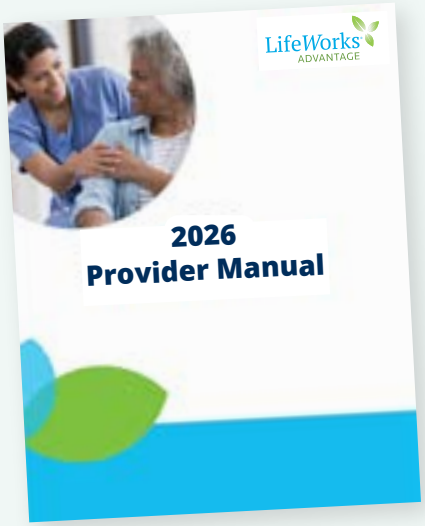
LifeWorks ADVANTAGE

# Provider Newsletter

Q1 2026

## THE PLAN PROVIDER WEBSITE

The Plan Provider Website is a valuable resource for both Provider and Facility staff. For more details on the topics covered in this newsletter, please visit the Plan website and navigate to the **"For Providers"** section. There, you will also find the comprehensive **Online Provider Manual**.




We encourage all providers to regularly consult the Provider Manual, which includes essential information such as:

- Key Contacts
- Eligibility
- Member Benefits
- Billing and Claims
- Credentialing Requirements
- Quality Improvement
- Provider Participation Standards
- Member Rights and Responsibilities
- Plan Compliance Program

As a participating provider, it is vital to stay informed about the Plan's participation standards. Detailed descriptions of each standard can be found in the Provider Manual.

Visit the plan website at: **LifeWorksAdvantage.com**

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## Contact Us

Provider Portal: **https://secure.healthx.com/LifeWorksAdvantage.provider**
Contact Us Page: **https://lifeworksadvantage.com/contact-us/**
Customer Service Phone: **1-844-854-6883 (TTY 711)**
Customer Service Email: **customerservice@lifeworksadvantage.com**

# Cultural Competency

CMS defines health equity as "the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes".

Participating providers must provide services to all plan customers, consistent with the benefits covered in their policy, without regard to English proficiency or reading skills, ethnic, cultural, racial or religious background, mental or physical disabilities, sexual orientation, gender identity, socioeconomic or financial background, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, source of payment, or any other bases deemed unlawful under federal, state, or local law.

We encourage providers to visit the U.S. Department of Health and Human Services Office of Minority Health website for resources, training, policies, programs and best practices on Cultural and Linguistic Competency: **Cultural and Linguistic Competency | Office of Minority Health (hhs.gov)**

## Make It Easy For Members To Find You

Accurate and complete provider information in our Provider Directory is essential to helping members find and access the care they need. The directory serves as a key resource for members seeking providers within our network. We encourage you to regularly review your directory listing and inform us of any updates or changes as soon as possible—and no later than thirty (30) calendar days before the effective date of the change.

To report updates, please contact your email Provider Network or call Provider Services. Timely updates help ensure that members can find and reach you when they need care most.

# Compliance

## Fraud, Waste, And Abuse (Fwa) Monitoring

Our plan has established robust policies and procedures to detect and prevent fraud, waste, and abuse (FWA) across all aspects of our network, including provider billing practices. These efforts support compliance with Medicare requirements and include coordination with CMS and law enforcement when necessary. We would like to remind you that as part of this work, we conduct routine analysis of CPT, ICD-9/ICD-10, and HCPCS coding to identify anomalies and ensure proper documentation. Participating providers must maintain accurate records and submit requested documentation promptly to avoid repayment obligations or regulatory referrals. Please ensure to reply to plan medical record request promptly. For more details, refer to the Provider Manual.

## Compliance With Federal And State Laws

Our plan is committed to full compliance with federal and state regulatory requirements applicable to our Medicare Advantage and Medicare Part D lines of business. Non-compliance with regulatory standards undermines plan business reputation and credibility with the federal and state governments, subcontractors, pharmacies, providers, and most importantly, our members. Our plan employees are also committed to meeting all contractual obligations outlined in plan contracts with CMS. These contracts allow the plan to offer Medicare Advantage and Medicare Part D products and services to Medicare beneficiaries.

The Corporate Compliance Program prevents violations of federal and state laws governing plan lines of business, including but not limited to, healthcare fraud, waste, and abuse laws. In the event such violations occur, the Corporate Compliance Program will promote early and accurate detection, prompt resolution, and when necessary, disclosure to the appropriate governmental authorities.

If you have compliance concerns or questions, call the Compliance Hotline as listed on the plan provider website.

# Provider Satisfaction Survey Results

## Your Voice Matters – Help Us Improve Provider Support

We are committed to fair and inclusive practices. We do not discriminate in terms of participation or reimbursement against any healthcare professional who is licensed or certified under applicable state law and operating within their scope of practice—regardless of the populations they serve. We deeply value our ongoing partnership with our provider community and actively seek your input to strengthen our services.

As part of our efforts to enhance the provider experience, we conducted an online Provider Satisfaction Survey in 2024, distributed through the emailed newsletter. While we received some valuable responses, the overall participation level was insufficient to generate a statistically valid sample.

We're asking for your participation this year to help shape meaningful improvements. Your feedback directly influences our strategic planning and helps us better support your practice and the members you serve.

Please take a few moments to share your insights with us. Your voice makes a difference. Thank you for your continued partnership and commitment to quality care.

**LifeWorks Advantage Provider Survey 2026**

# Provider Participation Standards

Please ensure that your office is in compliance with the following Plan Provider Participation Standards. These standards are essential to maintaining high-quality care and service for our members.

For additional information or clarification, please consult the Online Provider Manual or contact your Plan representative.

## Dual Eligibles And Cost Sharing

For all members eligible for both Medicare and Medicaid, members will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for members enrolled in Medicare and Medicaid. Provider may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will: (1) accept the MA plan payment as payment in full, or (2) bill the appropriate State source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

## Member Hold Harmless

Participating Providers are prohibited from balance billing plan members including, but not limited to, situations involving non-payment by the Plan, insolvency of the Plan, or the Plan's breach of its Agreement. Provider shall not bill, charge, collect a deposit from, seek compensation or reimbursement from, or have any recourse against customers or persons, other than the Plan, acting on behalf of customers for covered services provided pursuant to the Participating Provider's Agreement. The provider is not, however, prohibited from collecting copayments, coinsurances, or deductibles for covered services in accordance with the terms of the applicable customer's Benefit Plan, or for collecting payment when rendering non-covered services if the provider complies with the requirements of the non-covered services section of the Provider Manual. Participating providers should call Provider Services to check on member cost-share responsibility if not listed on the member ID card.

## HIPAA

Providers must ensure the security of patients' protected health information (PHI) and adapt reasonable safeguards to protect PHI against unauthorized use and disclosure. PHI uses and disclosures are restricted to those related to treatment, payment, and healthcare operations. In addition, providers shall supply the plan, CMS or any other state or federal agencies with copies of patient medical records upon reasonable request.

## No Plan Interference With Provider Advice To Patients

Members have the right to receive complete and accurate information from their providers about their medical care and to actively participate in the planning and decision-making process regarding their treatment.

Our plan does not prohibit or otherwise restrict providers—acting within the lawful scope of their practice—from advising or advocating on behalf of members regarding:

- Their health status, medical care, or available treatment options, including self-administered alternatives;
- The risks, benefits, and possible outcomes of treatment or non-treatment; and
- The right to refuse treatment and to express preferences concerning future care decisions.

Providers are responsible for ensuring that all information is presented in a way that is easily understandable to members. Members must be fully informed about all appropriate and medically necessary treatment options for their condition, regardless of cost or whether the Plan covers them. This includes information about available Medication Management Treatment Programs and any associated risks.

# Provider Participation Standards Continued

## Medical Record Documentation Standards & Maintenance Of Beneficiary Records

Participating providers are required to maintain complete medical, financial, and administrative records for all services rendered to plan members, consistent with standard business practices. These records must be retained in accordance with all applicable federal and state laws and regulations, and for no less than ten (10) years from the date of service.

During the term of the provider agreement and for ten (10) years thereafter, the Plan, as well as authorized state and federal agencies, may review records related to services provided to plan members. Such access will be granted during normal business hours with reasonable advance notice.

In compliance with state and federal regulations, including those applicable to Medicare, providers must maintain medical records in a format that supports the evaluation of service quality, appropriateness, and timeliness as outlined in the provider agreement.

All patient medical records must be current and maintained in accordance with HIPAA privacy requirements and document retention standards. Records must be stored securely, with access limited to authorized personnel. Member information must be kept confidential, and patients have the right to approve or refuse the release of their medical records as required by law.

Providers must utilize a clinical record system capable of accurately processing, storing, retrieving, and distributing medical records. This applies to both paper-based and electronic systems.

Medical documentation must reflect consistent and accurate entries that demonstrate alignment between diagnoses, treatments, assessments, referrals, therapies, and follow-up care. Each member's medical record must include the following:

- Member identification information
- Names of all providers involved in the member's care and services rendered
- Documentation of significant medical and psychological conditions
- Presenting complaints, diagnoses, and treatment plans
- Medication records, including prescribed dosages, refill dates, over-the-counter products, and supplements
- Allergy and adverse reaction information
- Medical history, physical examinations, treatments, and risk factors
- Immunization history
- Laboratory, radiology, and other diagnostic test results
- Power of Attorney preferences
- Advance directive documentation, if available
- Health education and wellness services accessed
- Notations of significant medical advice provided by phone, including after-hours triage or information services

Unless otherwise specified in the provider agreement, the Plan retains the right to request and access medical records for purposes such as claims processing, quality of care reviews, coordination of care, utilization management, and compliance with CMS, state, or federal audits.

# Provider Participation Standards

## Anti-Discrimination & Cultural Competency

### Commitment to Health Equity, Non-Discrimination, and Cultural Competency

The Centers for Medicare & Medicaid Services (CMS) defines health equity as "the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes."

As a participating provider, you play a vital role in advancing health equity and ensuring that all Plan members receive fair, respectful, and inclusive care.

### Non-Discrimination Requirements

Participating providers are prohibited from discriminating against Plan members and must deliver services in accordance with the benefits covered under the member's plan—without regard to:

- English language proficiency or reading level
- Ethnic, cultural, racial, or religious background
- Mental or physical disabilities
- Sexual orientation or gender identity
- Socioeconomic or financial status
- Claims history or medical background
- Evidence of insurability (including conditions related to domestic violence)
- Genetic information
- Source of payment
- Any other basis prohibited by federal, state, or local law

### Culturally Competent Care

Providers are required to ensure that all treatment information is communicated in a culturally competent manner. This includes:

- Presenting all treatment options, including the option of no treatment
- Providing meaningful access to individuals with disabilities through effective communication
- Ensuring accessibility across all points of care within the health system

### Interpreter and Teletypewriter (TTY) Services

If Plan members require assistance with communication—such as interpreter services or TTY access—they should be directed to contact the Member Services Department, which can also support members with facility accessibility concerns (e.g., wheelchair access).

### Cultural Competency Training Resources

To support providers in delivering culturally responsive care, we encourage you to explore resources available through the U.S. Department of Health and Human Services Office of Minority Health. Their website offers training modules, best practices, and guidance on cultural and linguistic competency:

**Cultural and Linguistic Competency | Office of Minority Health**

**https://thinkculturalhealth.hhs.gov/about**

# Provider Participation Standards Continued

## Member Rights and Responsiblities

All participating providers are required to respect and uphold the following member rights and responsibilities. These rights are designed to ensure that all Plan members receive equitable, respectful, and informed care.

### Member Rights

Plan members have the right to:

- The right to Advance Medical Directives
- Receive information about their health plan, covered services, and providers.
- Be treated with dignity, respect, and consideration at all times.
- Privacy and confidentiality regarding their medical records and care.
- Access participating providers and receive medically necessary covered services, including timely prescription fulfillment.
- Participate fully in decisions related to their health care, including the right to refuse treatment.
- Obtain accurate and complete information about their health and treatment options, including alternatives and potential outcomes, regardless of benefit coverage limitations.
- Receive medical advice and treatment recommendations from their providers that are in their best interest, free from plan interference.
- Have access to and be informed about Advance Medical Directives.
- File complaints, grievances, or appeals without fear of retaliation and have those concerns addressed in a timely and fair manner.
- Change primary care providers or specialists within the plan network.
- Decline participation in experimental or research-based treatments.
- Request and receive interpreter or translation services, including teletypewriter (TTY) access, when needed to communicate effectively.
- Request information about provider qualifications and verify malpractice coverage.

### Member Responsibilities

Plan members are expected to:

- Understand their health plan coverage, including benefits, limitations, and any rules for accessing care.
- Use network providers for covered services, except in emergencies or when authorized by the plan.
- Present their current member ID card when seeking services and inform providers of their plan enrollment.
- Provide accurate and complete information to their providers to support appropriate diagnosis and treatment.
- Promptly pay any applicable premiums, copayments, or cost-sharing amounts.
- Notify the plan and providers of changes to their address, phone number, or other contact information.
- Communicate any questions, concerns, or dissatisfaction with services, coverage, or care to the plan or provider.
- Be respectful of providers, office staff, and other patients.

# Provider Participation Standards Continued

## Safe and Sanitary Environments for Members

Provider sites are expected to comply with nationally recognized standards of safe and sanitary environments such as those of the CDC. Those standards should include:

- Having an infection control program
- Safeguards to prevent medication errors
- Fall and injury prevention procedures
- Proper management of potential threats and hazards
- By providing a safe and sanitary environment, you can avoid member grievances and potential

## Access & Availability Standards

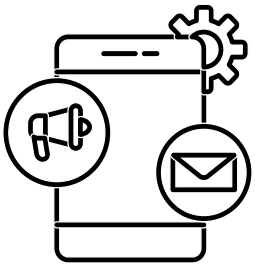
To guarantee that plan members receive timely care, the plan has implemented comprehensive written access and availability standards for participating providers. These standards encompass routine, urgent, preventative, and emergent services. Providers must adhere to these access standards, which are detailed in the provider manual, to maintain their participation in the plan. Compliance with these standards is assessed annually through the Access and Availability survey, which is distributed to providers. Your participation in this survey is highly encouraged.

## Marketing Activities in Healthcare Settings – CMS Compliance Reminder

Participating providers must adhere to Centers for Medicare & Medicaid Services (CMS) regulations regarding marketing and patient outreach activities in healthcare settings. The Provider Manual outlines specific guidance to ensure providers understand what is permissible.

**Providers must not:**

- Direct or attempt to steer an undecided potential enrollee toward a specific plan.
- Limit a beneficiary's options to a select number of plans based on the financial interests of the provider, agent, or organization.
- Engage in marketing activities that could be perceived as coercive, misleading, or biased.



Providers must remain neutral and impartial when discussing plan options or assisting beneficiaries with enrollment decisions.

For comprehensive details on CMS-compliant marketing practices, including what is and is not allowed, please refer to the Provider Manual.

## Advance Directives

Plan members have the **right to participate in decisions about their healthcare, including the right to create and enforce Advance Directives—**such as instructions to withhold resuscitative measures or decline/withdraw life-sustaining treatment.

As a participating provider, you are prohibited from conditioning the provision of care or discriminating against a member based on whether they have executed an advance directive.

When delivering services, you should request a copy of the member's advance directive for inclusion in their medical record. This ensures that the member's healthcare preferences are documented and respected.

If you are unable to honor a member's advance directive due to a conscientious objection, you are required to promptly inform both the member and the Plan. The Plan will coordinate with you to ensure a safe and appropriate transfer of care.

For additional guidance, please refer to the Advance Directives section of the **Provider Manual**.