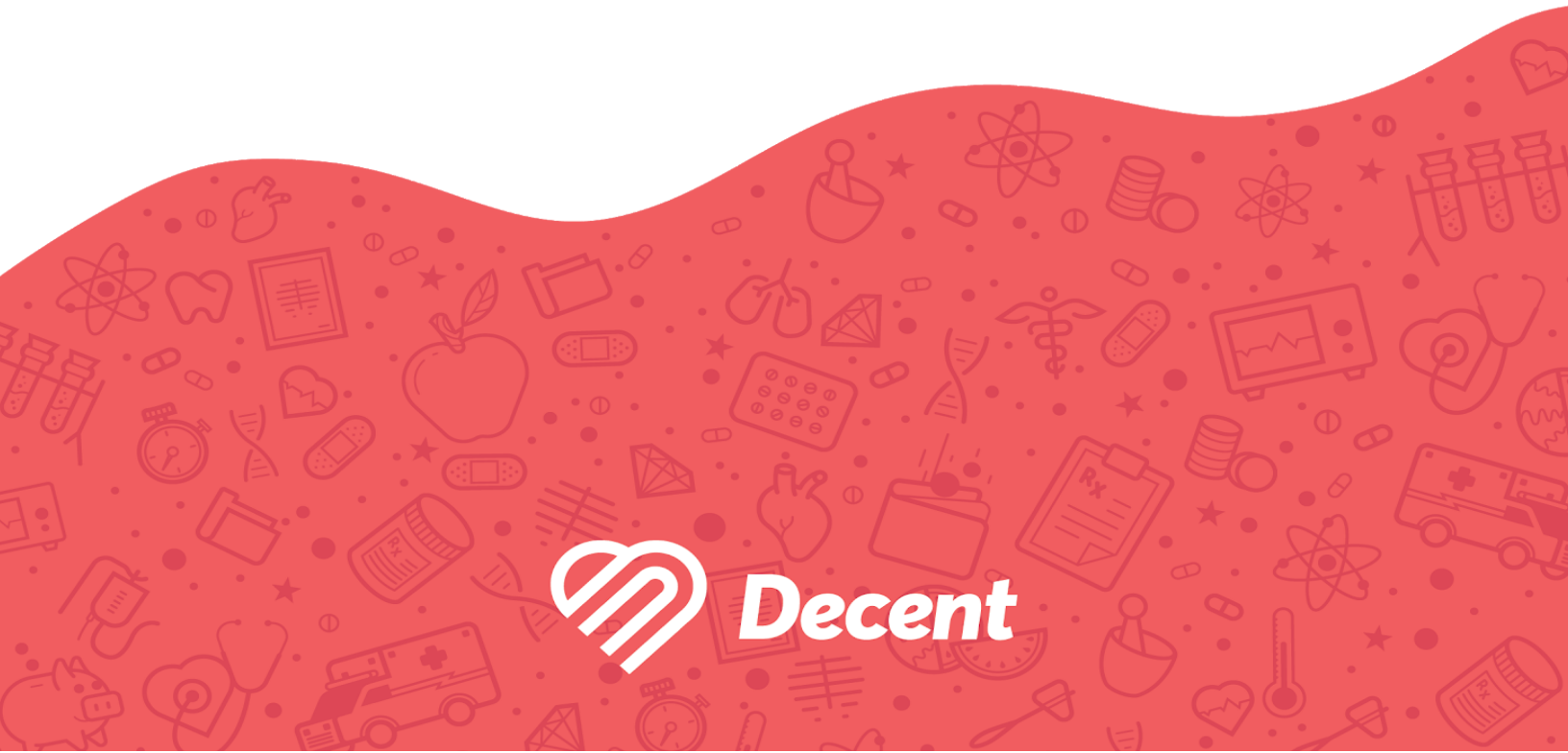
QUICK START PROVIDER MANUAL

APRIL 2019



1. Overview

We're so glad to have you in our network! To help make working with Decent simple, we have created this Quick Provider Manual with direction and guidance around the basic operational processes.

1. **The Basics**
   a. Decent and its Provider Organizations are considered **"Covered Entities"** under the Privacy Rule, implemented pursuant to HIPAA, and must comply with the strictest applicable federal and state standards for the use and disclosure of PHI.All contracted providers and provider organizations are required to provide appropriate training for employees and applicable subcontractors.
   b. **Provider Insurance Requirements** Throughout the term of the contract, providers must maintain a malpractice, general liability and any other insurance and bond in the amounts usual and customary for Covered Services provided with a licensed managed care company admitted to do business in the State and acceptable to Decent. Providers must immediately notify Decent of any material changes in insurance coverage and must provide a certificate of insurance coverage to Decent upon Decent's request.
   c. **Compliance with the Americans with Disabilities Act (ADA)** Decent employees, business partners and contracted Provider Organizations must comply with ADA requirements, including compliance with Section 504 of the Rehabilitation Act which requires that electronic and information technology be accessible to Explanation of Benefits with disabilities and special needs.
   d. **Decent's Commitment to Cultural Competence** In healthcare the ability of providers to understand social, ethnic, religious, and linguistic characteristics of a population and use this understanding to improve the quality of care providers deliver. Decent Health is committed to ensuring that our members are treated with dignity and respect and that their cultural needs are considered when interacting with providers.

2. Access Standards

a. Decent is dedicated to providing access to high quality providers and strives to ensure strong network coverage for all Decent members' needs. Decent will work with members and providers to ensure members have access to appropriate, timely, and continued care. We require that our contracted providers meet the following time frames:
   i. Urgent care appointments for medical conditions: within 24 hours
   ii. Routine appointments for primary care: within seven calendar days
   iii. Routine appointments for medical conditions: within three weeks
   iv. Routine appointments for behavioral health conditions: within two weeks

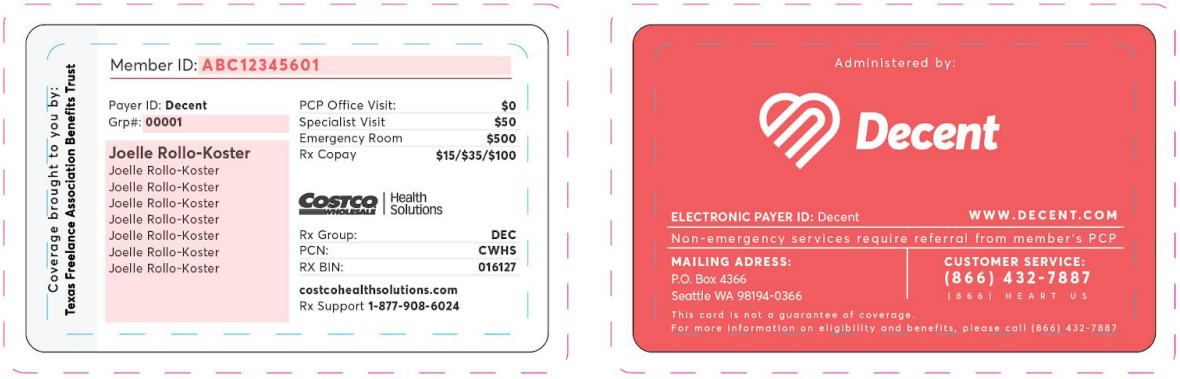
b. After-hours care: Each primary care and specialist physician must have a reliable 24-hour-a-day, 7-day-a-week answering service or machine with a beeper or paging system. A recorded message or answering service that refers members to emergency rooms is not acceptable. The same standard applies to behavioral health practitioners who are physicians with hospital admitting privileges.

c. **Gynecologist as principal physician** - When a woman uses both a gynecologist and a PCP for her care, the physicians should work together to coordinate her care. They should use their standard processes to communicate the treatment plans, services rendered and summaries of visits.

3. Doing Business with Decent

a. **Enabling ACH Payments**
   i. Organization admins with the should complete the Electronic 835 and EFT request form to start receiving payments electronically via ACH.

b. **Check Eligibility and Benefits**
   i. Visit www.decent.com or call 1-866-HEART-US. Our hours of operation are Mon-Fri 8am-6pm.
   ii. Sample Member ID Card - Please note: actual member cost share will vary based on plan type.



c. **Find In-Network Partners**
   i. Search for in-network providers, lab facilities, pharmacies, and hospitals on www.decent.com/provider
d. **Referrals are required -** Referrals can only be issued by patient's selected primary care physician and are required for all care not delivered in the primary care physician office.
e. **Pharmacy**
   i. Costco manages our pharmacy benefits. For drug Approvals, call 1-877-908-6024, or initiate one electronically at www.costcohealthsolutions.com
f. **Laboratory**
   i. Providers must send lab work to an in-network lab facility.
   ii. Some Decent plans include free labs from Quest Diagnostics.
   iii. Search our online directory for in-network labs and confirm member lab benefits at www.decent.com
g. **Prior Approval**
   i. To confirm which procedures require prior Approval, request prior Approval, or check the status of an existing Approval, log into provider or call 866-Heart-Us. List of services that require a prior approval are also listed out in **Section 4** of this document.

h. **Submit Claims**

Claim Type	Network	Submit To
Medical	Decent	**Electronic Payer ID:** DECENT **Address:** P.O. Box 4366 Seattle, WA 98194
Pharmacy	Costco	**Electronic Payer ID:** CWHS

i. **Members can enroll year round** We do not require a member to have a qualifying event in order to sign up for our plan

j. **Please note that Decent does not offer routine dental or vision coverage.**

k. Unless a different timely filing deadline is specified in the contract, the timely filing deadline for a provider to submit claims will be 95 days from the date of service.

l. Claims received with **unlisted or miscellaneous codes** that have no supporting documentation may result in a claim denial, and the member may not be held liable for payment.

m. **Timely Processing of Claims** Decent will process and pay all complete claims by the state-mandated timely payment deadlines. Usually within 30 or 45 days.

n. **Claim Denials** Decent will notify members in situations where a denied claim could lead to member financial responsibility. It will include the reason for denial as well as an explanation of appeal rights.

o. **Interim Billing** Decent does not accept interim claims for inpatient services. Claims may only be billed upon patient discharge.

p. **Claims for Emergency Services** Emergency services do not require prior Approval. However, post-stabilization services require notification and may be subject to review and medical necessity determination.

q. **Claims Overpayment**

   i. Should Decent determine that it has overpaid a claim, Decent will submit a refund request to the provider within 180 Calendar Days.However, no such time limit shall apply to overpayment recovery efforts which are based on a reasonable belief of fraud or other intentional misconduct, or abusive billing.

   ii. Upon receiving this request, the provider must issue the refund or submit a clear, explanation of why the refund request is being contested within 45 calendar days of the date the notice of overpayment was received.

   iii. Should the provider fail to issue the refund or notify Decent of a contested overpayment within 45 calendar days, the amount of the overpayment may be deducted from future claims payments until Decent has been fully reimbursed. An explanation will accompany all deductions made from future claims payments.

r. **Balance Billing**

i. Except for copayments and deductibles, providers must not invoice or balance bill Decent members for the difference between the provider's billed charges and the reimbursement paid by Decent.
ii. Additionally, if providers do not comply with rules laid out in their contracts, in this manual, or by state regulators (e.g. timely filing, surprise bills, pre-Approval checks, etc.), providers cannot hold members liable for payment.

s. **Reimbursement Policies**
i. Decent reimburses in-network providers according to the policies listed in the Policies section of the www.decent.com/provider site. Decent may modify its reimbursement policies and provide notice to providers of expected changes in accordance with state law if applicable.
ii. **Decent encourages providers to collect copayments upfront.** We have structured our member benefits to make the amounts owed at the time of service clear to our members and providers.
iii. Copayment and coinsurance amounts for the most common services are indicated on a member's ID card.

t. **Clinical Criteria** – Decent primarily leverages CMS medical policy protocols for the determination of Medical Necessity and appropriateness of healthcare procedures and services.
i. Decent's Clinical Criteria are made available to enrollees and providers at www.decent.com Additional clinical criteria are made available to members and providers upon request.

4. Approval Requests and Notifications

a. Decent **requires approval** for the services listed below. It is important to submit any elective or pre-service requests in advance to ensure everything is in place for your patients to get the right care.
b. Please note that the list of services within each category might not be exhaustive.
c. To confirm requirements for a specific code or service, request Approval, or check the status of an existing Approval, reference the New Approval tool www.decent.com or call 1-866-Heart-Us.
    1. Hospital Inpatient Stay - all scheduled admissions. Request must include the anticipated length of the Inpatient Stay to receive Prior Approval. The Provider may request additional days to be authorized, if needed;
    2. Transplants
    3. Ambulance – non-emergent air;
    4. Congenital Heart Disease surgeries;

5. Durable Medical Equipment that will cost more than $1,000 to purchase or rent, including diabetes equipment for the management and treatment of diabetes;
6. Genetic Testing – BRCA (breast cancer gene);
7. Home health care;
8. Hospice care
9. The transfer to another Hospital or to or from a specialty unit in a Hospital requires another Prior Approval;
10. Outpatient Sleep Studies
11. Orthognathic surgery performed on an Inpatient basis;
12. Private Duty Nursing;
13. Prosthetic devices that will cost more than $1,000 to purchase or rent;
14. Reconstructive Procedures, including breast reduction surgery;
15. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services;
16. Surgery – outpatient
17. Sleep apnea surgeries;
18. All outpatient therapeutic treatments

d. Emergency, Urgent, and Ambulance Services

i. No prior Approval is required for emergent or urgent services, including emergency ambulance. Post-stabilization care and services require notification and may be subject to review and medical necessity determination (see Post-Stabilization section below).

ii. Decent participating hospitals are responsible for notifying Decent of an emergent/urgent inpatient admission within 24 hours or by the end of the first business day following admission, unless otherwise specified in your contract.

iii. Non-participating hospitals are required to notify Decent prior to any emergent/urgent inpatient admission when further care or treatment is needed following stabilization of an emergent/urgent condition.

iv. Failure to comply with Decent's notification requirements will result in an administrative denial of the claim payment. Members cannot be held liable for claims denied for failure to notify. Notification may be communicated by phone (866-Heart-Us).

e. Post-Stabilization

i. Decent requires prior Approval as a prerequisite for payment for necessary inpatient medical care following stabilization of an emergency medical condition.

ii. Non-participating facilities are required to notify the plan once our member is stabilized and prior to any admission or post-stabilization care.

iii. Unless otherwise specified in their contracts, Decent participating facilities are required to notify the plan within 24 hours or by the end of the first business day following admission. The plan will review these requests for

medical necessity, level of care, appropriateness of care, and benefit determination.

f. **Experimental and Investigational Treatments**
   i. Decent reserves the right to deny benefits as experimental, investigational, or unproven for any service, treatment, therapy, procedure, device, or drug that is utilized in a manner contrary to standard medical practice or that has not been demonstrated through medical research to have a beneficial impact on health outcomes.

5. Prescription Benefits Overview

Decent contracts with Costco to provide and coordinate the outpatient prescription drug benefit. Costco, on behalf of Decent, is responsible for managing the pharmacy network, formulary, and all aspects of the outpatient prescription drug benefit, including any related medication management programs, approvals, denials and appeals. Costco adjudicates prescription claims at the point of sale.

a. **Drug Formulary**
   i. The Decent formulary is a dynamic document updated two times a year by Costco Pharmacists. Medications on Decent's formulary generally remain consistent throughout any coverage year, but new medications and generics that become available are evaluated by Decent and individual medications may be added to or removed from the formulary.
   ii. To access the drug formulary go to www.decent.com

b. To initiate a drug Approval, click Texas Drug Prior Approval Form

6. Provider Network Access

a. Decent offers plans that require a member to designate a specific PCP. Members do need a referral to see a specialist. The list of in-network providers and facilities by state can be found on the Decent website.

b. **Authorizing an Out-of-Network Provider**
   i. If it is determined that Decent does not have an in-network provider with the appropriate training and experience needed to treat a member's condition, Decent will approve an out-of-network utilization. Requests for out-of-network Approvals may be made by the member or an in-network provider.
   ii. Please note: approvals will not be made on the basis of convenience for either a member or a provider, and Decent may not approve the particular

out-of-network provider requested. If Decent approves, all services performed by the out-of-network provider are subject to a treatment plan approved by the members primary care physician in consultation with the member. All services rendered by the out-of-network provider will be paid as if they were provided by an in-network provider, and members are responsible for any applicable in-network cost-sharing. In the event that we do not approve, any services rendered by the out-of-network provider will not be covered.

We think health insurance should be affordable, transparent, and friendly. We built Decent to drive down the cost of healthcare by aligning incentives, reducing waste, and encourage our members to seek care when they need it. Our goal is Affordable Healthcare for All, thank you for being part of that journey.

We look forward to working together! Questions? We're here to help.

Phone
1-866-Heart-Us
Customer Service Hours of Operation: Mon-Fri, 8am-6pm CST

support@decent.com

Decent
P.O. Box 4366
Seattle, WA 98194