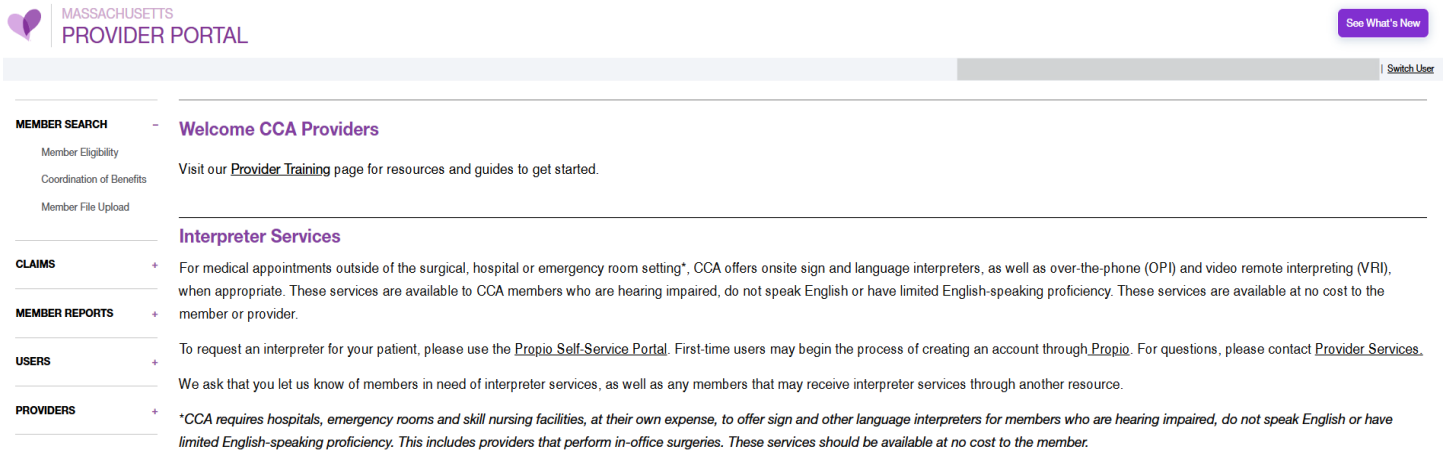
PROVIDER PORTAL

The Provider Portal is a key self-service tool for our providers and defines how our providers engage with us. Our Provider Portal is a secure, encrypted online tool available for any provider serving our members. Providers will need to register to use the Provider Portal.



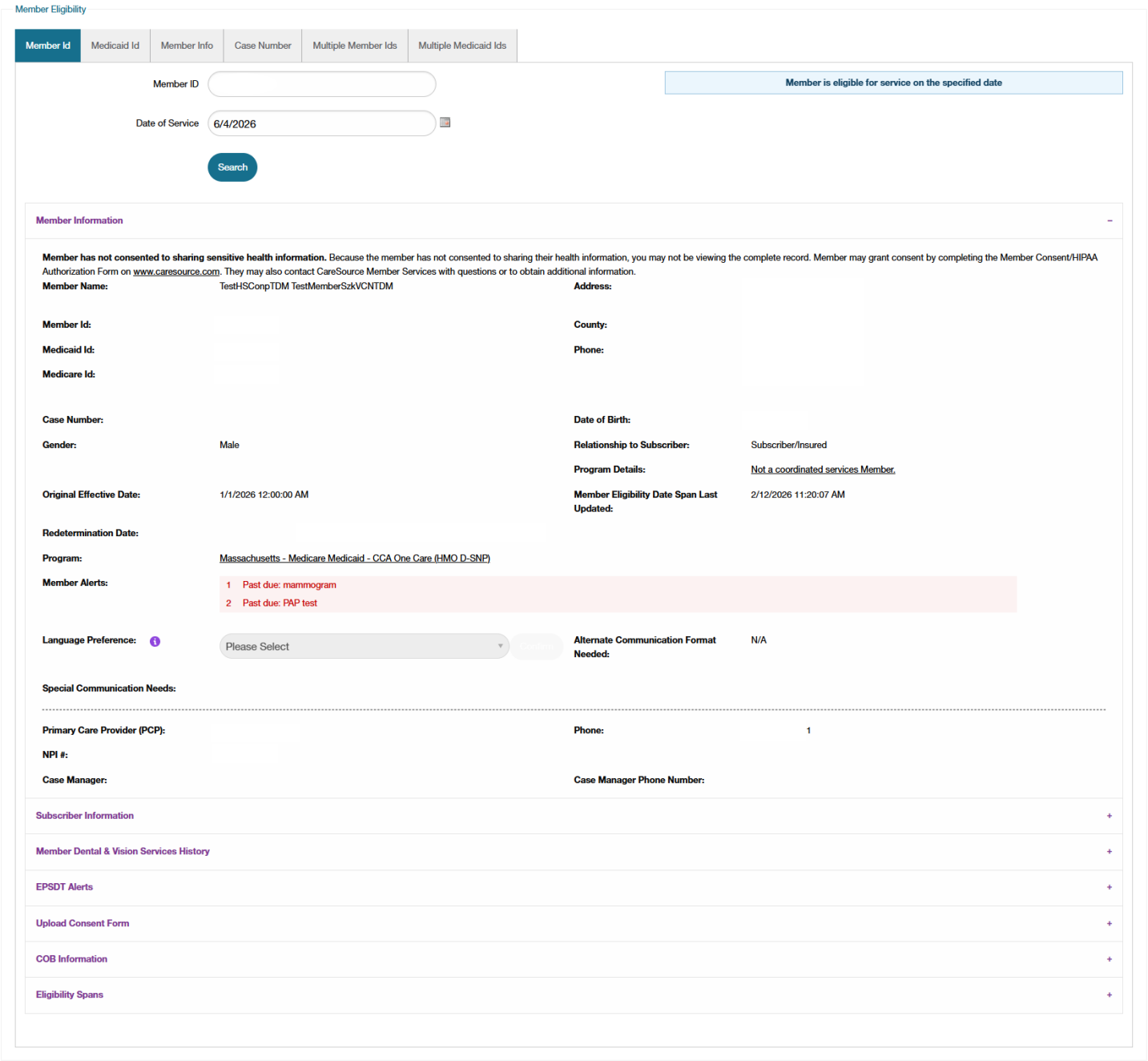
PROVIDER FEEDBACK

Provider satisfaction with the portal is a key metric that we monitor closely. We have implemented a feedback loop where we elicit provider feedback, gather that feedback into key enhancement themes, and then build a thoughtful, enhanced roadmap that delivers new features that our providers find useful. The enhancements are released iteratively throughout the year and target highly requested items. We place satisfaction surveys directly on the portal to capture feedback about your overall experience with completing your daily tasks.

MEMBER ELIGIBILITY

The portal enables quick access to relevant member information, such as member eligibility and enrollment, including a member's primary language information and any other special communication needs.

By going to Member Search > Member Eligibility, providers can search for member eligibility using one of the search options, or search for multiple members at a time. Providers can easily export and print member data as needed. Providers can also access a member's care management plan and submit a request to update care management information.

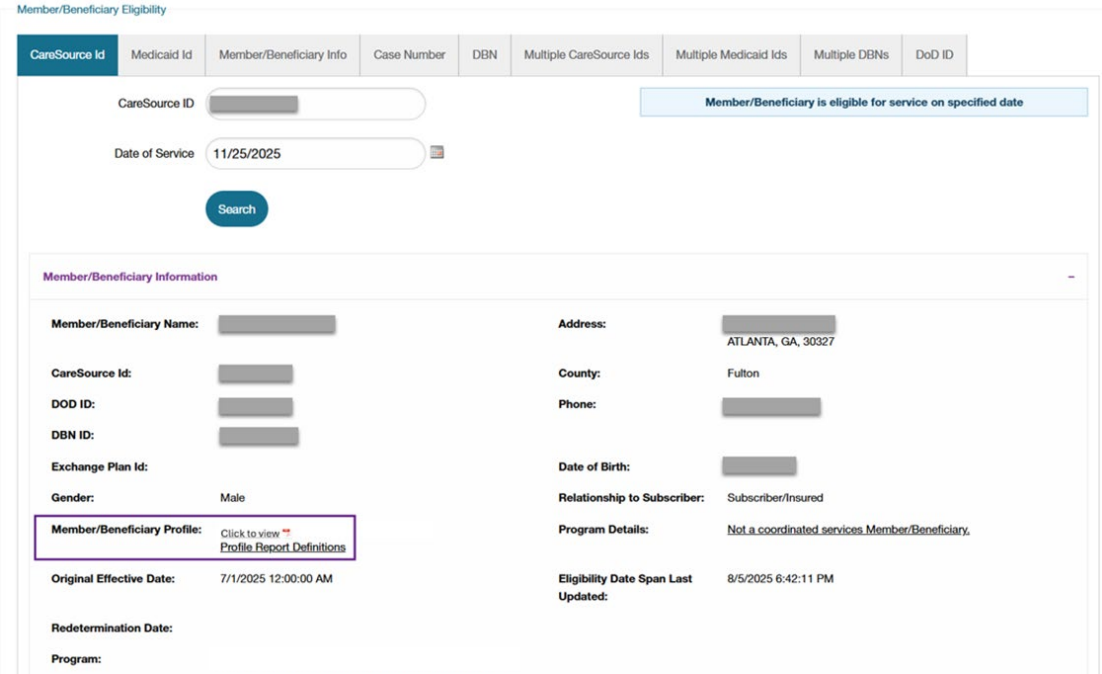


MEMBER PROFILE

The Member Profile supports coordinated beneficiary care between the member's primary care provider (PCP) and other care coordinators by providing access to comprehensive patient medical information in one convenient location. The data in the Member Profile can be used to offer coordinated, streamlined care for patients.

- Patient demographics
- PCP information
- Prior prescribing information
- Historical diagnoses
- Patient-specific quality metrics (such as mammography screening, A1C value and more)

- Prior hospital admissions
- Emergency room visits
- Specialist visits
- Care management activity



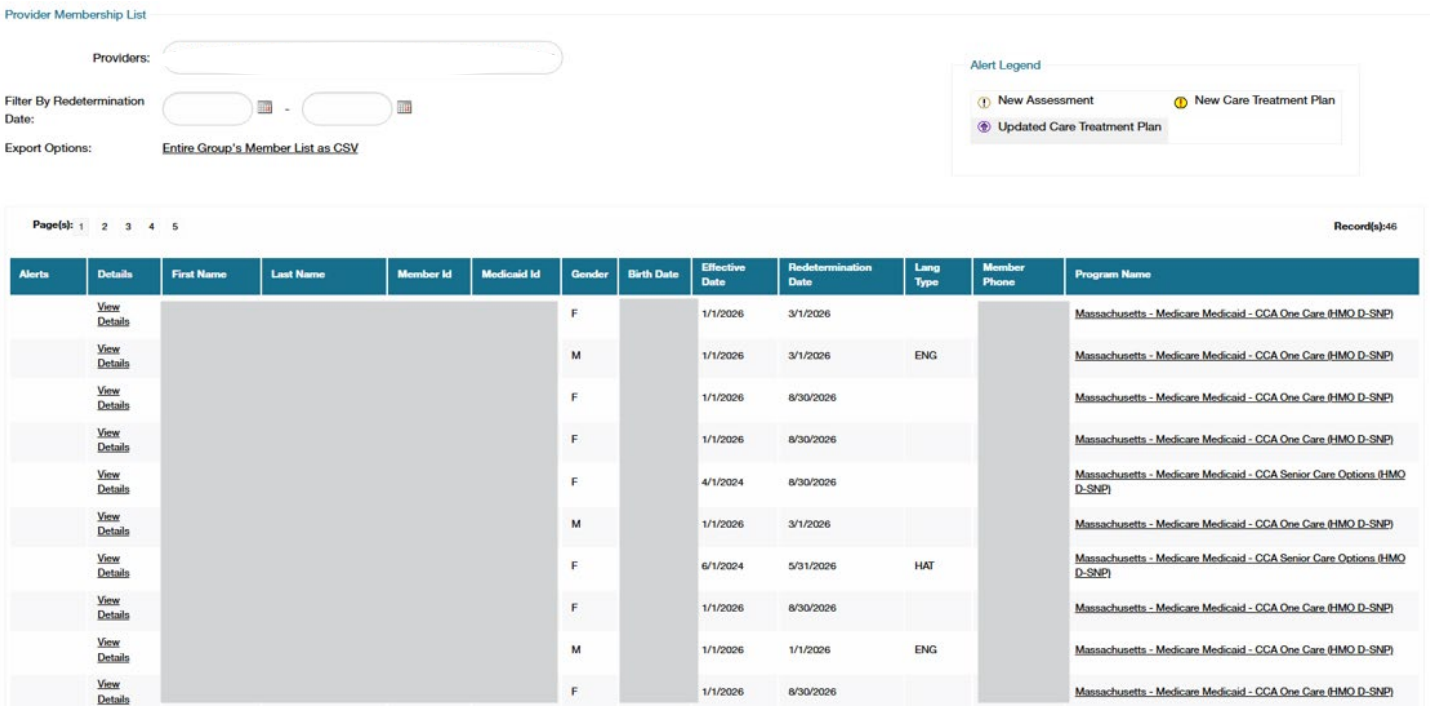
MEMBERSHIP LIST

The Membership List allows providers to view the member currently assigned to the providers acting as PCPs and who are related to their Affiliation Number. The list can be sorted by a specific provider related to a group or for the entire group's member list. Membership lists can be sorted by clicking on a column heading and/or exported in either plain text or comma delimited formats. To access the Membership List, go to the Member Reports section in the left-hand menu.

Alerts that display on the Membership List remain for 90 days from the triggering event.

Events include:

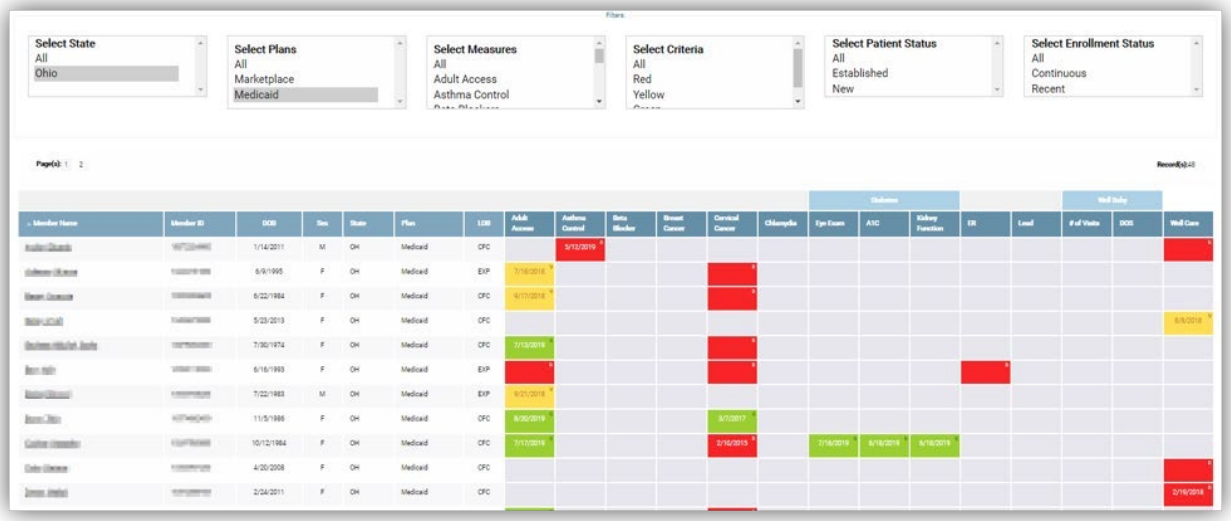
- New Assessment: The member has a new health risk assessment available for review.
- New Care Treatment Plan: The member has a new care treatment plan that can be reviewed/acknowledged.
- Updated Care Treatment Plan: The member has an updated care treatment plan that can be reviewed/acknowledged.



CLINICAL PRACTICE REGISTRY

The Clinical Practice Registry (CPR) is an online tool available to health partners to identify and prioritize needed health care services, screening, and tests for Commonwealth Care Alliance® (CCA) members. The CPR is easy to access via the secure Provider Portal on the Member Reports tab.

- Identify gaps in care: View preventive service history and easily identify Healthcare Effectiveness Data and Information Set (HEDIS®) gaps in care to discuss during appointments.
- Holistically address patient care: Receive alerts when members need tests or screenings, review beneficiary appointment histories, and view their prescriptions.
- Improve clinical outcomes: Easily sort members into actionable groups for population management.
- Attributed as PCP via claims: Indicates the member is attributed to a provider based on claims data. This type of attribution generally means the member has attributable claims history and is engaged with this provider or provider group.
- Attributed as PCP via self-selection: Indicates the member has selected a PCP for assignment and is attributed to their self-selected provider. This type of attribution generally means the beneficiary has no attributable claims history.
- Assigned as PCP: Indicates the member is attributed to their geographically assigned provider. This type of attribution generally means the member has no attributable claims history.



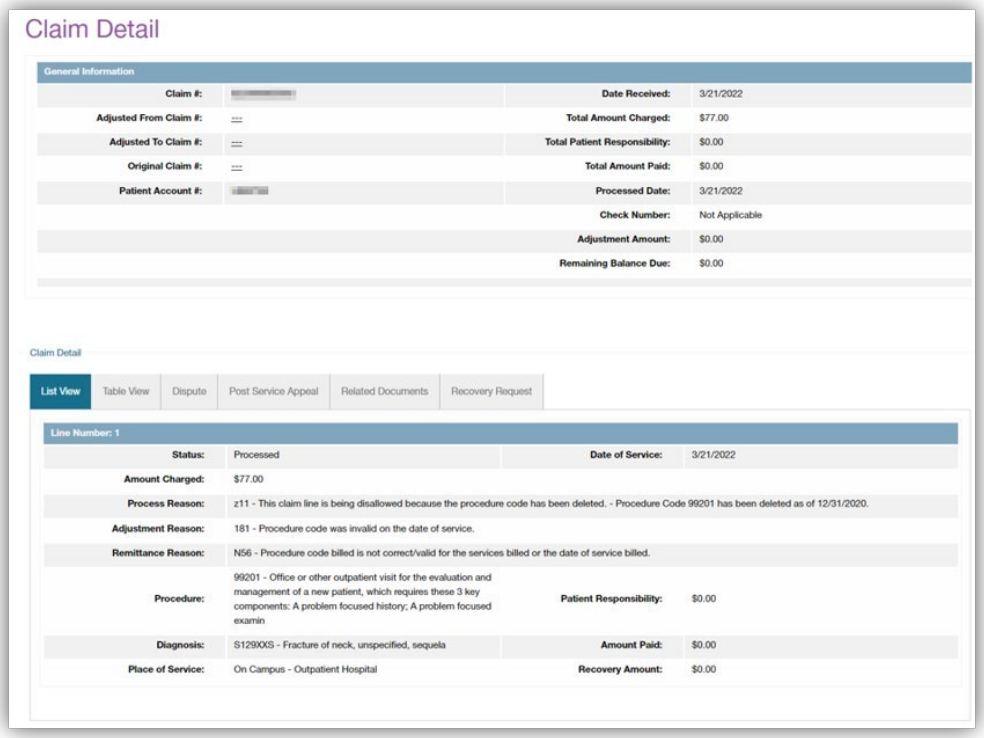
CLAIMS STATUS/CLAIM DETAIL

The Claim Information feature allows providers to review necessary claim information including payment information with check number, process and adjustment reason of how the claim was reviewed, and more.

Claim status is updated daily on the Provider Portal. Providers can check claims that were submitted for the previous 24 months. Search options include member information, patient number, check number, or external reference number. Claim information can be found on the Claims > Claim Information and Attachments page.

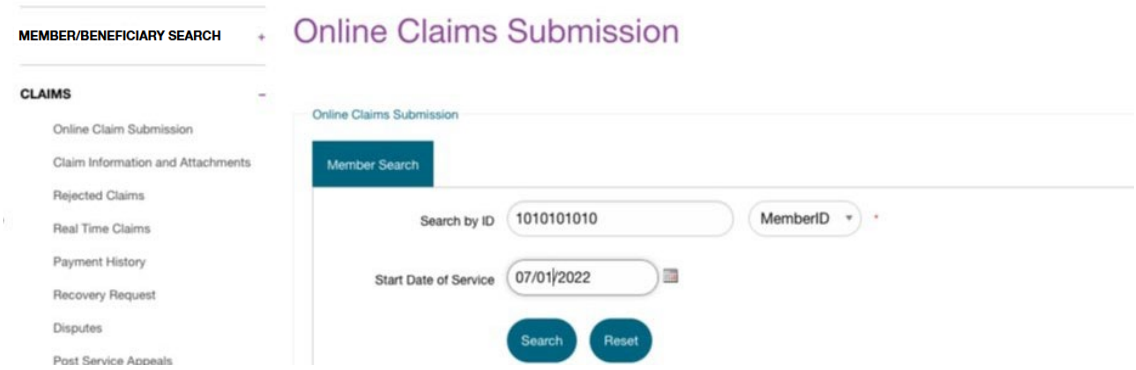
Highlights of the Claim Details include:

- Process Reason – Claim clinical edits
- Adjustment Reason
- Remittance Reason
- Authorization Number – The related authorization, if applicable
- Disallowed Amount – The disallowed amounts on the claim and line items
- Rendering Provider Name – The rendering provider on the claim



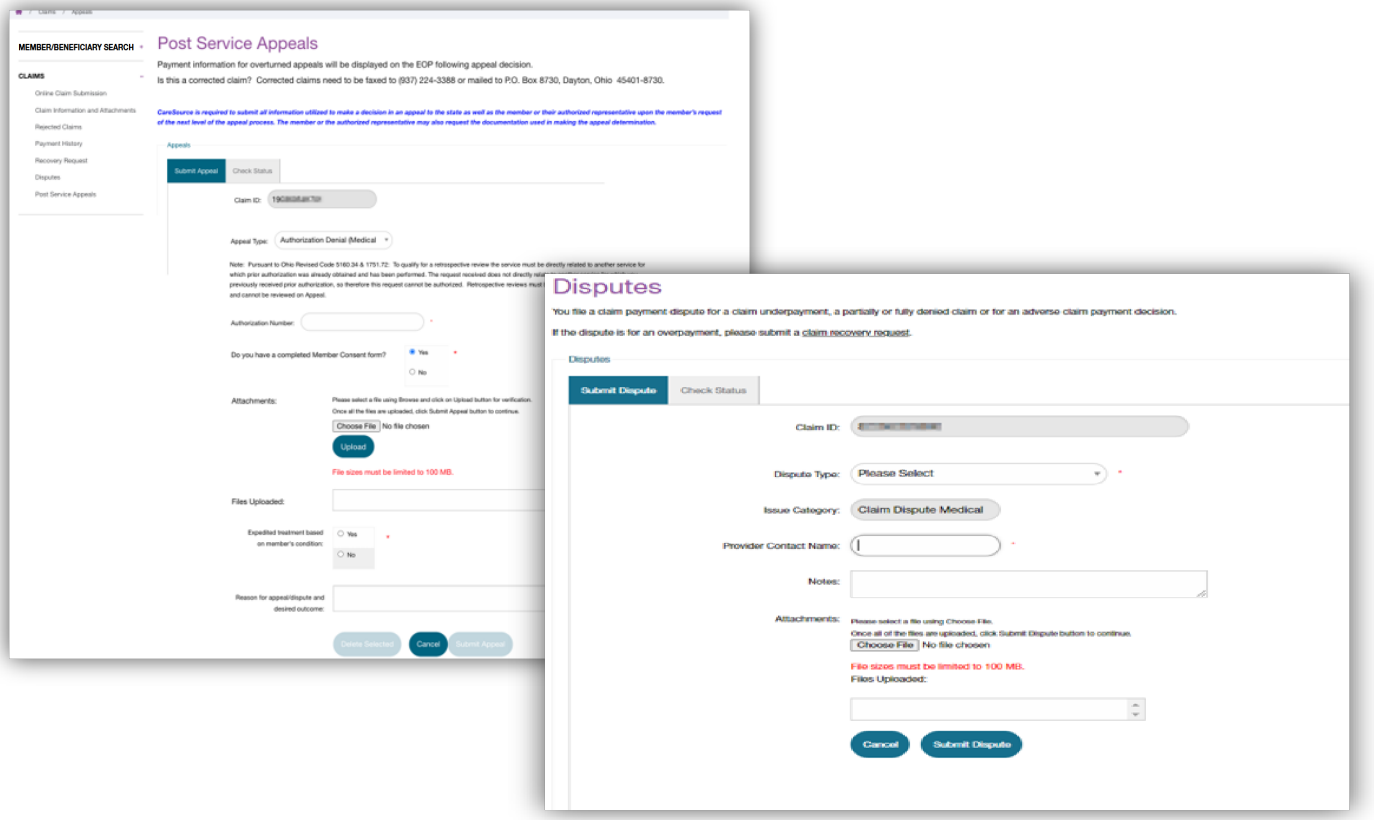
CLAIMS SUBMISSION

The option to submit a claim via the Provider Portal will be for June 28, 2026, or later. This can be found on the Claims > Online Claim Submission page.



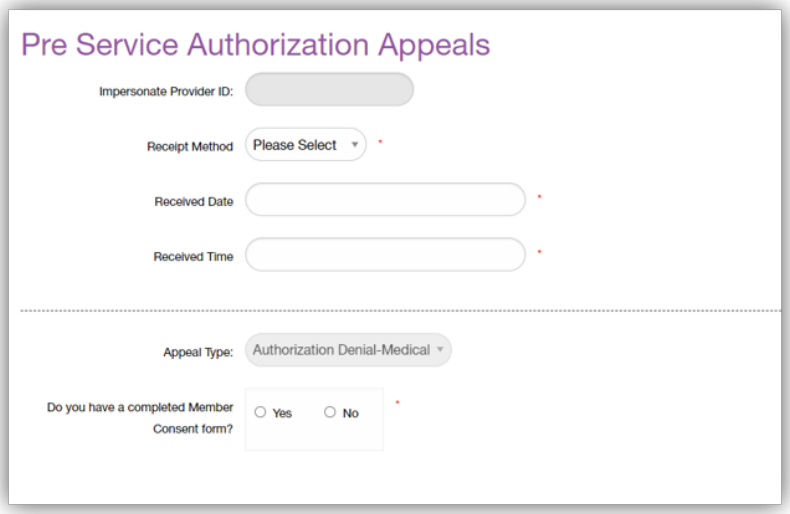
DISPUTES AND APPEALS

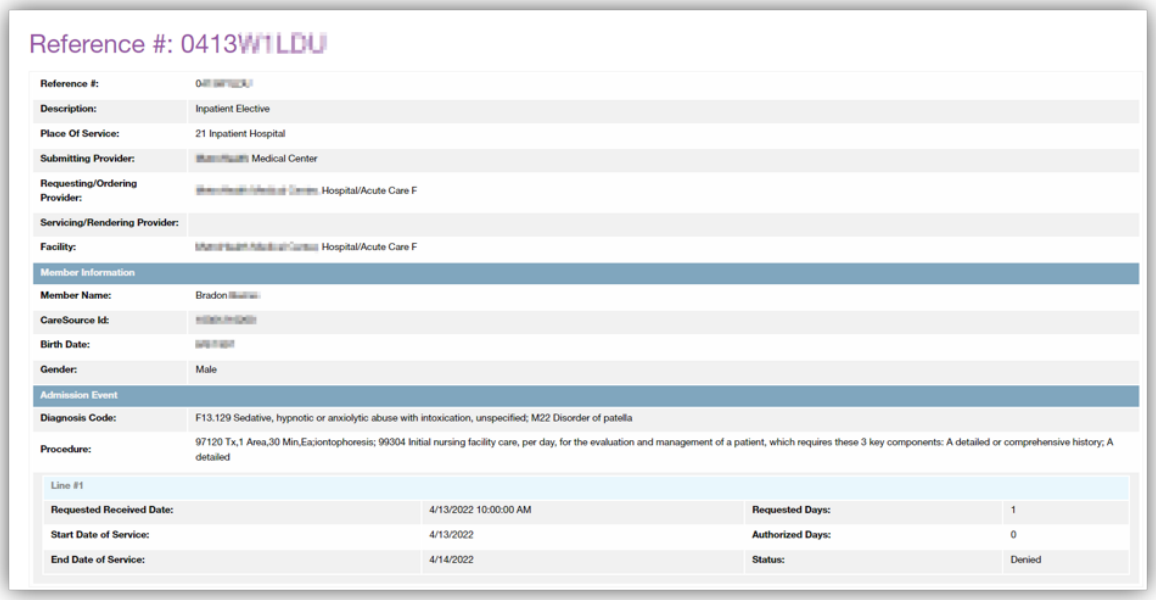
Providers can easily submit Disputes or Post-Service Claim Appeals while viewing a claim on the portal on the Claims tab. As part of the submission process, additional information or documentation can be submitted up to 100 MB. Using the reference number that is provided upon submissions, providers can check the appeal status and review acknowledgement and decision letters associated to the appeal.



PRE-SERVICE APPEALS

Providers can submit pre-service appeals while viewing a denied authorization on the portal. As part of the submission process, additional information or documentation can be submitted up to 100 MB. Using the reference number that is provided upon submissions, providers can check the appeal status and review acknowledgement and decision letters associated with the appeal.

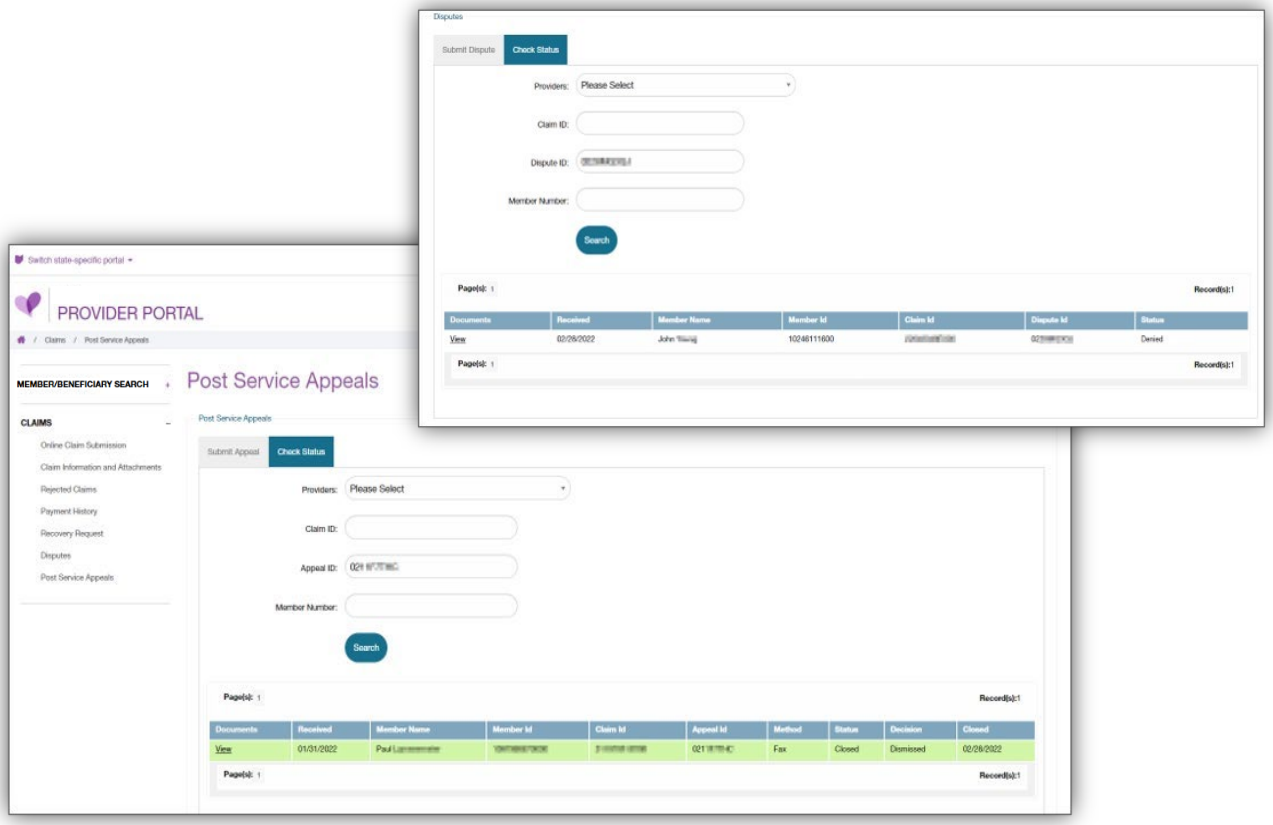




DISPUTE AND APPEAL LETTERS

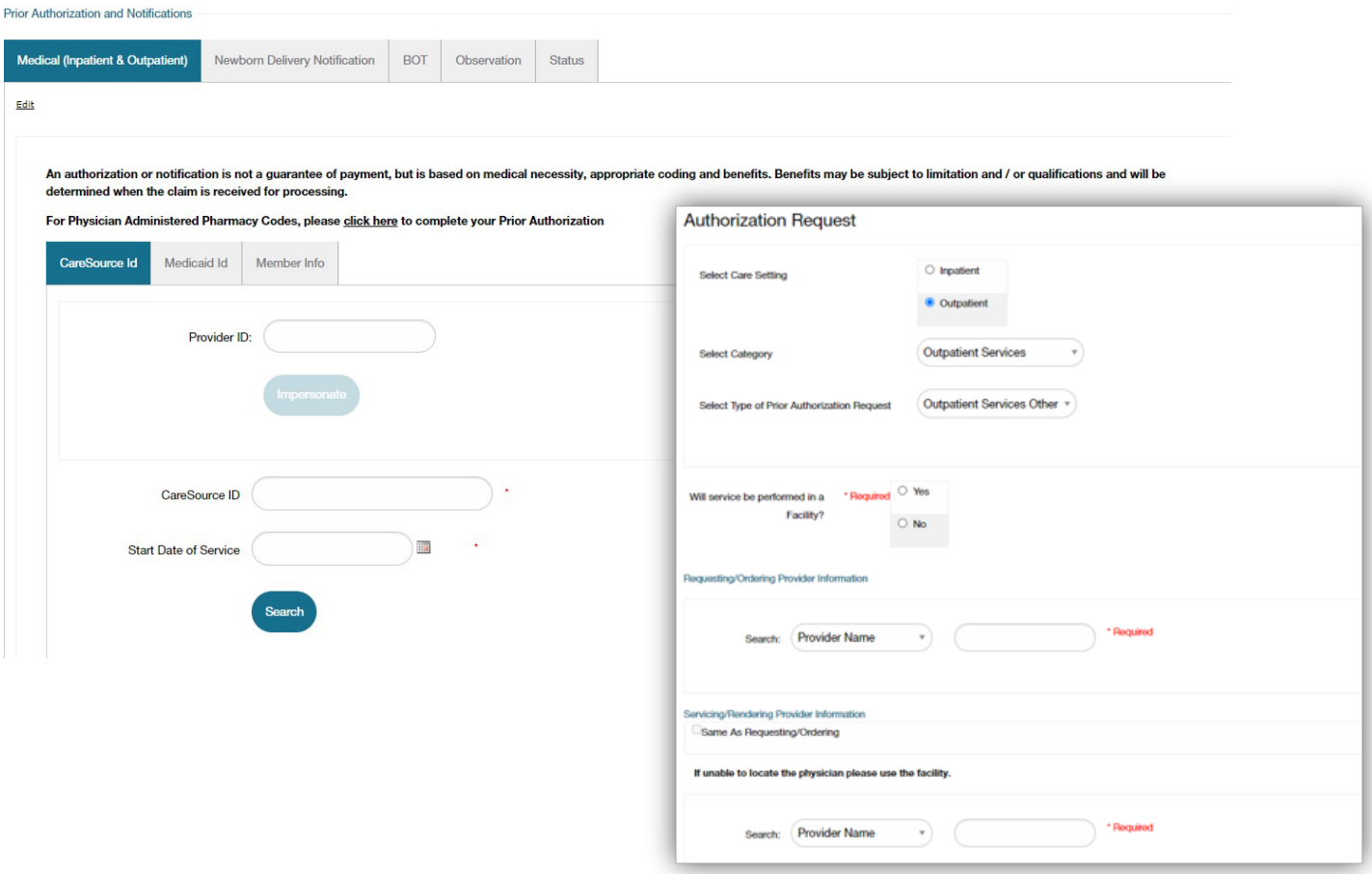
Providers can easily access Disputes or Post-Service Claim Appeal acknowledgement and decision letters on the Provider Portal from three locations:

- While checking the status of the dispute or appeal
- While viewing the associated claim
- From the Provider Documents page



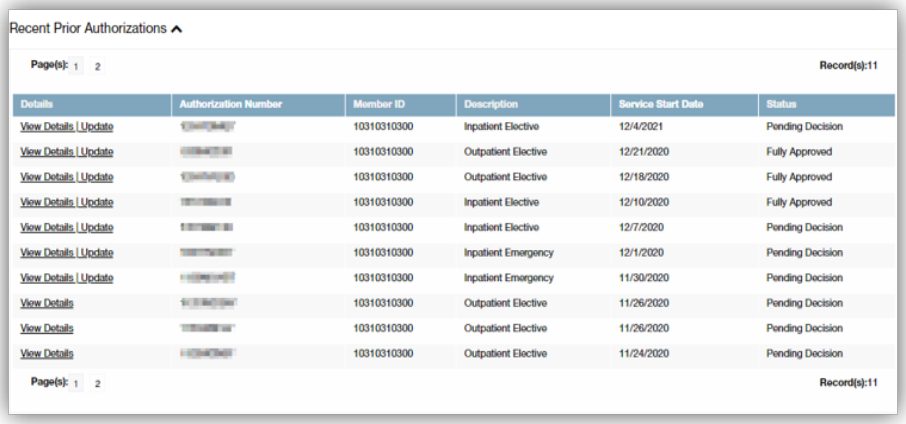
PRIOR AUTHORIZATION SUBMISSION

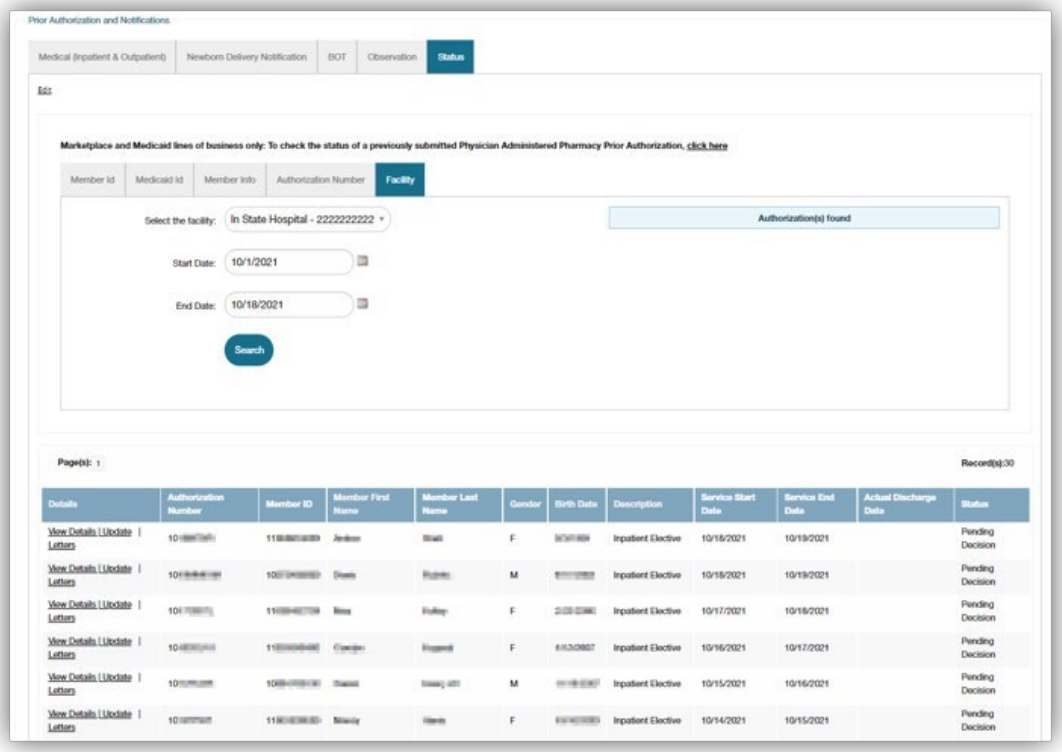
The Provider Portal allows providers to submit an inpatient or outpatient prior authorization request and receive an automatic approval for over 200 procedure codes. Through the Providers > Prior Authorizations and Notifications page, providers can enter clinical details and receive a decision on the authorization within seconds in addition to an authorization reference number. Cite AutoAuth matches the entered procedure and diagnosis information to the integrated clinical criteria and policies to display for the provider to complete that is required for the authorization to be processed. A determination is then made within seconds and given to the provider based on the selected clinical criteria. If a submitted authorization is pending and requires additional clinical information, providers may use our Provider Portal to update the authorization and attach documentation.



PRIOR AUTHORIZATION STATUS

Providers can check status of a prior authorization, make updates to an existing prior authorization, and view related letters.





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