirements or recommendations regarding medical record retention policies.

Provider Communications, Resources, and Appointment Standards

Sentara Health Plans encourages providers to visit the Sentara Health Plans provider site here to research and explore information such as:

- Provider self-service tools
- Medical policies at this link
- Health plan contact numbers
- Billing and claims resources
- Clinical references
- Formularies and drug lists
- HEDIS resources
- Provider update and other forms
- Provider manuals
- Educational materials, such as newsletters and provider announcements
- Access to the Availity provider portal and other secure provider portals

Sentara Health Plans Network Management

The network management department is responsible for keeping providers up to date on Sentara Health Plans services and resources, including:

- How to get in-network and contract with Sentara Health Plans
- How to update provider demographic information
- Directly addressing any provider's special needs, concerns, or complex situations, credentialing, services, and other requirements
- Provider education and training

Network educators are assigned to specific providers to directly help navigate products, policy, process, and service updates. The network education team can be reached at contactmyrep@sentara.com.

Provider Portal

Effective January 1, 2024, Sentara Health Plans selected Availity Essentials (Availity) as our exclusive Provider Portal. Availity Essentials is a multi-payer portal where providers can check eligibility and benefits, manage claims and authorizations to streamline their work. Many providers are already using Availity with other payers and are familiar with its ease of use.

Throughout 2026, the provider portals, including all features, functionality, and resources, will continue to transition to Availity. This is a phased transition with continued access to the Sentara Health Plans portal. For more information regarding Sentara Health Plans' transition to Availity, click here.

If a provider is already working in the Availity portal, the same user ID and password can be used to sign into the Availity account for Sentara Health Plans.

For providers new to Availity, the Get Started with Availity page has an abundance of resources and the ability to register the provider's organization.

Provider Notifications

Sentara Health Plans routinely distributes timely notifications via email to provide updates such as:

- Changes to policies and protocols
- Changes to medical policies
- Changes to the provider manual
- Publication of the quarterly provider newsletter
- Details about upcoming educational sessions
- Patient education initiatives
- Quality improvement efforts
- Health plan campaigns
- Other important news and information

Sentara Health Plans notifies providers of any planned policy changes through electronic communications 60 days before the effective date of such policy change. Any pertinent changes to policy and protocols are also communicated with an online provider notice posting. To avoid missing any important updates, providers are required to provide (and update as necessary) a valid email address to Sentara Health Plans via the Provider Update Form or during meetings with the assigned network educator.

Provider Trainings

Providers can access both required and encouraged trainings here.

Providers are encouraged to take Fraud, Waste, and Abuse; Trauma Informed Care; and Cultural Competency training during onboarding and as ongoing training.

Provider Webinars

Online educational webinars are held and are used to provide updates from Sentara Health Plans, provide information on how to fulfill obligations under the Provider Agreement, and allow providers to ask questions. Providers must register on the Sentara Health Plans provider website by the day before each event. The schedule is listed on the Provider Webinars page and in the provider newsletter, along with other educational opportunities.

Mailings and Newsletters

Providers may be notified of updates or changes to policies via targeted mailings or email. Sentara Health Plans notifies providers of news, updates, or changes to policies via the quarterly provider newsletter, with an email notification when the newsletter is available on the Sentara Health Plans provider website.

Telephone

Medical and behavioral health providers may contact provider services by phone. In the event an issue cannot be satisfactorily resolved by provider services, providers should contact their assigned network educator.

A complete directory of phone and fax numbers for Sentara Health Plans departments (including contacts for after-hours) may be found online on the provider website under "Contact Us." A listing is also provided in the **"Sentara Health Plans Key Contact Information"** section at the top of this manual.

Provider Responsibilities for Excluded Entity Screening and Reporting

The Office of Inspector General imposes exclusions from state and federal healthcare programs under the authority of sections 1128 and 1156 of the Social Security Act. The law requires that no payment be made by any federal healthcare program for any items or services furnished, ordered, or prescribed by an excluded individual or entity. The Centers for Medicare & Medicaid Services (CMS) administer federal healthcare programs. This payment prohibition applies to the excluded person, anyone who employs or contracts with the excluded person, any hospital or other provider for which the excluded person provides services, and anyone else who provides services through or under the direction of an excluded person. The exclusion applies regardless of who submits the claims and applies to all administrative and management services furnished by the excluded person.

Providers are obligated to ensure that Medicaid and Medicare funds are not used to reimburse excluded individuals or entities by taking the following steps:

1. Screen all new and existing employees and contractors to determine whether any of them have been excluded. This includes owners with a direct or indirect interest of 5% or more.
2. Search The Office of Inspector General website monthly to capture exclusions and reinstatements that have occurred since the last search.
3. Immediately report any exclusion information to Sentara Health Plans in writing.

Civil monetary penalties may be imposed against providers and managed care entities that employ or enter into contracts with excluded individuals or entities to provide services for federal healthcare programs.

Managing Provider Contact Information

Notice of changes, amendments, and updates to this provider manual and any sources that are referenced by and incorporated herein are communicated to providers via the Sentara Health Plans website and by email (for providers that have notified Sentara Health Plans of their email address) sixty (60) days before the changes become effective. For this reason, it is critical that providers keep their email address current to receive electronic communications with new and updated operational information, including amendments to the Provider Agreement and this Provider Manual. It is each provider's responsibility to ensure that the email address provided to Sentara Health Plans is correct and current. To update an email address or directory information, providers may contact their network educator or email contactmyrep@sentara.com.

HIPAA Privacy Statement

Sentara Health Plans entities follow the ***Notice of Privacy Practices*** available here.

Sentara Health Plans maintains compliance with the Privacy Rule and Security Rule under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) Act, and the American Recovery and Reinvestment Act (ARRA). To ensure the protection of confidential information and patient health information, Sentara Health Plans has implemented privacy and security policies and procedures, has developed required forms, has established safeguards to protect patient health information, and conducts HIPAA awareness training.

Provider Availability: Access and After-hours Standards

Access to care is recognized as a key component of quality care. As a condition of participation, providers must provide covered services to members on a 24-hour per day, 7-day per week basis, in accordance with Sentara Health Plans' standards for provider accessibility. This includes, if applicable, call coverage or other backup, or providers can arrange with an in-network provider to cover patients in the provider's absence.

Providers must make arrangements to refer members seeking care after regular business hours to an appropriate provider. Providers may direct the member to go to an emergency department for potentially emergent conditions, and this may be done via a recorded message.

After Hours Availability Standards

After Hours Standards (Live answer or Automated system)	Standards (Appropriate responses)
Emergency instructions provided	Caller is directed to hang up and dial 911 or go to the nearest emergency room for life-threatening emergencies.
Process to reach physician	• Directly connects or forwards caller to the physician/on-call physician or appropriate medical professional. • Caller can select an option on their telephone to be directly connected to the physician/on-call physician or appropriate medical professional. • Pages the medical professional; call returned within 30 minutes to the physician/on-call physician or appropriate medical professional. • Answering machines allows caller to leave message; call returned within 30 minutes by the physician/on-call physician or appropriate medical professional. • Call forwarding automatically call is automatically forwarded to the physician/on-call physician or medical professional.

Sentara Health Plans Appointment Standards

Appointment access standards for Commercial/Exchange (HMO/POS/PPO) plans:

Service	Sentara Health Plans Commercial/Exchange Standards
Emergency Services, including crisis services (medical and behavioral health)	Immediately upon the member's request
Non-life-threatening Behavioral Health emergency	Within six (6) hours or directed to emergency care.
Urgent care appointments (medical and behavioral health)	Within 24 hours of the member's request

Regular and Routine Services	Within 14 business days of the member's request. Standard does not apply to appointments for routine physical examinations; for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently; or for routine specialty services like dermatology, allergy care, etc.
Maternity care – first trimester	Within seven (7) calendar days of request
Maternity care – second trimester	Within seven (7) calendar days of request
Maternity care – third trimester	Within three (3) business days of requests
Maternity care – high-risk pregnancy	Within three (3) business days of high-risk identification, or immediately if an emergency exists
Postpartum	Within 60 days of delivery
Routine Behavioral Health Initial and Follow-up Visits	Within 10 business days
After-hours Care	As a condition of participation, providers must provide covered services to members on a 24 hour per day, seven (7) day per week basis

Continuity and Coordination of Care

Ongoing collaboration between PCPs, specialists, and behavioral health providers, as well as between PCPs and other types of providers, promotes a continuous plan of care that benefits the member. Other types of providers include hospitals, home health agencies, skilled nursing facilities, nursing homes, ambulatory surgical centers, and mental health services providers.

Sentara Health Plans monitors and identifies potential problems with continuity and coordination of care for all members. Information on continuity and coordination of care is collected at the time of HEDIS chart reviews. Sentara Health Plans also monitors continuity and coordination through transitions in care (changes in management of care between providers, changes in settings, or other changes in which different providers become active or inactive in providing ongoing care for a patient).

A provider shall continue to render health care services, except when the provider is terminated for cause, to any Sentara Health Plans member who has an existing provider-patient relationship:

- For a period of at least 90 days from the date the provider's termination.

- Who is in an active course of treatment from the provider prior to the notice of termination and requests to continue receiving health care services from the provider.
- Who has been medically confirmed to be pregnant at the time of the provider's termination. Such treatment shall, at the member's option, continue through the provision of postpartum care directly related to the delivery.
- Who is determined to be terminally ill as defined under §1861 (dd) (3) (A) of the Social Security Act at the time of the provider's termination. Such treatment shall, at the member's option, continue for the remainder of the member's life for care directly related to the treatment of the terminal illness.
- Who has been determined by a medical professional to have a life-threatening condition at the time of a provider's termination. Such treatment shall, at the member's option, continue for up to 180 days for care directly related to the life-threatening condition.
- Who is admitted to and receiving treatment in any inpatient facility at the time of provider's termination of participation. Such admission and treatment shall continue until the member is discharged from the inpatient facility.

Locum Tenens Providers

The participating provider must notify Sentara Health Plans of the need for coverage by a Locum Tenens provider by submitting a Provider Update Form on the provider website. In emergency/urgent cases, notification should be made prior to the Locum Tenens provider providing services to Sentara Health Plans members. All services performed by the Locum Tenens provider should be billed with the Locum Tenens provider's NPI number. Since the Locum Tenens provider status is as a covering provider, Locum Tenens providers will not be listed in provider directories, on the provider website, or on listings of participating providers for reporting purposes.

Physician Assistants and Nurse Practitioners

Physician Assistants, Advanced Practice Registered Nurses (including Licensed Nurse Practitioners, Clinical Nurse Specialists, Certified Nurse Midwives and Certified Nurse Anesthetists) may contract with Sentara Health Plans to provide covered services in accordance with the provisions of the state Boards of Medicine and Nursing licensure.

Nurse Practitioners and Physician Assistants will be reimbursed for services provided to Sentara Health Plan members provided:

- They are participating with Sentara Health Plans under an active Provider Agreement (either directly or from a group affiliation).
- They are operating within their license – meaning if their license requires them to be supervised, they meet criteria for supervision.
- The services they provide are covered and proper authorizations are in place.

Nurse Practitioners as PCPs

Nurse Practitioners who are willing and able to meet the Primary Care Provider requirements and obligations stated in the Sentara Health Plans Provider Agreement may, upon request, provide Primary Care services to members that are assigned directly to them as their Primary Care Provider for all Sentara Health Plans commercial products. This does not apply to Medical and Behavioral Health Nurse Practitioners who only provide specialty care services.

For new practices or existing practices, a Provider Update Form must be submitted to credential the Nurse Practitioner as a PCP with assigned members.

Nurse Practitioners that are approved by Credentialing as PCPs will be set up with an open panel status to be eligible for incentives available to PCPs based on their attributed members. They will be set up to appear in provider directories as PCPs.

If the Nurse Practitioner is working under a Practice Agreement in collaboration with a licensed patient care team physician as part of patient care team their participation cannot be effective prior to the licensed patient care team physician's effective date of participation.

Compliance/Ethics Program

Confidentiality

Subcontractors must comply with 42 CFR Part 2 that prohibits providers from re-disclosing substance use treatment information.

Program Integrity

Sentara Health Plans' Program Integrity Unit (PIU) has a fiduciary responsibility to protect our members and plays a crucial role in maintaining the integrity of Sentara Health Plans. The Program Integrity Unit is a dedicated team that focuses on detecting, resolving, and preventing potential fraud, waste, and abuse (FWA) by analyzing claims data, monitoring trends, and conducting in-depth investigations to uncover suspicious activities and unusual patterns of potential abusive behavior. The Program Integrity Unit's efforts not only help safeguard financial resources but also ensure that care and coverage remain accessible to those who truly need it.

The Program Integrity Unit has documented its efforts to detect, resolve, prevent, and report potential fraud, waste, and abuse by implementing an Anti-fraud Plan to ensure compliance with state and federal regulations.

To read more about Sentara Health's Anti-Fraud Plan, click here.

To report possible fraud, waste or abuse, please utilize the following options:

Hotline:

- (757) 687-6326 or (866) 826-5277
- Available 24 hours a day, seven (7) days a week. This is a voicemail service only; someone will contact providers within 48 hours.

Email:

- compliancealert@sentara.com

All referrals made to the Program Integrity Unit will remain anonymous. Reporters should leave a name and number to be contacted to follow up.

Business Information

Sentara Health Plans considers its pricing information, pricing policies, terms, market studies, business and strategic plans, and any other similar information to be confidential. The sharing of Sentara Health Plans' business information with competitors is a highly sensitive matter, particularly where that information could form the basis of a pricing agreement.

Equal Opportunity Employment

Pursuant to Section 503 of the Rehabilitation Act of 1973, as amended, and the Vietnam Era Veterans Readjustment Assistance Act of 1974, as amended, you are advised thatour subcontractors, suppliers, and vendors are obligated to take affirmative action to provide equal employment opportunity without regard to disability and/or veteran status.

Anti-Kickback Statute

The federal Anti-Kickback Statute requires each provider to promptly report in writing a violation of the Anti-Kickback Statute to the appropriate federal agency, inspector general, or the Department of Justice if the provider has reasonable grounds to believe that a violation exists.

Business Records

Sentara Health Plans' provider records are maintained in a manner that provides for an accurate and auditable account of all financial transactions in conformity with generally accepted accounting principles. No false or deceptive entries may be made, and all entries must contain an appropriate description of the underlying transaction. All reports, vouchers, bills, invoices, payroll and service records, time worked, member records, and other essential data must be prepared with care and honesty.

Billing Practices

Sentara Health Plans providers are committed to accurate billing and submitting claims for services that are medically necessary, reflecting the services and care provided to members, and are justified by documentation. Sentara Health Plans agents and vendors are required to report any potential or suspected improper billing practices or violations of standard billing practices or of company policies and procedures.

Government Sanctioning

Sentara Health Plans does not contract with individuals or companies sanctioned under government programs. All providers must:

- Notify Sentara Health Plans of any known or suspected violations of law or regulations pertaining to the provider's relationship with the company
- Disclose to Sentara Health Plans any government investigations in which the provider is, was, or may become involved
- Disclose to Sentara Health Plans any person affiliated with the provider, including any officer, director, owner, employee, or contractor, who has been disbarred or excluded from participation in any federal or state-funded healthcare program
- Immediately disclose to Sentara Health Plans any person affiliated with the provider, including any officer, director, owner, employee, or contractor of the provider, who has been convicted of or pleaded guilty to a felony or other serious offense and who remains in affiliation or employment relationship with the provider after the conviction or guilty plea.

Virginia Ethics and Fairness in Carrier Business Practices

Below is the text of Virginia Code § 38.2-3407.15, Ethics and Fairness in Carrier Business Practices Act effective as of July 1, 2025. This law applies only to fully insured plans issued in Virginia under the Sentara Health Plans HMO license or the Sentara Health Insurance Company Accident and Sickness license in the individual and group markets commercial plans.

A. As used in this section:

"Carrier," "enrollee," and "provider" shall have the meanings set forth in § 38.2-3407.10; however, a "carrier" shall also include any person required to be licensed under this title which offers or operates a managed care health insurance plan subject to Chapter 58 (§ 38.2-5800 et seq.) Or which provides or arranges for the provision of health care services, health plans, networks or provider panels which are subject to regulation as the business of insurance under this title.

"Claim" means any bill, claim, or proof of loss made by or on behalf of an enrollee or a provider to a carrier (or its intermediary, administrator, or representative) with which the provider has a provider contract for payment for health care services under any health plan; however, a "claim" shall not include a request for payment of a capitation or a withhold.

"Clean claim" means a claim that does all of the following:

1. Identifies the provider that provided the service with industry-standard identification criteria, including billing and rendering provider names, identification numbers, and addresses;

2. Identifies the patient with a carrier-assigned identification number so the carrier can verify the patient was an enrollee at the time of service;

3. Identifies the service rendered using an industry-standard system of procedure or service coding, or, if applicable, a methodology required under the provider contract. The claim shall include a complete listing of all relevant diagnoses, procedures, and service codes, as well as any applicable modifiers;

4. Specifies the date and place of service;

5. If prior authorization is required for the services listed in the claim, contains verification that prior authorization was obtained in accordance with the provider contract for those services; and

6. Includes additional documentation specific to the services rendered as required by the carrier in its provider contract. Notwithstanding the above criteria, a claim shall

be considered a clean claim if a carrier has failed timely to notify the person submitting the claim of any defect or impropriety in accordance with this section.

"Health care services" means items or services furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability.

"Health plan" means any individual or group health care plan, subscription contract, evidence of coverage, certificate, health services plan, medical or hospital services plan, accident and sickness insurance policy or certificate, managed care health insurance plan, or other similar certificate, policy, contract or arrangement, and any endorsement or rider thereto, to cover all or a portion of the cost of persons receiving covered health care services, which is subject to state regulation and which is required to be offered, arranged or issued in the Commonwealth by a carrier licensed under this title. Health plan does not mean (i) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid) or Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq. (CHIP), 5 U.S.C. § 8901 et seq. (federal employees), or 10 U.S.C. § 1071 et seq. (TRICARE); or (ii) accident only, credit or disability insurance, long-term care insurance, TRICARE supplement, Medicare supplement, or workers' compensation coverages.

"Provider contract" means any contract between a provider and a carrier (or a carrier's network, provider panel, intermediary or representative) relating to the provision of health care services.

"Retroactive denial of a previously paid claim" or "retroactive denial of payment" means any attempt by a carrier retroactively to collect payments already made to a provider with respect to a claim by reducing other payments currently owed to the provider, by withholding or setting off against future payments, or in any other manner reducing or affecting the future claim payments to the provider.

B. Every provider contract entered into by a carrier shall contain specific provisions which shall require the carrier to adhere to and comply with the following minimum fair business standards in the processing and payment of claims for health care services:

1. A carrier shall pay any claim within 40 days of receipt of the claim except where the obligation of the carrier to pay a claim is not reasonably clear due to the existence of a reasonable basis supported by specific information available for review by the person submitting the claim that:
   a) The claim is determined by the carrier not to be a clean claim due to a good faith determination or dispute regarding (i) the manner in which the claim form was completed or submitted, (ii) the eligibility of a person for coverage, (iii) the responsibility of another carrier for all or part of the claim, (iv) the amount of the claim or the amount currently due under the claim, (v) the benefits covered, or (vi) the manner in which services were accessed or provided; or

b) The claim was submitted fraudulently.

Each carrier shall maintain a written or electronic record of the date of receipt of a claim. The person submitting the claim shall be entitled to inspect such record on request and to rely on that record or on any other admissible evidence as proof of the fact of receipt of the claim, including without limitation electronic or facsimile confirmation of receipt of a claim.

2. A carrier shall, within 30 days after receipt of a claim, notify the person submitting the claim of any defect or impropriety that prevents the carrier from deeming the claim a clean claim and request the information that will be required to process and pay the claim. Upon receipt of the additional information necessary to make the original claim a clean claim, a carrier shall make the payment of the claim in compliance with this section. No carrier may refuse to pay a claim for health care services rendered pursuant to a provider contract which are covered benefits if the carrier fails timely to notify or attempt to notify the person submitting the claim of the matters identified above unless such failure was caused in material part by the person submitting the claims; however, nothing herein shall preclude such a carrier from imposing a retroactive denial of payment of such a claim if permitted by the provider contract unless such retroactive denial of payment of the claim would violate subdivision 8. Beginning no later than January 1, 2026, all notifications and information required under this subdivision shall be delivered electronically.

3. Any interest owing or accruing on a claim under § 38.2-3407.1 or 38.2-4306.1, under any provider contract or under any other applicable law, shall, if not sooner paid or required to be paid, be paid, without necessity of demand, at the time the claim is paid or within 60 days thereafter.

4. A carrier shall notify the provider in the provider contract if the carrier, or entity completing a transaction on behalf of the carrier, uses a payment method that imposes a transaction or processing fee or similar charge on the provider, and shall offer the provider an alternative payment method in which the carrier, or entity completing a transaction on behalf of the carrier, does not impose such a fee or similar charge. If the provider elects to accept the alternative payment method and has provided all required information to the carrier to enroll in such alternative method, the carrier shall pay the claim using such alternative payment method.

5. a. Every carrier shall establish and implement reasonable policies to permit any provider with which there is a provider contract (i) to confirm in advance during normal business hours by free telephone or electronic means if available whether the health care services to be provided are medically necessary and a covered benefit and (ii) to determine the carrier's requirements applicable to the provider (or to the type of health care services which the provider has contracted to deliver under the provider contract) for (a) pre-certification or authorization of coverage decisions,

(b) retroactive reconsideration of a certification or authorization of coverage decision or retroactive denial of a previously paid claim, (c) provider-specific payment and reimbursement methodology, coding levels and methodology, down coding, and bundling of claims, and (d) other provider-specific, applicable claims processing and payment matters necessary to meet the terms and conditions of the provider contract, including determining whether a claim is a clean claim. If a carrier routinely, as a matter of policy, bundles or down codes claims submitted by a provider, the carrier shall clearly disclose that practice in each provider contract. Further, such carrier shall either (1) disclose in its provider contracts or on its website the specific bundling and down coding policies that the carrier reasonably expects to be applied to the provider or provider's services on a routine basis as a matter of policy or (2) disclose in each provider contract a telephone or facsimile number or e-mail address that a provider can use to request the specific bundling and down coding policies that the carrier reasonably expects to be applied to that provider or provider's services on a routine basis as a matter of policy. If such request is made by or on behalf of a provider, a carrier shall provide the requesting provider with such policies within 10 business days following the date the request is received.

b. Every carrier shall make available to such providers within 10 business days of receipt of a request, copies of or reasonable electronic access to all such policies which are applicable to the particular provider or to particular health care services identified by the provider. In the event the provision of the entire policy would violate any applicable copyright law, the carrier may instead comply with this subsection by timely delivering to the provider a clear explanation of the policy as it applies to the provider and to any health care services identified by the provider.

6. Every carrier shall pay a claim if the carrier has previously authorized the health care service or has advised the provider or enrollee in advance of the provision of health care services that the health care services are medically necessary and a covered benefit, unless:
   a) The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized;
   b) The carrier's refusal is because (i) another payor is responsible for the payment, (ii) the provider has already been paid for the health care services identified on the claim, (iii) the claim was submitted fraudulently or the authorization was based in whole or material part on erroneous information provided to the carrier by the provider, enrollee, or other person not related to the carrier, or (iv) the person receiving the health care services was not eligible to receive them on the date of service and the carrier did not know, and with the exercise of reasonable care could not have known, of the person's eligibility status; or
   c) During the post-service claims process, it is determined that the claim was submitted fraudulently.

7. In the case of an invasive or surgical procedure, if the carrier has previously authorized a health care service as medically necessary and during the procedure the health care provider discovers clinical evidence prompting the provider to

perform a less or more extensive or complicated procedure than was previously authorized, then the carrier shall pay the claim, provided that the additional procedures were (i) not investigative in nature, but medically necessary as a covered service under the covered person's benefit plan; (ii) appropriately coded consistent with the procedure actually performed; and (iii) compliant with a carrier's post-service claims process, including required timing for submission to carrier.

8. No carrier shall impose any retroactive denial of a previously paid claim or in any other way seek recovery or refund of a previously paid claim unless the carrier specifies in writing the specific claim or claims for which the retroactive denial is to be imposed or the recovery or refund is sought, the carrier has provided a written explanation of why the claim is being retroactively adjusted, and (i) the original claim was submitted fraudulently, (ii) the original claim payment was incorrect because the provider was already paid for the health care services identified on the claim or the health care services identified on the claim were not delivered by the provider, or (iii) the time which has elapsed since the date of the payment of the original challenged claim does not exceed 12 months. Notwithstanding the provisions of clause (iii), a provider and a carrier may agree in writing that recoupment of overpayments by withholding or offsetting against future payments may occur after such 12-month limit for the imposition of the retroactive denial.

   A carrier shall notify a provider at least 30 days in advance of any retroactive denial or recovery or refund of a previously paid claim.

   Beginning no later than January 1, 2026, all written communications, explanations, notifications, and related provider responses applicable to this subdivision shall be delivered electronically.

   The electronic method and location for delivery shall be agreed upon by the carrier and provider and included in the provider contract.

9. No provider contract shall fail to include or attach at the time it is presented to the provider for execution (i) the fee schedule, reimbursement policy, or statement as to the manner in which claims will be calculated and paid that is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis and (ii) all material addenda, schedules, and exhibits thereto and any policies (including those referred to in subdivision 5) applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider under the provider contract.

10. No amendment to any provider contract or to any addenda, schedule, exhibit or policy thereto (or new addenda, schedule, exhibit, or policy) applicable to the provider (or to the range of health care services reasonably expected to be delivered by that type of provider) shall be effective as to the provider, unless the provider has been provided with the applicable portion of the proposed amendment (or of the proposed new addenda, schedule, exhibit, or policy) at least 60 calendar days

before the effective date and the provider has failed to notify the carrier within 30 calendar days of receipt of the documentation of the provider's intention to terminate the provider contract at the earliest date thereafter permitted under the provider contract.

11. In the event that the carrier's provision of a policy required to be provided under subdivision 9 or 10 would violate any applicable copyright law, the carrier may instead comply with this section by providing a clear, written explanation of the policy as it applies to the provider.

12. All carriers shall establish, in writing, their claims payment dispute mechanism and shall make this information available to providers. If a carrier's claim denial is overturned following completion of a dispute review, the carrier shall, on the day the decision to overturn is made, consider the claims impacted by such decision as clean claims. All applicable laws related to the payment of a clean claim shall apply to the payments due.

13. Every carrier shall include in its provider contracts a provision that prohibits a provider from discriminating against any enrollee solely due to the enrollee's status as a litigant in pending litigation or a potential litigant due to being involved in a motor vehicle accident. Nothing in this subdivision shall require a health care provider to treat an enrollee who has threatened to make or has made a professional liability claim against the provider or the provider's employer, agents, or employees or has threatened to file or has filed a complaint with a regulatory agency or board against the provider or the provider's employer, agents, or employees.

14. Effective July 1, 2025, every carrier shall make available through electronic means a way for providers to determine whether an enrollee is covered by a health plan that is subject to the Commission's jurisdiction.

    a) A provider shall not file a complaint with the Commission for failure to pay claims in accordance with subdivision B 1 unless:
        i) Such provider has made a reasonable effort to confer with the carrier in order to resolve the issues related to all claims that are under dispute. Any request to confer shall be made to the contact listed for such purpose in the provider contract and shall include supporting documentation sufficient for the carrier to identify the claims in question; and
        ii) At least 30 calendar days have passed from the date of the request provided that the carrier has been responsive to the provider's request to confer. However, if in the judgment of the provider, the carrier has not been responsive to such request, the provider shall not be required to wait at least 30 calendar days to file the complaint.

The provider shall attest in any such complaint that it has satisfied the provisions of this subsection.

D. If the Commission has cause to believe that any provider has engaged in a pattern of potential violations of subdivision B 13, with no corrective action, the Commission may submit information to the Board of Medicine or the Commissioner of Health for action. Prior to such submission, the Commission may provide the provider with an opportunity to cure the alleged violations or provide an explanation as to why the actions in questions were not violations. If any provider has engaged in a pattern of potential violations of subdivision B13, with no corrective action, the Board of Medicine or the Commissioner of Health may levy a fine or cost recovery upon the provider and take other action as permitted under its authority. Upon completion of its review of any potential violation submitted by the Commission or initiated directly by an enrollee, the Board of Medicine or the Commissioner of Health shall notify the Commission of the results of the review, including where the violation was substantiated, and any enforcement action taken as a result of a finding of a substantiated violation.

E. Without limiting the foregoing, in the processing of any payment of claims for health care services rendered by providers under provider contracts and in performing under its provider contracts, every carrier subject to regulation by this title shall adhere to and comply with the minimum fair business standards required under subsection B, and the Commission shall have the jurisdiction to determine if a carrier has violated the standards set forth in subsection B by failing to include the requisite provisions in its provider contracts and shall have jurisdiction to determine if the carrier has failed to implement the minimum fair business standards set out in subdivisions B 1 and 2 in the performance of its provider contracts.

F. No carrier shall be in violation of this section if its failure to comply with this section is caused in material part by the person submitting the claim or if the carrier's compliance is rendered impossible due to matters beyond the carrier's reasonable control (such as an act of God, insurrection, strike, fire, or power outages) which are not caused in material part by the carrier.

G. Any provider who suffers loss as the result of a carrier's violation of this section or a carrier's breach of any provider contract provision required by this section shall be entitled to initiate an action to recover actual damages. If the trier of fact finds that the violation or breach resulted from a carrier's gross negligence and willful conduct, it may increase damages to an amount not exceeding three times the actual damages sustained. Notwithstanding any other provision of law to the contrary, in addition to any damages awarded, such provider also may be awarded reasonable attorney fees and court costs. Each claim for payment which is paid or processed in violation of this section or with respect to which a violation of this section exists shall constitute a separate violation. The Commission shall not be deemed to be a "trier of fact" for purposes of this

Subsection.

H. No carrier (or its network, provider panel or intermediary) shall terminate or fail to renew the employment or other contractual relationship with a provider, or any provider contract, or otherwise penalize any provider, for invoking any of the provider's rights under this section or under the provider contract.

I. Except where otherwise provided in this section, beginning no later than July 1, 2025, carriers shall deliver provider contracts, related amendments, and notices exclusively to providers in an electronic format other than electronic facsimile. Beginning no later than January 1, 2026, the provider shall submit provider contracts, amendments, and notices to carriers exclusively in an electronic format other than electronic facsimile. The electronic method and location for delivery shall be agreed upon by the carrier and provider and included in the provider contract.

J. This section shall apply only to carriers subject to regulation under this title and shall apply to the carrier and provider, regardless of any vendors, subcontractors, or other entities that have been contracted by the carrier or the provider to perform duties applicable to this section.

K. Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such rules and regulations as it may deem necessary to implement this section.

L. The Commission shall have no jurisdiction to adjudicate individual controversies arising out of this section.

4938-9574-2843, v. 3

4938-9574-2843, v. 3