

PROVIDER MANUAL



July 2025

Welcome to OpenNetworks

OpenNetworks™ is a platform that connects the purchasers of health care services with you, the provider. We do this by defining rates and business terms with you and offering them to purchasers in a way that fosters transparency -- without changing your existing systems and workflows.

Our platform works differently than traditional health networks in three key ways:

Providers offer rates and terms

- You decide on the programs and rates to offer through OpenNetworks
- OpenNetworks establishes consistent standards for payments and other operational parameters such as prior authorization, audits, etc.

Purchasers curate provider networks

- Purchasers of health care services, which may be employers with self-insured Benefit Plans or third-party administrators, access the platform to build their own provider networks
- Employers make these customized provider networks available to their employees to access in-network providers
- Behind the scenes, OpenNetworks handles all the business logic to apply the correct rates and business terms to each Claim

Transparency for providers and purchasers

- Your process for submitting Claims is the same as usual, using your existing systems and clearinghouses
- OpenNetworks receives the Claim, and our systems apply the correct rates and business terms before forwarding the Claim to the Payor
- The Payor may be the purchaser, or a third-party administrator processing Claims on behalf of the purchaser
- The Payor processes the Claim and issues payment for Covered Services
- OpenNetworks captures the entire Claim resolution cycle and shares relevant data with you and the purchasers
- OpenNetworks charges purchasers a flat fee per employee to use our platform; our fees are not related to medical cost savings

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Overview

This OpenNetworks Provider Manual* (which we refer to in this document as the “Provider Manual”) supplements to the OpenNetworks Provider Agreement. It is not a complete explanation of all services, benefits, limitations, and exclusions of participation on the platform, and is not meant to interfere with or replace your clinical judgement. Decisions about a Member’s care are between you and the Member. If there is a conflict between this Manual and the documents that govern a Member’s benefit plan, the Member’s benefit plan will govern. If there is a conflict between this Manual and the OpenNetworks Provider Agreement, this Manual will govern unless the OpenNetworks Provider Agreement states otherwise. Applicable federal or state law will take precedence over any other OpenNetworks document.

* Capitalized terms in this document, if not defined here, are defined in the OpenNetworks Provider Agreement.

Joining OpenNetworks

To become an OpenNetworks, you must:

- Have an active, unrestricted license;
- Have active, unrestricted hospital privileges (if applicable);
- Have and maintain professional liability insurance coverage;
- Submit the credentialing form and all requested documents;
- Complete the credentialing process; and
- Execute an OpenNetworks Provider Agreement.

OpenNetworks Providers are independent contractors as defined in the OpenNetworks Provider Agreement. Joining OpenNetworks to provide health care services to Members does not create a relationship of employer or employee, or principal and agent.

Credentialing

Initial Credentialing

Below is a list of items that may be requested and reviewed as part of the OpenNetworks credentialing process, though other documentation may be required:

- CAQH ID or Application to OpenNetworks
- Confirmation of unrestricted license to practice within a specific state and specialty
- Verification of current, unrestricted DEA certificate, as applicable
- Verification of education, training, and board certification, as applicable
- Review of employment history
- Review of malpractice coverage
- Review of malpractice claims history
- Review of Medicare/Medicaid participation status and history
- Review of any disciplinary or sanction activity
- Review of clinical admitting privileges at an in-network hospital, as applicable

A provider must complete the credentialing process in order to be an OpenNetworks Provider and, until then, is a non-participating provider. Payments for Covered Services are based on the licensure and specialty under which a provider is credentialed, and not on academic credentials.

Recredentialing

OpenNetworks Providers are typically recredentialed every three years after the initial credentialing process.

Provider Responsibilities

Demographic Information

OpenNetworks relies on you to maintain accurate demographic information including, but not limited to, your location, phone number, email address, specialty, and hours of operation. You can update your information via the Provider Demographic Worksheet available at www.opennetworks.health/file-share/roster-updates. Your OpenNetworks Provider Agreement has additional details, including when you need to notify us regarding updates to your demographic information.

Primary Care Provider Responsibilities

- Act as the primary health care manager for Members; arrange and coordinate their medical care, including routine care, and follow-up care after Emergency Services.
- Refer Members for specialty services as appropriate.

Specialist Provider Responsibilities

- Provide continuity and coordination of care by sending written reports to the Member's Primary Care Provider regarding any treatment or consultation rendered.

Advance Directives

Each Member has the right to accept or refuse treatment and execute an advanced directive in accordance with applicable law. Reasonable steps should be taken to document in the medical record whether or not a Member has executed an advance directive and/or a health care proxy. If so, a copy should be maintained in the Member's record. Care should not be conditioned on whether or not a Member has an advance directive.

Administrative Fees

Members may not be billed for any administrative items or services.

Responsibilities of all OpenNetworks Providers

- Treat all Members with the highest level of service, quality, and respect.
- Schedule appointments in a timely and efficient manner consistent with the table below.
- Keep abreast of updates to this Provider Manual, and updates shared via our provider newsletter.
- Adhere to OpenNetworks policies and administrative requirements.
- Provide health care services in accordance with the standards of medical care and ethics outlined in your OpenNetworks Provider Agreement.
- Facilitate clear and candid discussions with Members about appropriate or treatment options regardless of the cost or coverage. These discussions should include comprehensive and current information regarding diagnosis, treatment, and prognosis in terms that the Member or the Member's designee can understand.
- Give Members the information necessary to give informed consent in advance of any procedure or treatment.
- Maintain appropriate liability insurance coverage, consistent with the terms of your OpenNetworks Provider Agreement
- Maintain medical records for Members consistent with applicable privacy regulations and your OpenNetworks Provider Agreement.
- Cooperate with OpenNetworks or its designee in the resolution of Member complaints, appeals, or other concerns.

- Foster the efficient delivery of healthcare services to minimize waste.
- Collect information from Members regarding other insurance carriers or other parties that might be responsible for claims payment (such as automobile, liability, worker’s compensation) and submit claims to those third parties as appropriate.

Appointment Standards	
Urgent Care	Within 48 Hours
Non-urgent Primary Care	Within 10 business days
Non-urgent Specialist Care	Within 30 business days
Non-urgent mental health	Within 10 business days
Non-urgent ancillary services	Within 15 business days

Additionally, all OpenNetworks Providers must be available to provide or arrange for emergency services:

- Either directly, or through coverage arrangements, 24 hours per day, 7 days per week, and 365 days per year.

If you use voicemail or other assistive technology to answer or triage calls, the Member must be able to directly contact you or your covering provider in cases of urgent or emergent needs. A general message directing all Members to the nearest emergency room is insufficient.

Nondiscrimination

Members are to be treated with respect and dignity and in consideration of their privacy. Members should be treated no less favorably than all other patients. Members shall not be discriminated against based upon race, religion, national origin, color, creed, income level, sex, gender, marital status, sexual orientation, age, health status, disability, or source of payment.

Member Identification

Members will be issued ID cards that may be paper or electronic, and each card will list the payor responsible for claims processing. The fact that a person has or doesn't have an ID card doesn't guarantee that the person is a Member or is not a Member.

Within 30 days of your effective date, you will receive in electronic format a list of payors, along with relevant demographic information, including assumed names or trade names. We will maintain the list and provide it to you on a monthly basis, with changes noted.

Member Eligibility

You can confirm Member eligibility by calling the phone number on the Member's identification card.

Prior Authorization

A Member's benefit plan may require prior authorization for specific services. For more information, including a list of services for which prior authorization may be required, please contact our Provider Support team at 1-833-673-6638. To confirm prior authorization requirements for a specific Member, or for general questions, please call the number on the Member's identification card or contact our Provider Support team at 1-833-673-6638.

Prior authorization, advance notice, or coverage verification is not required prior to rendering emergency services, but we must be notified of an emergency admission within 24 hours or the next business day, whichever is sooner.

If a Member requires a non-emergency service that arises out of an emergency screening assessment, you should contact us as a prior authorization of the non-emergency service may be required.

Referrals

Except for emergency services, Members should be referred to OpenNetworks Providers whenever possible, or to other providers in the Member's network. Along with the referral, you should submit all relevant information, including medical records as appropriate, to the referred provider.

Access to Members

OpenNetworks or a payor may access a Member, when the Member's medical condition permits, or may access someone acting on behalf of a Member in order to discuss benefits, discharge planning, follow up care, or other relevant procedures or requirements.

Claim Submission and Billing

All Claims are to be submitted per the terms of your OpenNetworks Provider Agreement and the Payor's policies. OpenNetworks provides pricing services for third-party administrators and self-funded employers. OpenNetworks is neither a Payor, nor an insurer, guarantor, or underwriter with respect to the provision of health care benefits or the payment of Claims.

Please refer to the Member's identification card for important information, including the Claim submission address and the Payor's customer service phone number.

If you have specific questions about Claim processing, please call the Payor using the number on the Member's identification card or contact our Provider Support team at 1-833-673-6638.

Clean Claims

Consistent with the OpenNetworks Provider Agreement, a Clean Claim, among other requirements, is timely submitted, includes all required data, requires no additional information to be processed, and does not involve coordination of benefits, third party liability, or subrogation.

Claim Forms

All Claims must: (1) be submitted utilizing standard billing format or, for electronic billing, ASC X 12N 837 format and following current HIPAA Administrative Simplification transaction standards; (2) include NPI numbers and provider taxonomy codes; (3) include the proper use and combination of billing codes and modifiers; (4) be consistent with usage guidelines and conventions in the current procedural terminology codes, the International Classification of Diseases codes, and the Diagnostic and Statistical Manual of Mental Disorders codes, as applicable; and (5) be consistent with this Provider Manual. Electronic claims submission is strongly preferred.

Timeliness of Claims Submission.

Untimely Claims are not Clean Claims and payment will be denied. However, when coordinating benefits if a payor is the secondary payor the Claims submission period will not begin until you receive notification of the primary payor's responsibility. For inpatient Covered Services continuing for longer than 30 days, you may submit interim Clean Claims in 30-day intervals.

Collection of Cost Sharing Amounts

Providers are required to collect Cost Sharing Amounts from Members and make reasonable efforts to verify them before doing so. If payment of a Claim is reduced or denied by a payor, the Member's Cost Sharing Amount must be

adjusted accordingly. You can waive Cost Sharing Amounts, but only consistent with your established financial hardship policy, and the same policy must apply to all your patients. If requested, you agree to share your financial hardship policy with us.

Coordination of Benefits

You are required to bill the primary insurer before submitting Claims for the same services to us. For claims involving coordination of benefits, when allowed by law, a Payor will pay you the lesser of: (i) the amount owed under your contract, or (ii) the amount owed under your contract, reduced by the amount paid or payable by the other payor(s). A payor will not be obligated to pay more than the Allowed Amount for Covered Services. Unless prohibited by law, a payor can recoup payments for items or services for which other insurers or payors are responsible.

Subrogation

We appreciate your cooperation with and assistance with any subrogation efforts.

Balance Billing Not Permitted

The allowed amount must be accepted as payment in full for Covered Services and neither the Member nor anyone else can be charged for any remaining balance.

Non-Covered Services

If a service isn't covered, you can bill the Member, but only if the Member is given a written statement, with the amount due, before being charged. A Claim that is denied due provider error, utilization management policies, or claim editing rules doesn't make the service non-covered, and the Member cannot be billed.

Non-Members

If it's determined that a patient was not a Member at the time of service, you may bill the individual directly. If a payor determines that the patient was not a Member after payment has already occurred, the amount of that payment may be offset against any other amount owed to you by the payor.

Suspension of Payments

If a governmental authority determines that there is a credible allegation of fraud against you and suspends payments to you, your OpenNetworks payments may also be suspended during that time.

Coverage Guidelines

OpenNetworks does not make medical decisions nor any coverage determinations. For any questions regarding Covered Services, please contact the number on the Member's identification card.

Dispute Resolution

Please contact us with questions via email at providersupport@opennetworks.health or contact us via our Provider Support line at 1-833-673-6638. The dispute resolution process, for a dispute you may have with OpenNetworks, is outlined in your OpenNetworks Provider Agreement. If you have a dispute about how a Claim was processed or paid, or about an overpayment refund please call the number listed on the Member's identification card.

Work Stoppage Impacting Care

If there is a strike or other event that prevents you from treating Members, you should notify us so that we can work with you to refer non-elective procedures to other OpenNetworks Providers and help support continuity of care until your operations have normalized.

Questions or Suggestions

We always welcome your feedback, and we encourage you to email us at providersupport@opennetworks.health or contact us via our Provider Support line at 1-833-673-6638.

Quick Reference Guide

Below is a table that outlines where to find information you may need. If you have a question or need information about a topic not listed below, please contact our Provider Support team at 1-833-673-6638 and we will be happy to assist you.

Information	Source
Group ID	Member Identification Card
Eligibility	Member Identification Card
Electronic Claim Filing Payor ID	Member Identification Card
EFT/ERA Information	Member Identification Card
Claims Address	Member Identification Card
Customer Service	Member Identification Card
Medical Management	Member Identification Card
Pre-authorization	Member Identification Card
Appeals	Member Identification Card
Provider Demographic Updates	www.opennetworks.health/file-share/roster-updates
Payor Listing	Provider Support - 1-833-673-6638