SIHO INSURANCE SERVICES

MyTru Advantage

PROVIDER MANUAL

Updated: September 2022

www.siho.org | www.mytruadvantage.com

PO Box 1787 | Columbus, IN 47202 | 812.378.7000
PO Box 428 | Columbus, IN 47202 | 844.425.4280

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INTRODUCTION

Welcome to the SIHO and/or MyTruAdvantage Networks. Medical providers are key to the successful delivery of healthcare for participants accessing the SIHO and/or MyTruAdvantage Network. We encourage your active participation in the network(s) and invite your inquiries on operational matters.

Purpose of this Manual

This Manual will acquaint you and your staff with the administration of SIHO's health plans. The manual explains SIHO's administrative policies and procedures as well as providing information on the various health plans and accounts we administer.

We suggest that this manual be kept available for easy reference. This manual is frequently updated, and the most current version is available on our web site at www.siho.org. A MyTruAdvantage provider manual is available on our web site at www.MyTruAdvantage.com.

Overview of SIHO

Southeastern Indiana Health Organization (SIHO) was formed in 1987 as a locally based health benefit program to effectively manage costs while continuing to assure quality medical care.

Overview of MyTruAdvantage

MyTruAdvantage was formed as a locally based Medicare Advantage health plan to effectively manage costs while continuing to assure quality medical care.

MyTruAdvantage has HMO and PPO plans with a Medicare contract. Enrollment in MyTruAdvantage depends on contract renewal.

Health Care Delivery System

SIHO is a provider-sponsored health plan that provides coordinated care to our fully insured and self-funded employer group customers and our MyTruAdvantage (Medicare Advantage) members. A common feature of our plans is working closely with our participating healthcare providers in performing utilization review, case management, and population health management programs.

- Fully Insured (Choice Preferred) plans, Prime Care Choice, Care Plus, HRA, HSA, SIHO Plus and CVS/Caremark Plans: These are managed care products with a traditional set of benefits providing incentives to members to use SIHO participating providers.

- Third party administrator (TPA) for self-funded employer sponsored plans: These plans are administered by SIHO, utilize the SIHO networks (SIHO, SIHO+, and Inspire) and benefits are paid according to the employer's Summary Plan Description (SPD). Each benefit plan is uniquely designed by the employer.

- MyTruAdvantage (Medicare Advantage) Plan: MyTruAdvantage offers HMO and PPO Medicare Advantage plans. Headquartered in Columbus, Indiana, powered by SIHO Insurance Services and owned by local health systems. MyTruAdvantage plans are available in the following cities and surrounding areas: Anderson, Columbus, Evansville, Indianapolis, Seymour, and Terre Haute. Provider directories, preferred drug lists, and more can be found at www.mytruadvantage.com.

Participating Providers

Participating Providers are primary care physicians, specialist physicians, ancillary providers, and facilities who are contracted with SIHO, Inspire Health Partners, SIHO Plus, and MyTruAdvantage networks.

Contact Information

A current provider directory, a preferred drug list, and SIHO's preventive health guidelines are available at www.siho.org. A current provider directory, a preferred drug list, and MyTruAdvantage's preventive health guidelines are available at www.MyTruAdvantage.com.

- SIHO and MyTruAdvantage has web portals that allows you to:
  - verify member eligibility
  - view plan benefit information
  - submit authorizations
  - check claim status

SIHO

Go to www.siho.org and create an account. You can create your own user id and password. If you have questions, contact our Provider Call Center.

MyTruAdvantage

If you have questions, contact our Member Call Center at MemberServices@MyTruAdvantage.com or go to the website at www.MyTruAdvantage.com.

Give us a call at 844-425-4280 (TTY: 711). Hours of operation are 8:00 a.m. – 8:00 p.m., local time, 7 days a week. On Thanksgiving and Christmas Day, and weekends and holidays from April 1 through September 30 alternate technologies (for example, voicemail) will be used and we will return your call within one (1) business day

- Provider Call Center
  For benefits, claims payment issues, multiple claims on the system, and coordination of benefits call:

Fully Insured and TPA	MyTruAdvantage
(800) 443-2980 Toll Free	(844) 425-4280 (TTY: 711) Toll Free

- Provider Services Department
  For: Contracting, credentialing, provider education, quality of care issues, Federal Tax Identification Number changes, fee schedules, contract termination procedures, and provider mailings.

  Email at provider.services@siho.org or Log into Web Portal at www.siho.org
  Fax: (812) 378-7048

- Medical Management Department
  For: Certification for hospital admissions, appropriate outpatient services, inpatient & outpatient mental health services and referral authorizations.

  Log into the Web Portal at www.siho.org
  Columbus (812) 378-7070 Local or (800) 443-2980

  Go to website at www.mytruadvantage.com
  Phone: (812) 348-4576

Email: memberservices@mytruadvantage.com

- Provider Disputes
  SIHO participants have the right to initiate a dispute pertaining to issues of professional competency and/or conduct, quality of care, patient safety, and administrative issues. All these disputes are subject to the participating network agreement between the contracted provider and SIHO Network, LLC.

  Providers can send all written disputes to:

  SIHO Fully Insured and TPA
  Attn: Provider Dispute
  PO Box 1787
  Columbus, IN 47202-1787

  MyTruAdvantage
  Attn: Provider Dispute
  PO Box 428
  Columbus, IN 47202-0428

ADMINISTRATIVE PROCEDURES

Overview

Section II of this manual details SIHO's administrative procedures. The information provided describes claims processing, member billing, SIHO's responsibilities and provider obligations.

Confidentiality

SIHO employees, in accordance with HIPAA, HITECH and other applicable laws, will maintain the privacy and confidentiality of its providers and members. SIHO acknowledges the importance of maintaining the privacy and confidentiality of provider information, peer review material, facility, and member information and documents associated with carrying out healthcare activities (verbal and/or written) and therefore, they will be kept confidential and comply with state and federal laws and regulations.

SIHO and MyTruAdvantage providers must comply with all State and Federal laws concerning confidentiality of PHI (Protected Health Information) about members. Providers must have policies and procedures in place for use and disclosure of PHI that comply with applicable laws.

Non-discrimination

Providers must have policies and procedures in place to ensure that covered services are provided to members regardless of member's race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion, national origin, cultural or educational background, economic or health status, and/or source of payment for care. Providers must also comply with the provisions of the Civil Rights Act, Age Discrimination Act, Rehabilitation Act of 1973, Americans with Disabilities Act, and the Genetic Information nondiscrimination Act of 2008.

Provider Responsibilities

Provider responsibilities include but are not limited to:

- Notifying SIHO of changes in name, phone number, address, panel status, languages spoken by physician, board certification, licenses, specialty, TIN or NPI changes, liability insurance and/or any other issue that could affect his or her ability to render medical care
- Maintaining centralized medical records for applicable members
- Meeting SIHO's credentialing/re-credentialing requirements

- Following SIHO's Utilization Management/Quality Improvement guidelines
- PCP -Providing primary care services to members
- PCP - Coordinating all aspects of members' health care
- PCP -Maintain procedures to inform members of follow-up care or provide training in selfcare as necessary

Additional provider responsibilities can be found in the Primary Care and Specialist Physicians sections of this manual.

Eligibility and Benefits

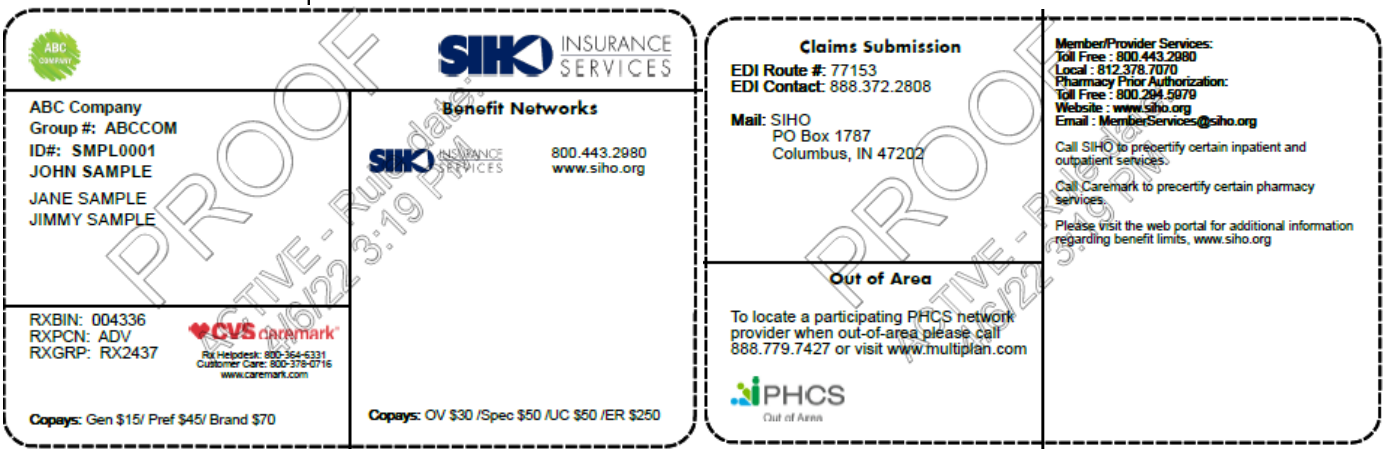
Member Identification

SIHO and MyTruAdvantage reimburses providers only for medically necessary covered services rendered to eligible members. A member ID Card does not guarantee member eligibility.

Member ID Card

Each covered member receives an ID card with the SIHO or MyTruAdvantage (Medicare Advantage) logo. Members are responsible for carrying their ID cards with them at all times. To receive benefits, members are to present these cards to their health care provider when they obtain medical services.

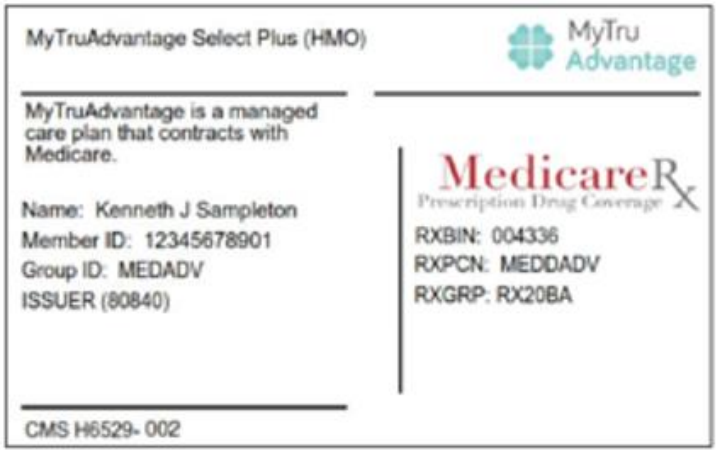
TPA and FI member sample ID Card



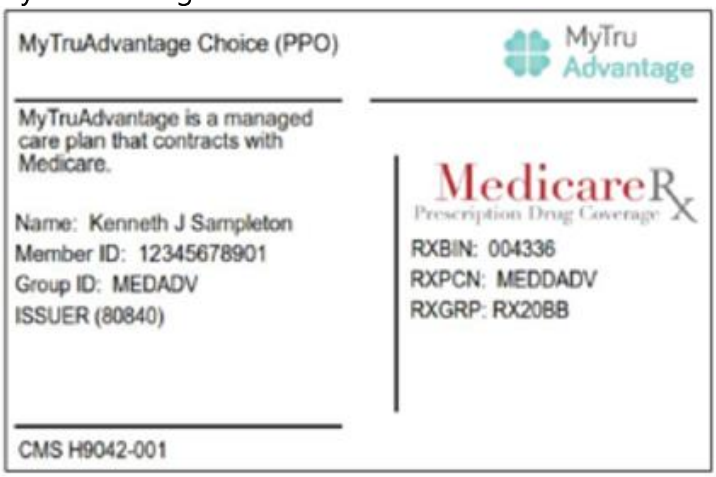
MyTruAdvantage member sample ID Card

MyTruAdvantage Select HMO

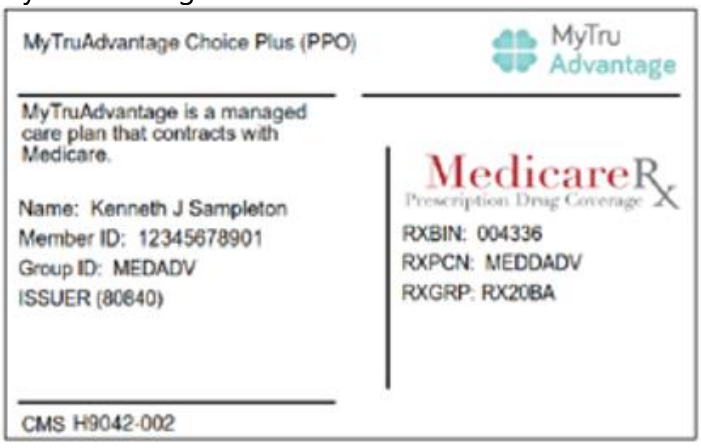
MyTruAdvantage Select Plus HMO



MyTruAdvantage Choice PPO



MyTruAdvantage Choice Plus PPO



Covered Benefits

- SIHO Members: If there is a question as to whether the service or care is a covered/limited benefit, visit the SIHO web site at www.siho.org or call our Call Center.

- MyTruAdvantage Members: All services must be medically necessary and covered by the beneficiary's contract to be paid by MyTruAdvantage. MyTruAdvantage determines whether services are medically necessary as defined by the beneficiary's Evidence of Coverage (EOC). For both HMO and PPO plans, certain

procedures, services, and drugs may need "prior authorization" or "preauthorization" from MyTruAdvantage. To verify covered or excluded services, or services requiring prior authorization, please see the MyTruAdvantage Summary of Benefits and Prior Authorization list on www.MyTruAdvantage.com or call MyTruAdvantage Member Services at the number listed on the back of the patient's MyTruAdvantage ID card. All services are subject to applicable copayments, deductibles, and coinsurance.

- With the MyTruAdvantage Select (HMO) and MyTruAdvantage Select Plus (HMO) plans, beneficiaries select a primary care physician (PCP) to coordinate all their health care services. The PCPs are beneficiaries' partner in helping them stay healthy and proactively managing their health. PCPs also help arrange or coordinate beneficiary services, including consulting with other providers about their care.

- With the MyTruAdvantage Choice (PPO) and MyTruAdvantage Choice Plus (PPO) plans, beneficiaries can receive care not only from network providers, but may receive covered services from out of network providers as well.

Member Rights and Responsibilities

SIHO and MyTruAdvantage members have the right to timely and high-quality care and to be treated with respect and dignity. Participating providers must respect the rights of all members.

Member Rights

- To be treated with dignity and respect and right to personal privacy recognized
- To have information about their diagnosis, treatment, and prognosis so they can have candid discussions with providers about appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage and actively participate in decisions regarding their health and medical care
- To have timely access to their PCP, and if out of service area, receive emergency care, if necessary
- To have medical records kept confidential (except when disclosure is required by law or permitted by patient in writing) and have access to copies or request amendments to their medical records in accordance with HIPAA regulations
- To extend their rights to a guardian, next of kin or legally authorized person on their behalf
- To be advised of the probable consequences of their actions when they refuse treatment or leave a medical facility against the advice of their providers
- To receive information about the organization, its providers and services and your rights
- To exercise these rights regardless of member's race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion, or national origin, cultural or educational background, economic or health status, and/or source of payment for care

Member Responsibilities

- To be familiar with their plan and benefits and any rules that may apply
- To inform providers (to extent possible) of the information they may need to provide care and to follow treatment plans and instructions that the member and their provider have agreed upon
- To ask any questions they may have of their provider

Special Requirement for Hospitals – MyTruAdvantage (Medicare Advantage) members

- Hospital Discharge rights for Medicare Advantage members: The Centers for Medicare & Medicaid Services (CMS) requires that hospitals deliver the Important Message from Medicare (IM), CMS-R-193, to all Medicare

members, including Medicare Advantage members who are hospital inpatients. Hospitals are required to provide the IM to MyTruAdvantage members upon admission and at least two days prior to the anticipated last covered date. The notice must be given on the standardized CMS IM form.

- Medicare Outpatient Observation Notice (MOON): Medicare requires hospitals and critical access hospitals (CAHs) to provide the Medicare Outpatient Observation Notice (MOON) to Original Medicare members and MyTruAdvantage (Medicare Advantage) members or their authorized representatives. This includes members who do not have Part B coverage, members who are subsequently admitted as an inpatient prior to the required delivery of the MOON and member for whom Medicare is the primary or secondary payer. The MOON is intended to inform members who receive observation services for more than 24 hours that they are outpatients, not inpatients, and the reasons for their status.

Billing Members

Participating providers may NOT seek payment directly from the member, except for required copayments, deductibles, coinsurance, elective services, and non-covered services. Providers are reimbursed per their provider agreement and may not balance bill members.

Members that are dually eligible, either as full benefit dual eligible or as part of a Medicare Saving Program, are protected from liability of Medicare premiums, deductible, coinsurance, and copay amounts. This includes cost share being applied to this/these claims. Providers may not bill a dual eligible member that has this coverage for any balance left unpaid (after submission to Medicare, a Medicare carrier and subsequently Medicaid) as specified in the Balanced Budget Act of 1997. Providers that service dual eligible members must accept as payment in full the amounts paid by Medicare as well as any payment under the state Medicaid guidelines. Providers who balance bill the dual eligible member are in violation of these regulations and are subject to sanctions. Providers also may not accept dual eligible members as "private pay" to bill the patient directly. Providers identified as continuing to bill dual eligible members inappropriately will be reported to CMS for further investigation.

Members may not be billed for services provided that are denied due to CCI edits** or the provider's failure to file a timely claim, submit a complete clean claim, respond to requested information, or comply with policy and procedures as required by the provider's agreement with MyTruAdvantage.

Members can be billed for non-covered services but must be made aware of their financial obligation prior to the service being rendered.

**The National Correct Coding Initiative (NCCI, or more commonly, CCI) is an automated edit system to control specific Current Procedural Terminology (CPT) code pairs that can be reported on the same day. The purpose of the CCI edits is to prevent improper payment when incorrect code combinations are reported.

Claims submitted by mail should be addressed to:

Fully Insured and TPA
PO Box 1787
Columbus, IN 47202-1787

MyTruAdvantage
PO Box 428
Columbus, IN 47202-0428

Claim Code Editing

For most commercial providers and networks, SIHO uses Change Healthcare's ClaimsXten™ claim editing software to apply code editing rules to medical claims.

The rule editing logic considers AMA/CPT coding guidelines, national specialty and academy guidelines, the Centers for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (NCCI) coding guidelines, and input from Change Healthcare's medical review board.

Change Healthcare releases quarterly data file updates to support the rule editing logic. These updates reflect additions and/or revisions to CPT/HCPCS codes and modifiers, procedure-to-procedure edits, add-on codes, and Medically Unlikely Edits (MUE) limits, among others. Critical updates are loaded immediately as needed.

Providers are responsible for accurately reporting services with the correct CPT and/or HCPCS codes and for appending applicable modifiers, when appropriate. Codes and modifiers must be active for the date of service and describe the services provided during the encounter. Providers should be familiar with AMA/CPT coding instructions as well as CMS code editing logic and submit claims that comply with existing guidelines.

Code Editing Logic

Claim codes may deny or adjust when:

- A procedure code is inconsistent with a member's age or gender
- A procedure code/modifier combination is invalid
- A procedure code is unlisted and no description is included on the claim
- An "add-on" procedure code is submitted without a primary procedure code
- An Assistant Surgeon, Co-Surgeon, or Team Surgeon modifier is submitted with a procedure code that does not typically require it
- A procedure code is incidental, mutually exclusive, or a component of another code submitted for the same member, on the same day, by the same provider *
- A single, more comprehensive procedure code exists for multiple submitted procedure codes
- An E&M (Evaluation and Management) procedure code or global procedure code is submitted by the same provider within a procedure's pre- or post-operative period
- An E&M (Evaluation and Management) procedure code or global procedure code is submitted by the same provider on the same date of service as a code with a global period (e.g., maternity or some surgeries)
- A procedure code's units exceed the code's Medically Unlikely Edit (MUE) limit
- Multiple surgery procedure codes are submitted for the same member, by the same provider, on the same date of service (payment reduction applied)

* Depending on the individual editing rule, provider matching may be based on rendering provider, billing provider NPI, or provider Tax ID number.

Electronic Claims Submission

SIHO encourages and accepts electronic claims using Payer ID # 77153 for Fully Insured and TPA groups. Payer ID # MTAMA is used for MyTruAdvantage (Medicare Advantage). For quicker claims payment and processing, please submit claims electronically.

Not using a clearinghouse?

If your billing system has the necessary functionality you may be able to submit claims directly to SIHO.

- Your system must be able to generate an ASC X12N 837 (005010X222A1/005010X223A2) file.
- Your system must be able to split claims by payer so that we only receive claims for SIHO customers.
- Your system must be able to submit both Individual and Group NPI numbers.

Clean Claim Submission

A clean claim is a claim that has all fields required by CMS for both 1500 and UB 04 claim forms completed. A claim will not be considered clean if it is missing any of the required fields or attachments required to adjudicate the claim. To be considered "clean," a claim must meet the following criteria:

- HIPAA compliant
- EDI compliant format
- Have all required fields completed
    - National provider identifier (NPI) numbers
        - Paper Claims: Box/field 24j displays the rendering provider (Individual NPI); box/field 33a displays the billing provider location (Group NPI)
        - Electronic Transactions: NM1 *85 segment contains the Group NPI; MN1 *82 segment contains the Individual NPI
    - Provider's name and NPI
    - Provider's federal tax identification number (TIN)
    - Vendor name and address
    - Member's full name, date of birth, and ID number
    - Date of service
    - Valid diagnosis code(s)
    - Valid procedure codes(s) and modifier code(s), if applicable
    - Valid place of service
    - Charge information and units
    - National Drug Codes, when applicable
- Not require further investigation by the plan
- Be received within the timely filing period (varies depending on group or plan) please call SIHO Member Services for group and plan specific instructions. MyTruAdvantage timely filing limit is one (1) year from date of service.
- Have all information necessary to adjudicate a claim including any necessary supporting documentation (primary carrier explanation of benefits (EOB), medical records, etc.)

If a claim does not meet all the criteria listed above, the statutory period for processing will not apply. In some cases, if the information is incomplete or incorrect, we will be required to return the claim with a cover letter that will include what is necessary to process the claim.

Resubmitting Claims

Prior to resubmitting a claim, check the claim's status through the SIHO website or call the SIHO Call Center. The provider should only resubmit the claim if one of the following is not received within 30 days:

- Payment
- Remittance advice
- Letter requesting additional information
- Any other form of notification from SIHO regarding the status of a submitted claim

Submitting a Corrected Claim

- HCFA 1500- Indicate "Corrected Claim Submission" on the claim or provide a cover letter to indicate the claim is a revision of a previous submission.
- UB 04—Indicate the appropriate bill type on the claim.

Payment Listing—Remittance Advice

The SIHO Remittance Advice form explains the payment or denial on each claim that was submitted by the provider and processed by SIHO.

Fraud, Waste & Abuse

SIHO and MyTruAdvantage are dedicated to the detection, prevention, and correction of potential healthcare Fraud, Waste, and Abuse ("FWA"). Our FWA Program was developed in accordance with the following Federal and State statutes, regulations, and guidelines:

- Applicable State laws and contractual requirements
- Civil False Claims Act, 31 U.S.C. §§3729-3733
- Criminal False Claims Act, 18 U.S.C. §287
- Anti-Kickback Statute, 42 U.S.C. §1320a-7b
- 42 C.F.R. 422 and 423
- Regulatory guidance produced by the Centers for Medicare and Medicaid Services (CMS), including requirements in Chapter 9 of the Medicare Prescription Drug Benefit Manual and Chapter 21 of the Medicare Managed Care Manual.

The FWA Program has been developed to comply with all standards set forth by the regulations and laws of the United States Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS). The FWA Program and the FWA Program Description are reviewed periodically by MyTruAdvantage's Compliance Committee with revisions made as needed.

Definitions:

- Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

- Waste is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

- Abuse includes actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically necessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other facts.

Examples of Fraud, Waste, and Abuse

Please report fraud, waste, and abuse if you see it. There are many examples of fraud, waste, and abuse. Some examples are below.

- A provider charges MyTruAdvantage for services it did not provide.
- A provider offers a MyTruAdvantage member money or kickbacks to use their services.
- A MyTruAdvantage member lends an ID card to someone else.

- A MyTruAdvantage member sells drugs they were prescribed or forges a prescription.
- A provider performs medically unnecessary services to receive payment from MyTruAdvantage.

FWA Hotline

MyTruAdvantage accommodates anonymous, confidential, and private, good faith reporting of instances of suspected FWA. MyTruAdvantage maintains confidential reporting mechanisms that individuals can use to report suspected FWA. MyTruAdvantage's FWA Hotline is available 24/7.

To report an issue by telephone, call toll-free at 844-255-7120.

Coordination of Benefits (COB)

Coordination of benefits is a provision in an insurance plan that guarantees each responsible insurer (when a patient is covered under more than one plan) pays only its own portion of claims and prevents double recovery of claims.

Coordination of benefits also designates the order in which multiple carriers pay benefits. The following is a list of definitions used when coordinating benefits. Note that self-funded employer sponsored plans may have specific rules for their member benefit plan. The listed definitions are standard industry guidelines.

Fully Insured and TPA

- Birthday Rule
  - The Birthday Rule is a guideline used by SIHO to identify the primary and secondary benefit plan for a child of parents who are not divorced or separated.
  - This guideline as established by the National Association of Insurance Commissioners (NAIC) defines the benefit plan of the parent whose birthday falls earlier within a calendar year (month and day) as the child's primary benefit plan. The child's secondary coverage is determined by the benefit plan of the parent whose birthday falls later in the year. For example: if the mother of the child has a birth date of 5/17 and the father of the child has a birth date of 8/21, the primary benefit plan for the child is the mothers. The secondary coverage is the fathers.
- Medicaid
  - The Medicaid Medical Assistance Program (Title XIX of the Social Security Act) provides matching funds to states to help provide medical care and services for the lower income persons. Once Medicaid has been billed, the provider must accept the reimbursement rate as payment in full and cannot bill the recipient or an insurer for the balance.
- Medicare
  - Medicare is the Federal Health Insurance Program (Title XVIII of the Social Security Act) for people aged 65 years and older and those with certain disabilities. Medicare is composed of two parts: Part A (Hospital Inpatient Insurance) and part B (Hospital Outpatient and Medical Insurance).
- SIHO Primary
  - SIHO Primary means the member's first source of insurance coverage is his/her SIHO health plan. Primary coverage is determined by the SIHO Coordination of Benefits specialist.
- SIHO Secondary
  - SIHO Secondary means the member has other health insurance, which is considered before SIHO coverage.
- Standard COB
  - Standard COB means SIHO processes the balance on the claim after the Primary's benefit has paid. Charges paid will not exceed what SIHO would have paid if primary.
- Benefit less Benefit COB

- Benefit less Benefit COB means SIHO processes the claim using the member's SIHO benefit and then subtracts their primary benefit. If the primary carrier's benefit is greater than or equal to the SIHO benefit, no excess payment will be made. If the primary carrier's payment is less than the SIHO payment, then additional payment may be made based on the eligible amount and the plan design.

- MyTruAdvantage (Medicare Advantage)
  - Retiree with
    - Retiree insurance (insurance from former employment) – Medicare pays first
  - 65 or older who have
    - Group health plan coverage based on their or their spouse's current employment, and the employer has *20 or more employees* – The group health plan pays first
    - Group health plan coverage based on their or their spouse's current employment, and the employer has *less than 20 employees* – Medicare pays first
  - Under 65 and Disabled who have
    - Group health plan coverage based on their or their family member's current employment, and the employer has *100 or more employees* – The group health plan pay first
    - Group health plan coverage based on their or their family member's current employment, and the employer has *less than 100 employees* – Medicare pays first
  - End-Stage Renal Disease (ESRD)
    - If a patient has Medicare because of End-Stage Renal Disease (ESRD – permanent kidney failure requiring dialysis or a kidney transplant) – The group health plan will pay first for the first 30 months after you become eligible to join Medicare. Medicare will pay first after this 30-month period.

Appeals

A provider or facility may initiate an inquiry of issues related to the pricing or reimbursement of covered services as priced and outlined in the contract.

For any issues related to adverse benefit determinations per the member's summary plan description and any other applicable rules/laws, contracted providers may submit an appeal to the address listed below.

For MyTruAdvantage (Medicare Advantage), non-contracted providers are permitted to file a standard appeal for a denied claim only if the non-contracted provider completes a waiver of liability statement, which provides that the non-contracted provider will not bill the member regardless of the outcome of the appeal. These non-contracted providers who have completed the waiver of liability form are not required to complete the Appointment of Representative form since they are not representing the member.

A written appeal of a contractual issue on behalf of the provider or facility may be submitted to the Appeals Coordinator at the address identified in the "Provider Disputes" information located on page 5. A response to such an appeal will be issued to the provider within the timeframe allotted within the member's plan.

Both contracted and non-contracted providers or facilities shall submit all documentation that supports the details described in their appeal request.
Appropriate medical and non-medical staff will consider initial appeals. If the decision rendered by the reviewing party is unsatisfactory to the provider or facility acting on behalf of the member, in certain situations, the provider or

facility may request in writing a second level, or External Review, appeal. For MyTruAdvantage members, the case file will automatically be sent to a second level reviewing party by SIHO.

Providers can submit all appeals to:

SIHO Fully Insured and TPA
Attn: Appeals
P.O. Box 1787
Columbus, IN 47202-1787

MyTruAdvantage
Attn: Appeals
P.O. Box 428
Columbus, IN 47202-0428

Complaints

SIHO recognizes that providers may encounter situations in which our operation does not meet their expectations. When this happens, the provider is encouraged to contact SIHO. SIHO will promptly consider all complaints by its providers.

Complaints are classified by SIHO into three categories:

- Administrative complaints: such as claim payment issues, balance billing, benefit applications, etc.
- Medical complaints: such as denial of a referral, denial of certification.
- Quality of Care complaints: such as appropriateness of care, continuity of care or refusal of care.

The Medical Management Department addresses medical complaints. The Quality Improvement Department evaluates and resolves quality of care complaints. Administrative complaints are routed to the appropriate department. Complaints are resolved in a timely manner at the department level.

If the resolution of a complaint is unsatisfactory to the provider, he/she may file a written appeal. The written appeal should state the reason(s) for the provider's dissatisfaction with the original decision. Any additional information the provider wishes to have considered should be submitted with the written appeal.

Credentialing and Recredentialing of Providers

Credentialing

SIHO credentials contracted providers to verify their professional qualifications. SIHO uses CAQH (Council for Affordable Quality Healthcare) for all credentialing activities. New providers joining the SIHO Network should complete the CAQH application online to begin the credentialing process. The CAQH DataSource is free and offers a fast and easy way for providers to securely submit their credentialing information to health plans and networks.

If you are adding a physician to your practice, contact our Provider Call Center at 800-443-2980 or by email at provider.services@siho.org.

Once the application has been received, our staff completes the Primary Source Verification process to verify education, licensing, and board certification where applicable. Incorrect or incomplete applications must be corrected within 15 days. Applications are reviewed and approved by SIHO's Quality Improvement Committee before the provider is deemed in-network. Completed applications are credentialed within 90-180 days of receipt and notified of final approval/disapproval within 10 days of determination. SIHO ensures the confidentiality of credentialing information.

Recredentialing

SIHO may recredential any participating provider within the scope of the network as often as every three years or otherwise required. Approximately 3-6 months before the recredentialing date, the application is obtained from CAQH, and we will contact the office if additional information is required. Recredentialing is similar to the initial credentialing process as the standard CAQH application will be reviewed. Providers will be notified of any discrepancies between recredentialing applications and SIHO's review of the information allowing them a chance to submit additional materials to resolve any issues. All recredentialing application are reviewed and approved by SIHO's Quality Improvement Committee. Providers who fail to submit required credentialing documents in a timely manner may be terminated from the network and no longer eligible to see members.

SIHO monitors participating providers and reserves the right to terminate or suspend a provider from the network. Monitoring can include, but is not limited to, reviewing Medicare or Medicaid sanctions, limitations on licensures, member complaints and information regarding adverse events or quality issues.

Appeals process

An appeals process is available to providers in the event he/she should be denied participation, suspended, or terminated from our network due to a credentialing review or quality issues. At the time of notice of an adverse credentialing/recredentialing decision, the provider will be notified of appeal rights and procedures, including but not limited to:

- Provider may request a hearing and the specific time for submitting the request
- Allow 30 calendar days after the notification for provider to request a hearing
- Allow provider to be represented by an attorney or another person of his/her choice
- Allow a hearing officer or a panel of individuals to review the appeal
- Written notification of the appeal decision that contains specific reasons for the decision

Except for the following reasons, termination from the network will not occur until the appeals process is exhausted by the provider or the provider chooses not to appeal in the required time period. In addition to the termination provisions contained in the provider's contract, providers are terminated immediately from SIHO's network for any of the following confirmed reasons:

- Loss or surrender of license
- Loss of sufficient liability coverage
- Exclusion or suspension from Medicare or Medicaid program

SIHO Insurance Services is responsible for reporting provider quality deficiencies that affect network participation to the appropriate state and/or federal organizations. Reportable deficiencies may be related to professional competence or conduct as well as quality of care.

If you have questions about credentialing, please contact our Provider Relations Department:

- Email at provider.services@siho.org
- Provider Portal at www.siho.org
- Provider Call Center at 800-443-2980

Primary Care Physicians

Overview

SIHO Primary Care Physicians are defined as physicians who specialize in Family Practice, General Practice, General Internal Medicine, Geriatrics, and General Pediatrics. SIHO's MyTruAdvantage plans require members to select a Primary Care Physician and some SIHO Fully Insured and TPA plans also require members to select a Primary Care Physician.

The Primary Care Physician provides, coordinates, or is aware of all aspects of the member's health care and history. Primary care physicians shall not discriminate or differentiate in the treatment of members based on race, color, gender, age, religion, national origin, health status, or source of payment.

Responsibilities

The responsibilities of the primary physician include:

- Providing primary care services to members
- Maintaining centralized medical records for applicable members
- Coordinating all aspects of members' health care
- For some SIHO plans, make referrals to appropriate participating providers, ancillary services, and facilities
- Providing 24-hour coverage with appropriate call coverage arrangements to ensure that health care services are available to members in the primary care physician's absence
- Meeting SIHO's credentialing/re-credentialing requirements
- Following SIHO's Utilization Management/Quality Improvement guidelines and adhering to its policies and procedures
- Notifying SIHO of changes in name, phone number, address, panel status, languages spoken by physician, board certification, licenses, specialty, TIN or NPI changes, liability insurance and/or any other issue that could affect his or her ability to render medical care
- Participating in and supporting SIHO's products, procedures, and other delivery system requirements
- Maintain procedures to inform members of follow-up care or provide training in selfcare as necessary
- Contributing to SIHO's improvement and accomplishment of its goals and mission by voice, written word, and committee involvement in a cooperative, collaborative manner

Panel Status

Unless otherwise notified, SIHO will consider the practice to have an open panel status. If at any time, the practice no longer accepts new patients, please contact SIHO to have the panel status updated.

Appointment Standards

Providers should make their best efforts to accommodate members and provide service as quickly as possible. At a minimum, providers should adhere to the following standards:

Waiting time for adult well appointment	4-6 weeks
Waiting time for child well appointment	3-4 weeks
Waiting time for semi-urgent care visits	2-3 days
Waiting time for urgent care visits	Same day
Waiting time for new obstetrical appointment	1 month

Average waiting time to see physician from appointment time	30 minutes or less

On-Call Requirement/Covering Physicians

Primary care services must be available to SIHO members 24 hours a day, 7 days a week. When the primary care physician is unavailable, it is his or her responsibility to arrange coverage for SIHO members. The covering physician should report calls and services to the member's primary physician.

Covering physicians, whether participating or not, must adhere to all administrative requirements and agree not to bill the member for services other than the copay, deductible, coinsurance or to the extent as defined in the member's benefit plan. It is the physician's responsibility to explain SIHO's applicable billing, referral, and certification requirements to the covering physician.

When a covering physician sends a claim to SIHO, covered services will be reimbursed at the rate contracted with the primary care physician at the time the services were rendered.

Specialist Physicians

Overview

This section discusses the responsibilities of the SIHO Specialist Physician.

Responsibilities

Contact with the primary care physician should be maintained throughout the Specialist Physician's treatment of the member. In some SIHO products, such communication is required.

Specialists are responsible for the following:

- Meeting SIHO's credentialing/re-credentialing requirements
- Following SIHO's Utilization Management/Quality Improvement guidelines and adhering to its policies and procedures
- Notifying SIHO of changes in name, phone number, address, panel status, languages spoken by physician, board certification, licenses, specialty, TIN or NPI changes, liability insurance and/or any other issue that could affect his or her ability to render medical care
- Participating in and supporting SIHO's products, procedures, and other delivery system requirement
- Maintain procedures to inform members of follow-up care or provide training in selfcare as necessary
- Contributing to SIHO's improvement and accomplishment of its goals and mission by written word and committee involvement in a cooperative, collaborative manner

Panel Status

Unless otherwise notified, SIHO will consider the practice to have an open panel status. If at any time, the practice no longer accepts new patients, please contact SIHO to have the panel status updated.

Facilities

Overview

Facility is defined as a party which includes any persons employed by such facility and any persons or entities that provide Covered Services to Covered Persons under such facility's tax identification number. The term includes affiliates of any Facility that provide Covered Services to Covered Persons which may have a unique tax identification number, but which the Facility either owns or controls.

Responsibilities

Facility will provide services in accordance with the terms of the contractual Agreement. Facility will notify SIHO of changes in name, phone number, address, licenses, specialty, TIN or NPI changes, liability insurance and/or any other issue that could affect rendering medical care to our patients.

Work Stoppage

In the event of a work stoppage at Facility, Network agrees to work with the Participating Providers to defer elective admissions, and Facility agrees to cooperate with Network in using its best efforts to provide continuity of care to Covered Persons who have been admitted until normalization of operations at Facility

Disaster or epidemic

In the event of any major disaster or epidemic, Facility agrees to render COVERED SERVICES insofar as practical according to its best judgment, within the limitations of those facilities and personnel which are available.

Medical Management

Overview

The purpose of the Medical Management Program (MMP) is to ensure that members receive the clinically necessary and appropriate care (including frequency of service and duration) in the right setting; the care is cost effective; and the care results in improved functional, clinical and financial outcome, all while following the client specific summary plan document, and local, state and federal guidelines.

Managed Care responsibilities include, but are not limited to, precertification, referral, determination of medical necessity, steerage to in-network services, evaluation of protocol compliance and Case Management.

Precertification Guidelines

Precertification ensures that a high quality, cost effective and medically necessary method of treatment has been selected for a member's illness. In most cases, Precertification occurs prior to services being rendered, but retro authorizations are also processed when a prior authorization is not an option.

Important Note:

The following services require Precertification for most of SIHO's health plans:

- Inpatient Admission

- Outpatient Mental Illness or Disorder, or Substance Abuse Treatment
- Durable Medical Equipment purchase more than $1000
- Rental of all Durable Medical Equipment
- Home Health Care
- Hospice Care
- Selected Outpatient Surgical Procedures Physical, Speech, Occupational Therapy
- Genetic Testing
- Chemo, radiation, PET scan
- Renal Dialysis
- Transplants

Precertification needs are plan specific. Contact the provider call center for specific requirements. MyTruAdvantage pre-certification requirements are listed at www.mytruadvantage.com.

To obtain Precertification, the Covered Person or the Physician must provide SIHO's Medical Management Department with the appropriate medical information prior to obtaining the proposed services. Please go to www.siho.org or www.mytruadvantage.com and visit the "provider" tab for authorization forms. You may also choose to submit a pre-certification directly online utilizing the provider portal.

Generally, if a SIHO Network Physician is seen, he/she will obtain the necessary Precertification from SIHO. The required information may be sent to:

SIHO Fully Insured and TPA
P.O. Box 1787
Columbus, IN 47202-1787

Fax: (812) 378-7054 (SIHO)

MyTruAdvantage
P.O. Box 428
Columbus, IN 47202-0428

Fax: (317) 860-3624 (MyTruAdvantage)

For services requiring pre-certification: Information must be received by SIHO as soon as possible, prior to services being received. In the case of an emergency admission the Covered Person, or someone acting on his/her behalf, must provide the appropriate information to SIHO within forty-eight (48) hours of the event, or as soon as the Covered Person's medical condition permits.

If pre-certification is not obtained, a penalty may be applied if the service is covered at all. Providers are ultimately responsible for obtaining pre-certification for services, though a member submission of authorization request is permissible. If the admission, service, or equipment requiring pre-certification is not approved, the member or the physician may request another review of the case. Upon presentation of *new* evidence of extraordinary circumstances or justifying medical cause, SIHO may certify service which is justified upon second review.

Failure to recertify *continued* services (concurrent review) will cause claims to be denied and no payment will be made. If this occurs, providers may submit medical documentation supporting the need for the continued services to SIHO. If appropriate, claims may be reopened and processed according to the member's benefit plan.

Precertification does not guarantee either payment of benefits or the amount of benefits.

Written Orders

Durable Medical Equipment, Speech, Occupational, and Physical Therapy, Home Care, and all medications require submission of a written order with the supporting clinical documents for review for precertification.

SIHO's definition of Durable Medical Equipment is equipment that can withstand repeated use, is generally not useful to a person in the absence of sickness or injury and is appropriate for use in the home. Durable Medical Equipment must serve a medical need and not be considered items of convenience.

Out of Network Authorizations

Members who wish to use non-network providers may be subject to higher cost-share including deductibles and out of pocket expenses. SIHO and MyTruAdvantage offer both HMO and PPO plans and certain network designs are established based on the type. SIHO Medical Management reviews requests from members and providers for services provided out of network that are asked to be paid at the in-network benefit level. This is subject to scrutiny of medical necessity and ability for care to be provided in the primary network. If services are available in-network, SIHO may deny coverage at a higher benefit level.

Case Management

The Plan provides for special handling of catastrophic and long-term care cases. This feature is designed to assure that care is provided in the most appropriate and cost-effective care setting. Case Management is a cooperative effort between the member, the Physician, the member's family, and SIHO. It also allows SIHO to customize benefits by approving otherwise non-covered services or arranging an earlier discharge from an inpatient setting for a patient whose care should be safely rendered in an alternate setting. SIHO Nurse Case Managers work to reach out to members after discharge from the inpatient setting based on specific screening criteria. Your involvement as a provider is extremely valuable to their efforts. Often, they rely on your records to update their own care plans. They will also reach out to your office to communicate care plan goals to collaborate on assisting the member with meeting their goals. You may see letters written to your office highlighting a mutual patient's SIHO Case Management care plan. Please call the Case Manager if you have any questions.

Disease Management

Members with a chronic illness such as heart disease or diabetes account for a very high proportion of healthcare dollars and services Opting into the disease management program allows the plan to provide a focused effort of resources into the management and education of the member in programs designed to improve their health and reduce costly and tragic complications associated with their chronic illnesses.

If a member has an illness that falls into one of SIHO's Disease Management Programs, the member may receive specialized educational materials regarding this illness from time to time. A member may be contacted by mail, telephone, or electronic means to participate in meetings or programs designed to improve their health. SIHO may use one or more of its Business Associates to perform these functions. To the extent permitted by law, a listing of names, addresses and phone numbers may be shared with SIHO's Business Associates. These lists will be maintained with the strictest of confidentiality as required by law and will not be used or sold with the intent of solicitations or for any purpose outside the scope of Disease Management.

Additionally, SIHO will collaborate with the provider network to maximize in their initiatives toward disease management as much as possible. Recognizing that maintaining rising risk of the member population is of utmost importance, Disease Management is a cooperative effort.

Denials and Appeals

- In the event a medical service is not approved, the process requires that the member is notified in a timely manner of the reason for the denial

- A member whose referral or certification request is not approved has the right to appeal such adverse determination in accordance with SIHO's appeal procedure.

SIHO's criteria or guidelines include but are not limited to:

- InterQual– we use these guidelines to help make decisions on allocation of services based on members' medical conditions. They are nationally recognized and evidence based.
- NCCN – National Comprehensive Cancer Network – these are nationally recognized recommendations for the care of cancer. These are treatment plans for services of cancer by site along with supportive cancer treatment care and principles of adjuvant care such as monitoring, imaging, etc. Many oncology practices utilize NCCN to guide their prescribing.
- FDA – We focus on ensuring services and therapies are certified by the FDA if they are new to the market or not common to certain diagnoses – FDA approval and "non-experimental" is often a requirement per SPD on most groups
- Center for Medicare and Medicaid Services (CMS) – If coverage for a certain service is indeterminable based on guidelines or available criteria, sometimes we turn to the Center for Medicare and Medicaid Services to see if coverage is provided as a guide to assist in our final decision-making
- CDC and US Preventative Services Task Force – These entities guide preventative health benefits and/or coverage for similar services
- SIHO Clinical Guidelines – Established by the SIHO Medical Management staff, validated by the Quality Management Committee; for services with little to no formalized criteria from the entities above, or for services with SIHO-specific limitations

Review criteria are available onsite and when permitted by license, will be distributed on request. Criteria is reviewed regularly to ensure that the most recent versions are being utilized and are approved.

Quality Improvement Program

Overview

The Southeastern Indiana Health Organization (SIHO) Quality Improvement Program (QIP) strives to improve the quality of health care and administrative services offered to members, physicians, and employers. It does so through the establishment of a formal process and an infrastructure for continuously monitoring, evaluating, and improving the health care and administrative services provided under all managed medical products. SIHO places great emphasis on the QI process because it is the organization's desire to assure that the quality of clinical and administrative services provided to SIHO members is continuously improving.

Quality Improvement Committee (QIC)

The committee is comprised of SIHO Medical Directors, Network Physicians, and SIHO leadership. Functions of the QIC include but are not limited to:

- Oversight of SIHO quality management activities, with recommendations for improvement, as appropriate.
- Systematic, ongoing monitoring and evaluation processes to identify opportunities for improvement.
- Establishment of medical policy.
- Maintenance of disease management protocols.
- Oversight and approval of credentialing and recredentialing activities.

Medical Record Guidelines

SIHO's medical record guidelines were developed and approved through the Quality Improvement Committee. The goal of these guidelines is to improve the quality of documentation in medical records. SIHO requires that individual medical records be maintained for each member according to accepted professional guidelines, which include that records are current, dated and have the provider's signature.

All information in the medical record and information received from physicians, practitioners and health facilities must be kept confidential.

Each office must have established policies to assure that the medical records are complete, promptly filed and safely retained in accordance with acceptable professional practices and state statutes. SIHO expects that patient confidentiality will be practiced by every provider.

General Guidelines

Medical record documentation must include the following:

- Patient's name and ID #
- Patient's biographical data
- Allergies or absence of allergies noted
- Significant illnesses and medical conditions are indicated on a problem list.
- Past medical history is identified and includes serious accidents, operations, and illnesses.
- The history and physical examination documents appropriate subjective and objective information for the presenting complaints.
- Documentation of informed consent for applicable procedures or treatment where appropriate.

All entries should be:

- In ink or EHR
- Legible
- Signed
- Dated

Each visit must be documented in the medical record to support the diagnosis and to justify the treatment.

Documentation for a visit should include the following:

- Date of visit
- Chief complaint or purpose of the visit
- Pertinent vital signs
- Objective findings
- Diagnosis or clinical impression
- Studies ordered, such as laboratory or x-ray procedures
- Therapies administered
- Disposition, recommendations, and instructions to members
- Referrals to specialists or therapy practitioners.
- Signatures or initials of practitioners, practitioners' names, and professional designation (such as MD, DC, DO, DPM, RN)
- Advanced directives or documentation of discussions regarding advanced directives, when appropriate.

Follow-up

Notes should indicate follow-up care, telephone calls or visits. A specific time for the follow-up should be noted in weeks, months or as needed.

Follow-up documentation should indicate:

- Adverse clinical findings
- Unresolved problems from previous office visit
- If a consultation had been requested, there is a note from the consultant
- Results of studies ordered should be filed in the chart and initialed by the primary care physician to signify review
- Discharge summaries include condition at time of discharge and post-operative instructions given to the patient
- Emergency care

Health Education and Preventive Services

Health education, preventive services, recommendations, and wellness counseling should be clearly noted and incorporated in the progress notes or in a specially designated section.

These services should be documented as applicable:

- For patients 14 years and over, smoking cessation and alcohol or substance abuse.
- Immunizations
- Pap smear
- Breast exam and/or mammogram
- Medication compliance

Medical Records Review

The objectives of the medical records review are:

- To evaluate the structural integrity of the medical record
- To evaluate ambulatory medical record documentation for the presence of information that conforms to good medical practice which includes continuity and coordination of care and is necessary to provide quality care
- To evaluate compliance with preventive health care guidelines as designated by SIHO

Never Events, Serious Reportable Events, and Hospital Acquired Conditions

SIHO reviews inpatient claims to identify eight (1) specified hospital-acquired conditions, as defined by the National Quality Forum. SIHO does not pay hospitals for additional inpatient days that directly result from the condition beyond the expected length of stay or that result in a preventable admission. Patients likewise are not responsible for payment.

In addition, the health plan and its members do not pay any charges related to three never events (2) or for a set of eight (3) serious reportable events, also defined by the National Quality Forum.

If a never event or a serious reportable event occurs, SIHO requires hospitals in its network to notify the health plan, along with at least one of three designated patient safety organizations: The Joint Commission; the state reporting program for medical errors; or a patient safety organization such as a state-specific patient safety center.

SIHO's Quality Improvement Department reviews all identified never events and serious reportable events and follows up with individual facilities. Facility representatives must identify root causes of never events and serious reportable events, and the must identify changes to improve patient care systems and processes. Facility representatives must communicate with patients and their families when these events occur.

I. The eight specified hospital acquired conditions, as defined by the National Quality Forum, are as follows: (1) unintended retention of a foreign object in a patient after surgery or other procedure; (2) hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products; (3) failure to identify and treat hyperbilirubinemia in neonates; (4) a burn incurred from any source while being cared for in a healthcare facility; (5) intravascular air embolism that occurs while being cared for in a healthcare facility; (6) medication error; (7) a fall while being cared for in a healthcare facility; and (8) deep vein thrombosis and/or pulmonary embolism following certain orthopedic procedures: total knee replacement and hip replacement.

II. The National Quality Forum defines a "never event" as "errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and indicate a real problem in the safety and credibility of a healthcare facility." For purposes of this policy, SIHO defines the following events as never events: (1) surgery or invasive procedure performed on the wrong person; (2) surgery or invasive procedure performed on the wrong side or body part; (3) performance of the wrong surgical or invasive procedure.

III. SIHO will not pay facilities for a set of eight serious reportable events, as defined by the National Quality Forum: (1) unintended retention of a foreign object in a patient after surgery or another procedure; (2) patient death or serious disability associated with a hemolytic reaction due to administration of incompatible blood or blood products; (3) patient death or serious disability associated with an electric shock while being cared for in a healthcare facility; (4) intraoperative or immediately post-operative death in an ASA Class I patient; (5) patient death or serious disability associated with use of contaminated drugs, devices, or biologics provided by a healthcare facility; (6) death or serious disability associated with failure to identify and treat hyperbilrubinemia in neonates; (7) any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances; and (8) patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility.

Preventive Health Benefit Guidelines

Overview

This section details SIHO's preventive health benefit guidelines. The information provided describes policy benefits and elements of periodic health evaluation visits.

Preventive Health Benefit

The Preventive Health Benefit, in general, is intended to cover exams, immunizations, and diagnostic testing for non-high risk, asymptomatic patients. Therefore, it represents suggested testing for patients who present with no additional complaints and are not high risk. The tests, immunizations, and exams indicated on the benefit grid are covered at 100% when administered within the appropriate time frame for those members who have SIHO's Preventive Health Benefit.

Remember: Not all SIHO plans include the Preventive Health Benefit as a part of the health care benefit.

Coding for Preventive Health Benefits

When additional, medically appropriate, tests are indicated for patients who present for a preventive health exam but have other complaints and/or family history that would indicate the need for additional testing, the physician should submit an appropriate ICD-10 Diagnosis Code in addition to the preventive health V-Code. If additional testing is done without medical documentation, the patient may be responsible for the charges. Please have your office staff let patients know when they may be responsible for such charges.

Sources

Organizations whose standards are used in developing and updating the preventive health benefit include the American Academy of Family Practice Standards, the American College of OB/GYN Standards, the Advisory Committee on Immunization Practices, the Center for Disease Control Recommendations, the American Cancer Society Recommendations, the American Academy of Pediatric Standards, and the US Preventive Services Task Force Recommendations.

Pharmacy Services

Overview

This section provides a summary of the SIHO Pharmacy Procedures and is designed to assist you and the member's Pharmacy in filing claims for services rendered to SIHO members who utilize CVS/Caremark as their PBM. Members whose plans utilize a Pharmacy Benefit Manager other than through SIHO's contract with CVS/Caremark should consult the terms specific to that PBM's program.

Fully Insured and TPA groups

Most plans administered by SIHO use CVS/CAREMARK Prescription Services as the Pharmacy Benefits Manager. Always check the current ID card of the patient to confirm the appropriate Pharmacy Benefits Manager vendor to be used.

MyTruAdvantage (Medicare Advantage)

CVS/CAREMARK administers Part D benefits for MyTruAdvantage plans.

SIHO Pharmacy Services

SIHO prescription services have been provided through CVS/CAREMARK Prescription Services for more than 20 years. CVS/CAREMARK operates the nation's largest independent Prescription Benefit Management (PBM) program, providing cost-effective prescription drug benefits to members, retirees, and members of funded benefit plans. More than 1000 clients including corporations, unions, employer coalitions, federal and state agencies, insurance companies, and managed care organizations use CVS/CAREMARK for their prescription benefit services.

Pharmacies can conduct the following transactions on-line

- Member Eligibility verification
- Drug pricing information
- Deductible/co-pay/co-insurance calculations
- Coordination of Benefit determinations
- Drug interaction analysis
- Automatic claim filing with SIHO

Covered Prescriptions

- Drugs which by Federal Law require a prescription and have received FDA approval for the intended use
- Insulin and insulin syringes
- Compounded medications that include at least one Federal Legend Drug or State Restricted Drug in a therapeutic amount
- Drugs covered under member benefits

Some plans, including MyTruAdvantage, provide no coverage for drugs that are not on its formulary.

Days Supply/Refills

Fully Insured and TPA groups: Maximums will vary among the specific SIHO plans. Typically, 30 is the maximum number of days that a prescription may be filled at retail and 90 for mail order. These maximums will vary among the specific SIHO plans.

MyTruAdvantage (Medicare Advantage): MyTruAdvantage plans have 30, 60, or 90-day options to supply or refill.

Pharmacy Prior Authorization

Fully Insured, TPA Groups, MyTruAdvantage

Certain prescriptions may require prior authorization by CVS/Caremark.

Some of the most common drugs requiring a prior authorization are:
Biotech or specialty medications such as Synagis and Enbrel, and Erectile Dysfunction medications such as Viagra and Cialis.

It is important to submit the prior authorization at the time the prescription is written so that a member's prescription is not denied when being filled at the Pharmacy. All prior authorization requests are processed within 72 hours. If you believe that waiting 72 hours for a standard decision could seriously harm the patient's life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. CVS/Caremark will automatically give a decision within 24 hours, for an expedited (fast) decision. An expedited (fast) coverage determination cannot be requested if the prescription has already been received by the member.

Listed below are the Caremark phone numbers for prior authorization:

Fully Insured/TPA Groups
800-294-5979

MyTruAdvantage
844-283-2788
www.caremark.com

SIHO/CAREMARK Preferred Drug List

The SIHO prescription drug benefit program's goal is to provide quality pharmaceutical care at lower costs. As a means of controlling costs, SIHO encourages its physicians to prescribe drugs on the SIHO/CAREMARK preferred drug list. Prescribing preferred drugs usually results in lower member costs and helps keep overall drug costs down. Allowing substitution of generic products is encouraged when appropriate. Questions about the preferred drug list should be directed to CVS customer service.

The CVS/Caremark Preferred Drug List for SIHO's HMO and TPA members is included in these materials and available on the SIHO website @ www.siho.org.

The CVS/Caremark Preferred Drug List for MyTruAdvantage's M.A. members is included in these materials and available on the MyTruAdvantage website @ www.mytruadvantage.com.

Step Therapy Programs

Some SIHO health plans, including MyTruAdvantage, use pharmacy step therapy programs, which require members to try generic or preferred brand medications before being allowed to use non-preferred brands. Both the applicable member and physician will receive advanced communication about such programs before they are effective.

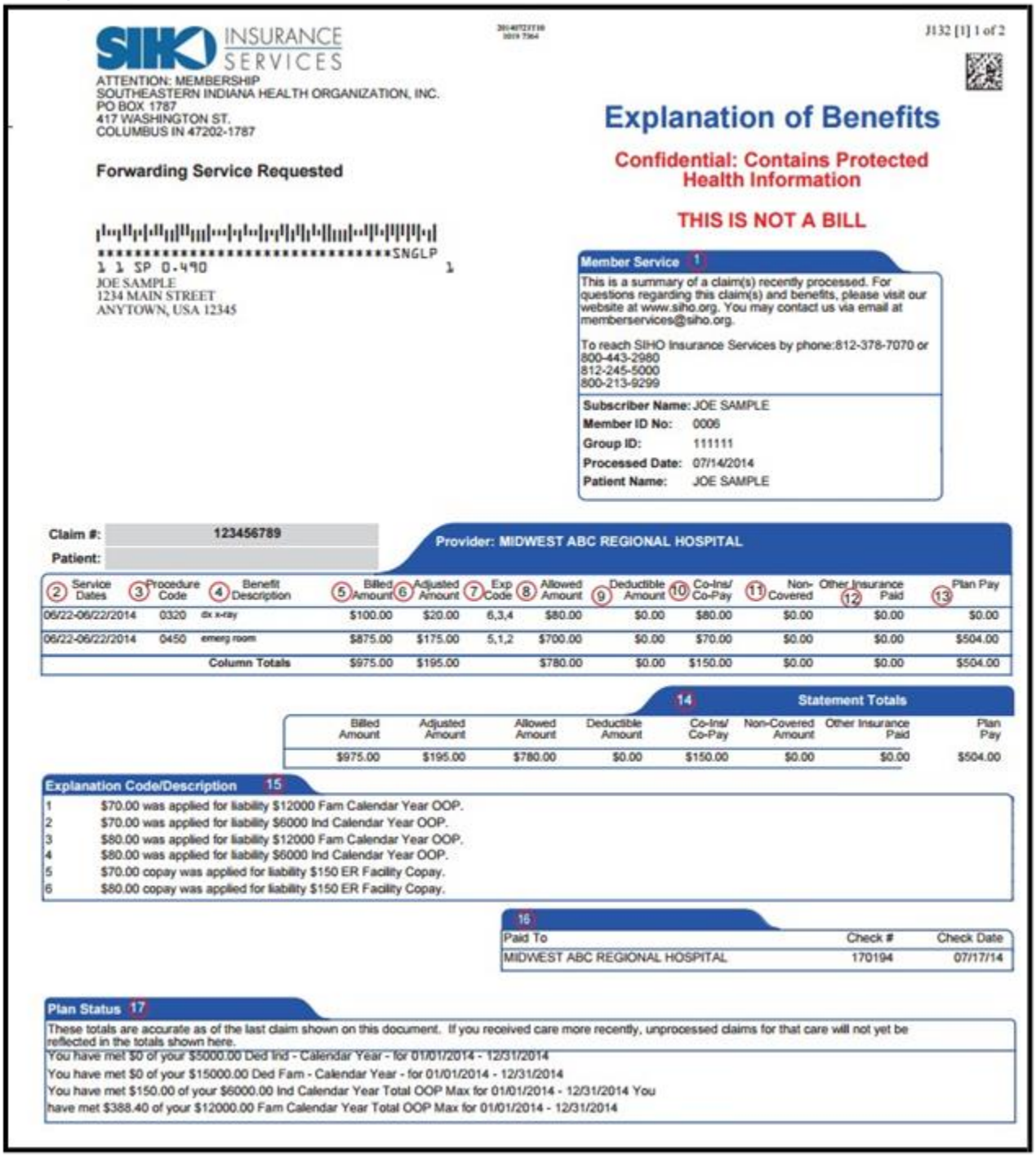
Miscellaneous

Electronic Forms

SIHO.org and MyTruAdvantage.com offer electronic forms available for your convenience. The forms and additional resources are found in the provider section of the SIHO website, specifically http://www.siho.org/Forms/ or the provider section of the MyTruAdvantage website at www.mytruadvantage.com.

How to Read Your EOB (for members) and EOP (for providers)

Sample EOB



SIHO INSURANCE SERVICES

ATTENTION: MEMBERSHIP
SOUTHEASTERN INDIANA HEALTH ORGANIZATION, INC.
PO BOX 1787
417 WASHINGTON ST.
COLUMBUS IN 47202-1787

Forwarding Service Requested

J132 [1] 1 of 2

Explanation of Benefits

Confidential: Contains Protected Health Information

THIS IS NOT A BILL

SNGLP
1 1 SP 0.490 1
JOE SAMPLE
1234 MAIN STREET
ANYTOWN, USA 12345

Member Service 1

This is a summary of a claim(s) recently processed. For questions regarding this claim(s) and benefits, please visit our website at www.siho.org. You may contact us via email at memberservices@siho.org.

To reach SIHO Insurance Services by phone:812-378-7070 or
800-443-2980
812-245-5000
800-213-9299

Subscriber Name: JOE SAMPLE
Member ID No: 0006
Group ID: 111111
Processed Date: 07/14/2014
Patient Name: JOE SAMPLE

Claim #: 123456789
Patient:

Provider: MIDWEST ABC REGIONAL HOSPITAL

(2) Service Dates	(3) Procedure Code	(4) Benefit Description	(5) Billed Amount	(6) Adjusted Amount	(7) Exp Code	(8) Allowed Amount	(9) Deductible Amount	(10) Co-Ins/ Co-Pay	(11) Non-Covered	(12) Other Insurance Paid	(13) Plan Pay
06/22-06/22/2014	0320	dx x-ray	$100.00	$20.00	6,3,4	$80.00	$0.00	$80.00	$0.00	$0.00	$0.00
06/22-06/22/2014	0450	emerg room	$875.00	$175.00	5,1,2	$700.00	$0.00	$70.00	$0.00	$0.00	$504.00
		Column Totals	$975.00	$195.00		$780.00	$0.00	$150.00	$0.00	$0.00	$504.00

14 Statement Totals

Billed Amount	Adjusted Amount	Allowed Amount	Deductible Amount	Co-Ins/ Co-Pay	Non-Covered Amount	Other Insurance Paid	Plan Pay
$975.00	$195.00	$780.00	$0.00	$150.00	$0.00	$0.00	$504.00

Explanation Code/Description 15

1 $70.00 was applied for liability $12000 Fam Calendar Year OOP.
2 $70.00 was applied for liability $6000 Ind Calendar Year OOP.
3 $80.00 was applied for liability $12000 Fam Calendar Year OOP.
4 $80.00 was applied for liability $6000 Ind Calendar Year OOP.
5 $70.00 copay was applied for liability $150 ER Facility Copay.
6 $80.00 copay was applied for liability $150 ER Facility Copay.

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Paid To	Check #	Check Date
MIDWEST ABC REGIONAL HOSPITAL	170194	07/17/14

Plan Status 17

These totals are accurate as of the last claim shown on this document. If you received care more recently, unprocessed claims for that care will not yet be reflected in the totals shown here.

You have met $0 of your $5000.00 Ded Ind - Calendar Year - for 01/01/2014 - 12/31/2014
You have met $0 of your $15000.00 Ded Fam - Calendar Year - for 01/01/2014 - 12/31/2014
You have met $150.00 of your $6000.00 Ind Calendar Year Total OOP Max for 01/01/2014 - 12/31/2014 You have met $388.40 of your $12000.00 Fam Calendar Year Total OOP Max for 01/01/2014 - 12/31/2014

Appeal Rights 18

IMPORTANT NOTICE CONCERNING YOUR COVERAGE

Benefits and eligibility will change from time to time. Be sure to use the most recent Summary Plan Document (SPD) to read any special notices about your coverage. Do not rely on outdated information.

Appeals Procedure

If you disagree with the decision on your claim, you (or your authorized representative) may file a written appeal within the timeframes allowed under your Plan, generally within 180 days of the denial of your claim.

Upon your request, you are entitled to receive, free of charge, copies of all documents, records and the identity of medical or vocational experts consult by the Plan in determining benefits. In lieu of copies, you may be given reasonable access to the documents.

Your appeal must give the reason(s) you believe the claim was improperly denied, and include any additional relevant information or documents in support of your appeal. Failure to file a timely appeal may prevent you from any further review of this benefit decision in State or Federal Court of Law. Send your appeal to: SIHO Insurance Services, PO Box 1787, Columbus, IN 47202-1787.

The Plan will notify you of the decision on your request for review no later than 60 days from the date your request is received. If you receive an adverse decision following your appeal, you have the right to bring a Civil Action under Section 502(a) of ERISA. Please consult the Summary Plan Description (SPD) for more information about the appeal procedures. Your SPD can be viewed online at *www.siho.org*. Select *Member Login* and enter your unique, sign-on information.

You Should Know 19

How to Read Your EOB can be found at www.siho.org by clicking the FAQ Link

To access your complete Summary Plan Document (SPD), access the SIHO member portal at www.siho.org. Once logged in, click on My Benefits and then Plan Information on the drop down box.

Go Green 20

Go paperless for your Explanation of Benefits (EOB) online. When you go paperless, you will receive email notifications when an EOB is posted to your account. You can view, print and download an EOB any time. There is no cost for this service. You simply sign into the SIHO member web portal at www.siho.org. Go Green today!

How To Read EOB

1. Member Service: If you have questions, please call us at the toll free number listed at the top of your Explanation of Benefits. Our friendly and knowledgeable representatives are here to assist you.

2. Service Dates: Represents the date in which the patient was treated and the date in which you are submitting charges.

3. Procedure Code: This section is to determine what procedure was performed.

4. Benefit Description: This sections provides additional information regarding the procedure that was performed.

5. Billed Amount: This is the billed amount before any negotiated adjustments, co-pays, deductibles or any ineligible amount.

6. Adjusted Amount: This amount will indicate any reduction or increase in benefits payable.

7. Exp. Code: This code is used to explain the reason for an adjustment, deductible, copay or coinsurance.

8. Allowed Amount: The amount remaining before any non-covered, deductible or copayment amounts have been subtracted from the amount your provider charged. Your coinsurance, if applicable, will be determined from the allowed amount.

9. Deductible Amount: This amount reflects the deductible requirement at the time charges were processed. If you see an amount in the deductible column, you would be responsible for these amounts.

10. Co-Ins/Co-Pay Amount: Represents amounts responsible to the patient. Copays - Typically office visits, emergency room and in-patient facility charge.

11. Not-Covered: Any specific amount that was determined to be ineligible for payment by the plan.

12. Other Insurance Paid: The amount paid by another health plan or insurance company toward services you received.

13. Plan Pay: The amount paid by your plan.

14. Statement Totals: This sections provides totals for each column for your entire document.

15. Explanation Code/Description Tab: This code is used to explain the reason something is not covered or is discounted from the billed amount or deductible, coinsurance, and copay explanations.

16. Payment Details: This section determines who is receiving the payment and the payment check number and total.

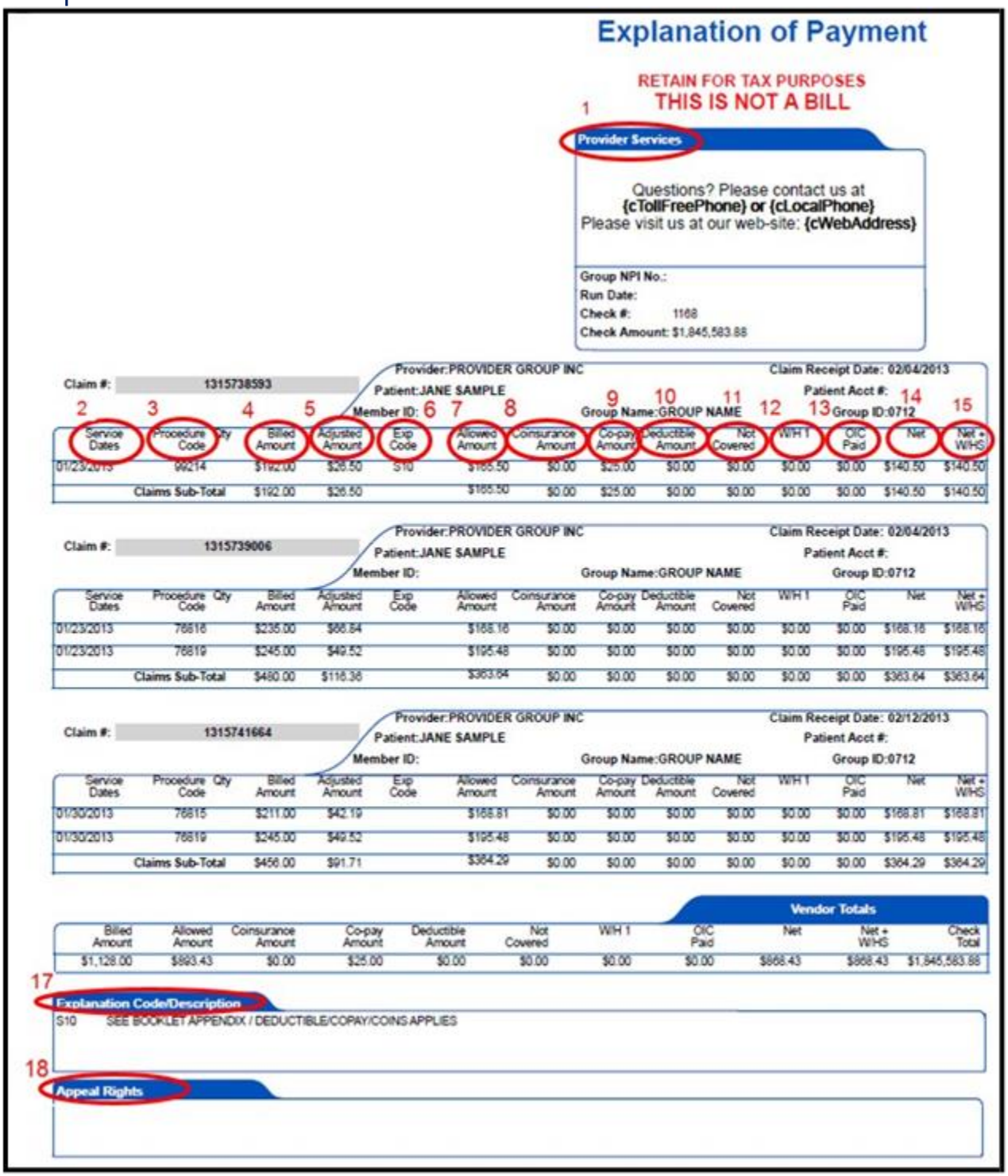
17. Plan Status: This area explains how much you have paid toward your deductible, if applicable. It shows how much of this claim went toward your out-of-pocket expenses and how much you've paid toward your out-of-pocket maximum so far this benefit period. It also shows how much we've paid in benefits for the patient during this benefit period.

18. Appeal Rights: This will be the procedure and information needed to file a formal review for any denied claim.

19. You should Know: Provides step-by-step directions on where to find the 'How to Read EOB' documentation.

20. Go Green: This section provides additional information on how to receive Member EOBs electronically.

Sample EOP



Explanation of Payment

RETAIN FOR TAX PURPOSES
THIS IS NOT A BILL

1

Provider Services

Questions? Please contact us at
{cTollFreePhone} or {cLocalPhone}
Please visit us at our web-site: **{cWebAddress}**

Group NPI No.:
Run Date:
Check #: 1168
Check Amount: $1,845,583.88

Claim #: 1315738593 — **Provider:** PROVIDER GROUP INC — **Patient:** JANE SAMPLE — **Member ID:** — **Group Name:** GROUP NAME — **Group ID:** 0712 — **Claim Receipt Date:** 02/04/2013 — **Patient Acct #:**

2 Service Dates	3 Procedure Code	Qty	4 Billed Amount	5 Adjusted Amount	6 Exp Code	7 Allowed Amount	8 Coinsurance Amount	9 Co-pay Amount	10 Deductible Amount	11 Not Covered	12 W/H 1	13 OIC Paid	14 Net	15 Net + W/HS
01/23/2013	99214		$192.00	$26.50	S10	$166.50	$0.00	$25.00	$0.00	$0.00	$0.00	$0.00	$140.50	$140.50
	Claims Sub-Total		$192.00	$26.50		$166.50	$0.00	$25.00	$0.00	$0.00	$0.00	$0.00	$140.50	$140.50

Claim #: 1315739006 — **Provider:** PROVIDER GROUP INC — **Patient:** JANE SAMPLE — **Member ID:** — **Group Name:** GROUP NAME — **Group ID:** 0712 — **Claim Receipt Date:** 02/04/2013 — **Patient Acct #:**

Service Dates	Procedure Code	Qty	Billed Amount	Adjusted Amount	Exp Code	Allowed Amount	Coinsurance Amount	Co-pay Amount	Deductible Amount	Not Covered	W/H 1	OIC Paid	Net	Net + W/HS
01/23/2013	76816		$235.00	$66.84		$168.16	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$168.16	$168.16
01/23/2013	76819		$245.00	$49.52		$195.48	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$195.48	$195.48
	Claims Sub-Total		$480.00	$116.36		$363.64	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$363.64	$363.64

Claim #: 1315741664 — **Provider:** PROVIDER GROUP INC — **Patient:** JANE SAMPLE — **Member ID:** — **Group Name:** GROUP NAME — **Group ID:** 0712 — **Claim Receipt Date:** 02/12/2013 — **Patient Acct #:**

Service Dates	Procedure Code	Qty	Billed Amount	Adjusted Amount	Exp Code	Allowed Amount	Coinsurance Amount	Co-pay Amount	Deductible Amount	Not Covered	W/H 1	OIC Paid	Net	Net + W/HS
01/30/2013	76815		$211.00	$42.19		$168.81	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$168.81	$168.81
01/30/2013	76819		$245.00	$49.52		$195.48	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$195.48	$195.48
	Claims Sub-Total		$456.00	$91.71		$364.29	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$364.29	$364.29

Vendor Totals

Billed Amount	Allowed Amount	Coinsurance Amount	Co-pay Amount	Deductible Amount	Not Covered	W/H 1	OIC Paid	Net	Net + W/HS	Check Total
$1,128.00	$893.43	$0.00	$25.00	$0.00	$0.00	$0.00	$0.00	$868.43	$868.43	$1,845,583.88

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Explanation Code/Description

S10 SEE BOOKLET APPENDIX / DEDUCTIBLE/COPAY/COINS APPLIES

18

Appeal Rights

1. Provider Service: If you have questions, please call us at the toll free number listed at the top of your Explanation of Payment. Our friendly and knowledgeable representatives are here to assist you.
2. Service Dates: Represents the date in which the patient was treated and the date in which you are submitting charges.
3. Procedure Code: This section is to determine what procedure was performed.
4. Billed Amount: This is the billed amount before any negotiated adjustments, co-pays, deductibles or any ineligible amounts.
5. Adjusted Amount: This amount will indicate any reduction or increase in benefits payable.
6. Exp. Code: This code is used to explain the reason for an adjustment, deductible, copay, or coinsurance.
7. Allowed Amount: The amount remaining before any non-covered, deductible, or copayment amounts have been subtracted from the amount you, the provider, charged. Your coinsurance, if applicable will be determined from the allowed amount.
8. Coinsurance Amount: Amount represents amounts responsible from the patient through coinsurance
9. Co-pay Amount: Amount represents amounts responsible from the patient. Copays – Typically office visits, emergency room and in-patient facility charge
10. Deductible Amount: This amount reflects the deductible requirement at the time charges were processed. If you see an amount in the deductible column, the patient is responsible for these amounts.
11. Not Covered: Any specific amount that was determined to be ineligible for payment by the plan.
12. W/H 1: Amount represents amount for clinical oversight of in-network physicians
13. OIC Paid: Amount represents the amount covered by another health plan or insurance company on behalf of the patient
14. Net: Sum the health plan will be reimbursing the provider
15. Net + WHS: Sum the health plan will be reimbursing the provider added to the withhold amount
16. Vendor Totals: This section provides totals for each column for your entire document
17. Explanation Code/Description Tab: This code is used to explain the reason something is not covered or is discounted from the billed amount or deductible, coinsurance, and copay explanations.
18. Appeal Rights: This will be the procedure and information needed to file a formal review for any denied claim.