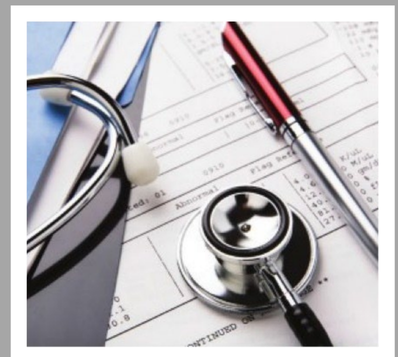
EHN | EMPLOYERS HEALTH NETWORK

NETWORK PROVIDER REFERENCE MANUAL

Effective: July 1, 2023



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CONTACTS AT A GLANCE

www.employershealthnetwork.com

Phone: 469-825-4825

Executive Administrative Office
1212 Corporate Drive, Suite 225
Irving, TX 75038

providers@ehnllc.com

- To request a participating provider application
- To submit additions, changes, and terminations to provider data information or panel
- To update demographic information

credentialing@ehnllc.com

- For all questions or concerns regarding provider credentialing

See phone numbers on the member's ID card to verify member information or for any of the following:

- Eligibility
- Benefits
- Precertification requirements
- Claim payment status

INTRODUCTION

Employers Health Network is a healthcare company dedicated to delivering innovative solutions, services, and tools to our payors and their members. These solutions, services, and tools not only manage costs, but most importantly improve our members' health and well-being. Our commitment to this vision goes hand-in-hand with our desire to work in partnership with both our payors and our network providers. We are proud to have you as a valued member of the team.

This network provider reference manual is cited in your participating provider agreement. Please read this reference manual carefully and refer to it as questions arise. Note that if a provision in this reference manual conflicts with state or federal law or the terms of your participating provider agreement, the state or federal law or your participating provider agreement takes precedence.

The terms of this reference manual may be modified per the terms of your agreement. In addition to the obligations specified in your participating provider agreement, this reference manual provides information about contractual obligations for network providers. When the word "you" or "your" appears, it means the network provider that is party to a participating provider agreement with EHN, or is obligated directly or indirectly to comply with the terms of a participating provider agreement. When "Employers Health Network" or "EHN" is referenced, it includes Employers Health Network and its subsidiaries or affiliates.

We are committed to collaborative relationships with our network providers, payors, clients, and members. To strengthen these relationships, we provide useful information, including the most current version of this manual, at https://www.employershealthnetwork.com/providers/.

Please read this reference manual carefully and refer to it as questions arise. Note that if a provision in this reference manual conflicts with state or federal law or the terms of your participating provider agreement, the state or federal law or your participating provider agreement takes precedence.

IMPORTANT DEFINITIONS

Application
Application is a request to participate or join Employer Health Network.

Billed Charges
The fees for a specified health care service or treatment routinely charged by a network provider regardless of payment source.

Benefit or Program
Any self-funded health benefit plan, insurance policy, contract, government program, or other plan or program under which members are eligible for benefits.

Benefit Program Maximum
When the cumulative payment by a payor has met or exceeded the annual or lifetime benefit maximum (e.g., dollar amount or service count) for a particular type of covered service rendered to a member in accordance with the terms of the member's benefit program.

Case Management or Care Management
Case Management is a service designed to identify members that can benefit from close review and management of their care due to length, severity, complexity, and/or cost of health care services. Case managers locate and assess medically appropriate settings for the members and manage their health care benefits as cost effectively as possible.

Pre-Authorization or Pre-Certification
The determination made by a licensed, registered, or certified health care professional engaged by the payor's utilization management program that the health care services rendered by a network provider meet the requirements of care, treatment, and supplies for which payment is available by a payor pursuant to the member's program.

Clean Claim
A claim that has no defect or impropriety (including lack of substantiating documentation) or any other circumstance requiring special treatment that would prevent timely payment.

Client
A company, employer, or other organization that has an agreement with EHN for network services for their employees and eligible members for commercial health insurance coverage.

Concurrent Review
Utilization review conducted during a patient's hospital stay or course of treatment. After the admission, utilization management personnel may monitor services on a concurrent basis. If the member is not discharged within the number of days initially approved, utilization review personnel may contact the attending physician for additional medical information. Both care and services for each case are monitored. Further certification will depend upon the establishment of medical necessity.

Contract Rates
The rates of reimbursement to a network provider for covered services, as set forth in the participating provider agreement. Unless specifically stated otherwise, contract rates include any member payment responsibility, including copays, deductibles, and coinsurance.

Covered Services
Health care treatment and supplies rendered by a network provider and provided to a member for which a payor is specifically responsible for payment pursuant to the terms of the applicable benefit program.

Discharge Planning
The process that assesses a member's needs after hospitalization to help arrange for the necessary services and resources to affect an appropriate and timely discharge from the hospital. Services may include, but not limited to home health services, extended care facilities, or home I.V. therapy. Timely discharge planning is intended to ensure cost effective and appropriate quality care.

Disease Management or Chronic Condition Management
Disease or chronic condition management encompasses the oversight and education activities conducted by care management personnel to help members with chronic diseases and health conditions such as: diabetes, high blood pressure, asthma, congestive heart failure, and other conditions learn to understand their condition and live successfully with it.

Emergency Admission
An unplanned admission of an urgent nature, at a time of crisis, in order to alleviate a situation or risk until such time a care assessment can be implemented.

Medical Criteria
A system used by utilization management personnel with clearly established, nationally recognized criteria for determining the appropriateness of medical services provided or to be provided.

Member
Any individual and/or dependent eligible to receive health services that are covered by a plan administered by Employers Health Network or an EHN network payor.

Network
An arrangement between Employers Health network and health care providers or a network of providers, including facilities, physicians, and other health care professionals. This network providers have agreed to accept certain contract rates for covered services provided to members.

Network Provider
A licensed facility or licensed, registered, or certified health care professional that agrees to provide health care services to members and that has been contracted for participation in the network. Network providers may be referenced in this manual individually as "network facility", "network ancillary provider", or "network professional".

Payor or Network Payor
The corporation, partnership, labor union, association, program employer, multiple employer welfare arrangement, individual, or other entity responsible for the payment of covered services for members. Payors have the sole obligation for benefit funding and to provide or arrange for the provision of plan administration,

claims processing, and the determination of covered services for their respective benefit programs. Employers Health Network is not a payor.

Policyholder

The primary enrollee, generally an employee, under a health insurance policy, contract, or self-funded benefit program. This term may include a sole proprietor, a partner, a retiree, or an independent contractor if the sole proprietor, partner, retiree, or independent contractor is included as an "employee" under a benefit program of the policyholder's client or payor.

Pre-Admission Testing

Routine tests such as x-rays, lab tests, EKGs, etc., done on an outpatient basis prior to the hospital confinement. During pre-certification, the attending physician may be asked to determine if testing may be provided on an outpatient basis.

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) impacts what is referred to as covered entities, specifically inclusive of providers, health plans, and health care clearinghouses that transmit health care information electronically. HIPAA establishes national standards for managing the security and privacy of health information, as well as standards for electronic health care transactions and national identifiers. All providers are required to adhere to HIPAA regulations.

Protected Health Information (PHI)

Individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium as defined by 45 C.F.R. 160.103 or successor federal legislation and/or promulgated rules.

Confidentiality

Sharing information only with those individuals or agencies who have authority to receive such information.
All members have rights of privacy and confidentiality as provided by state and federal law. Confidentiality of a member's records and information will be maintained by adhering to all applicable regulations.

Quality Management

A program designed to promote quality assurance and improvement activities within an organization and assess the credentials of network providers and the quality of health care services rendered by each network provider. A quality management program may include a complaint investigation and resolution process.

Retrospective Review

Utilization review conducted after services have been provided to a member. The company providing utilization management recognizes that there will be members who will not have precertification and concurrent review performed. These cases may be reviewed retrospectively focusing on day of admission and continued hospital stay. In this case, utilization management personnel will contact the health care facility or attending physician to obtain all necessary information. Using established medical criteria, utilization management personnel will determine the medical necessity of the care provided. If the criteria are met, the hospital admission will be certified. If the medical criteria are not met the claim may be denied. In such cases the denial and appeal procedures for precertification and concurrent review will be followed.

Third-Party Administrator or TPA
An organization to which a payor has delegated some or all duties for payment of covered services for members, the provision of plan administration, claims processing, and the determination of covered services for the payor's respective benefit programs. A Third-Party Administrator may arrange for and coordinate plan payment of benefits; however, this does not relieve the payor from the ultimate responsibility of the funding of plan benefits.

Utilization Management
The process of evaluating proposed hospital admissions and medical services to identify patterns of treatment for quality and appropriateness. This is accomplished through pre-admission certification, concurrent review, retrospective review, discharge planning, and case management.

Utilization Review
A program established by the utilization management provider on behalf of a network payor under which a request for care, treatment, and/or supplies may be evaluated against established clinical criteria for medical necessity, appropriateness, and efficiency.

Wrap Network
A network that is used when claims fall outside the primary coverage area. It effectively expands discount arrangements beyond a geographic location or specific set of providers. It can be used to cover employees that reside outside the core service area, or to protect against costs incurred while those member's travel. The member pays in-network co-pays and/or co-insurance and the provider is reimbursed accordingly.

NETWORK PARTICIPATION

Responsibilities of Provider Participation

As a condition of network participation, network providers agree to the following:

- Know and comply with applicable state specific regulations
- Accept EHN contracted rates as payment in full (refrain from balance billing and collecting payments up-front, with the exception of verified copays, coinsurance or deductibles)
- Participate with individual network payors' utilization management/pre-certification programs
- Use best efforts to refer patients to EHN hospitals, physicians, and other outpatient care providers (provider search is available via the web at https://members.ehnconnects.com/)
- Notify EHN of demographic changes/information updates (e.g., address or federal tax identification number changes)
- Work with EHN and network payors to resolve issues
- Respond promptly to requests for information related to re-credentialing or database updates

Subcontracts of Physician Agreement

The provider agreement may be assigned only with the written consent of the network, and any assignment attempted without such prior consent shall be null and void. Network may assign the agreement to an affiliate subsidiary, parent, or other related party or successor entity with notification to the network provider. It is expressly agreed that the Network may contract with other entities in order to meet its obligations under the agreement without notifying a network provider and all subcontracts shall be subject to the terms and conditions of the agreement. It is the responsibility of the network provider to notify the subcontracted provider where they can locate a copy of the EHN provider manual at www.employershealthnetwork.com/providers/.

Network providers shall, as applicable, make available and provide covered services to member(s) in accordance with the terms of this network provider reference manual and the applicable agreement. In addition, providers shall comply with all applicable federal and state laws, licensing requirements, and professional standards in respect to medical services. All such services shall be deemed medically necessary, covered services rendered in accordance with generally accepted medical practices and standards prevailing in the medical community at the time of treatment and shall be within the scope of provider's license. Providers shall provide covered services to member(s) in the same time and manner as customarily and regularly provided to other patients who are not member(s). Providers shall render covered services without regard to race, age, religion, sex, national origin, marital status, sexual orientation, or source of payment or disability of member(s).

Medical Records: Maintenance and Access

Provider shall maintain complete and professionally adequate medical records to the extent necessary for continuity of care and in compliance with all applicable laws. Physician shall maintain for at least a four (4) year period of time or for any longer period of time specified by federal, state, or other governing law and make readily available to network, payor, and governmental agencies with regulatory authority all medical and related administrative and financial records of the member(s) that receive covered services, as required by the network in accordance with this agreement or pursuant to applicable law. A network payor or its TPA may request, and provider shall not unreasonably withhold, additional records as may be required to verify that the provider's charges are reasonable and in line with prevailing community standards, to the extent not prohibited by applicable law. Such records shall be available to network, payors, TPAs, and certain governmental agencies with reasonable notice to provider and during regular business hours for the provider.

As an Employers Health Network participating provider, it is understood all members have rights of privacy and confidentiality as required by applicable state and federal laws. Providers are contractually required to safeguard and maintain the confidentiality of data that addresses medical records as well as confidential provider and member information, whether oral or written in any form or medium. Medical information will be released only to persons authorized to receive such information.

For some types of treatment, payors or TPAs may require the member's consent (and possibly the consent of family members) to release protected health information. These signatures should be kept on file with the member's record.

All information and materials provided to you by Employers Health Network, payors, or members remain proprietary to Employers Health Network, payors, or members. This includes, but is not limited to, your participating provider agreement and its terms, conditions, and negotiations; any program, rate, or fee information; EHN payor, client, or member lists; and any administrative handbook(s) and/or other operations manuals. You may not disclose any of such information or materials or use them except as may be permitted or required by the terms of your participating provider agreement.

A network payor or its TPA may request, and provider shall not unreasonably withhold, additional records as may be required to verify that provider's charges are reasonable and in line with prevailing community standards, to the extent not prohibited by applicable law.

Professional Responsibilities and Requirements

As part of the network, you are responsible for meeting certain requirements for network participation. You have the responsibility for:

- The care and treatment of members under your care. You must ensure that all care is rendered in accordance with generally accepted medical practice and professionally recognized standards and within the scope of your applicable license, accreditation, registration, certification, and privileges.
- Abiding by any and all applicable state and/or federal laws related to the delivery of health care services and the confidentiality of protected health information while taking all precautions to prevent the unauthorized disclosure of such member's medical and billing records.
- Complying with EHN, payor, TPA, and/or member requests for copies of a member's medical and billing records for those purposes which EHN, payor, TPA, and/or members deem reasonably necessary, including without limitation and subject to any applicable legal restrictions, quality assurance, medical audit, credentialing, re-credentialing, or payment adjudication and processing.
- Cooperating with the quality management and utilization management programs of payors.
- Meeting the EHN credentialing criteria, as referred to later in this section.
- Share data from care plans, clinical data, and reports with all necessary health care professionals in a HIPAA compliant manner which will be integrated into the EHN database or designated third party.
- Honesty in all dealings with EHN, payors, and/or members. As a network professional you agree not to make any untrue statements of fact in any claim for payment, nor any untrue statements of material fact, or any intentional misrepresentations of any fact in any statement made to EHN or any EHN payor, TPA, or member.
- You may not engage in inappropriate billing practices, including but not limited to billing for undocumented services or services not rendered, unbundling, up-coding, or balance billing.
- You may not change hospital affiliations, admitting privileges, or specialty status in such a way as to substantially limit the range of services you offer and/or members' access to your services.
- You may not be the subject of publicity that adversely affects the reputation of EHN, as determined by EHN.
- You may not commit professional misconduct that violates the principles of professional ethics.
- You may not engage in any action or behavior that disrupts the business operations of EHN or network payor.
- Responses to inquiries from EHN shall be timely, complete, and delivered in a professional manner.
- Providers have the right to review information submitted in the credentialing process and the right to correct erroneous information. Further, practitioners have the right to request a status of their credentialing or recredentialing application.

Credentialing

We apply NCQA criteria and processes when we credential providers into our network(s). EHN has established credentialing criteria for all categories of health care professionals it accepts into its network(s) including but not limited to physicians, physician assistants, certified nurse midwives/licensed midwives, certified registered nurse anesthetists, nurse practitioners, podiatrists, chiropractors, audiologists, and private therapists – occupational, physical and speech therapists.

Behavioral health practitioners that are credentialed include but are not limited to: psychiatrists, psychologists, licensed clinical social workers, licensed social workers, licensed professional counselors, licensed marriage and family therapists, and substance abuse treatment practitioners.

Hospital-based practitioners who are practicing exclusively in an inpatient setting are not credentialed or recredentialed. Hospital based practitioners are defined as, but not limited to pathologists, anesthesiologists, radiologists, neonatologists, emergency room practitioners, and hospitalists. Practitioners who have been credentialed through a delegated arrangement are not credentialed by EHN.

The credentialing criteria include but are not limited to:

- Board certification or requisite training in stated specialty
- Acceptable licensure history as provided by the National Practitioner Data Bank (NPDB) and/or state licensing board(s)
- Acceptable malpractice claims payment history
- Current malpractice insurance with limits of liability commensurate with state requirements
- Admitting privileges at a network facility
- Current, valid, clinically unrestricted license
- Current, active DEA license, if applicable
- Current state-controlled substance certificate, if applicable

EHN strives to maintain the highest possible quality network. This commitment involves credentialing each provider and re-credentialing in accordance with the NCQA every three (3) years. All providers are required to complete an application and agreement. A provider application may be obtained by contacting EHN or through CAQH. A complete application packet must be received to process the application and the provider must be approved by the credentialing committee before providing services to enrolled members.

EHN offers delegated credentialing for groups that meet NCQA guidelines for initial and re-credentialing of providers. Each provider must be approved by the credentialing committee. A delegated credentialing agreement must be signed for all groups granted delegated status. In addition, these groups agree to an annual audit process, submission of provider updates at the minimum on a quarterly basis, and to provide any policy changes.

During the credentialing and recredentialing processes, health care providers are entitled to the following rights:

- To review information submitted to support their credentialing applications, with the exception of references, recommendations, and peer-protected information obtained by us.
- To correct erroneous information. When information obtained by the Credentialing department varies substantially from information provided by the provider, the Credentialing department will notify the provider to correct the discrepancy.
- To be informed, upon request, of the status of their credentialing or recredentialing applications.
- To be notified within 60 calendar days of the Credentialing Committee or Medical Director review decision.
- To appeal any recredentialing denial within 30 calendar days of receiving written notification of the decision.
- To know that all documentation and other information received for credentialing and recredentialing purposes is considered confidential and is stored in a secure location that is only accessed by authorized EHN associates.
- To receive notification of these rights.

To request any of the above, providers should contact:

Employers Health Network
Attn: Credentialing Department
1212 Corporate Drive, Suite 225
Irving, Texas 75038

Re-credentialing

Network Professionals
EHN re-credentials network professionals every three (3) years in accordance with state and federal law and national accreditation standards. EHN utilizes the same NCQA standards in its re-credentialing process as it does in the initial credentialing process. Network professionals are considered to be successfully re-credentialed unless otherwise notified by EHN.

Delegated Re-credentialing for Groups of Professionals
EHN may conduct annual group audits and may delegate the re-credentialing function using the same process used to initially delegate the credentialing function.

Quality Management

EHN maintains quality management processes and procedures to acknowledge, track, investigate and resolve complaints about network professionals. These complaints may originate from various sources, including payors, TPAs, clients, or members. Complaints may include but are not limited to perceptions of:

- Quality of care: Unsatisfactory clinical outcome or unsafe/unclean provision of care
- Service: Unprofessional, rude, negative, or biased behavior by a network professional or office staff
- Inappropriate billing practices
- Office environment: safety concerns, office inadequacy, office appearance, waiting and exam rooms, and security of medical records.
- Access to services: difficulty obtaining appointments, wait times, availability (office hours and after hours), ability to obtain referrals.

Grievances that fall into any of these categories may be referred to EHN's credentialing committee. As part of your participation in the network, you are responsible for observing EHN policies and participating in any investigative processes.

Investigation Process
EHN facilitates the complaint investigation process by gathering information from various parties (including the network professional involved) to determine the circumstances surrounding the complaint. Requests for information from network professionals may include a patient's medical and/or billing records. EHN recognizes that the network professional's participation in the investigation process is critical. When requesting information, EHN reports the complainant's concerns and affords the network professional an opportunity to respond to the complaint. EHN conducts the investigation process with strict confidentiality. If the complaint is of a clinical nature, EHN clinical staff – including an EHN medical director – will participate in the investigation process.

Outcome of Investigation
Investigation outcomes vary based on the type and severity of the complaint and the complaint record of the network professional. If the investigation reveals the presence of imminent danger to members, provider's loss of license, exclusion from Medicare/Medicaid programs, or lack of liability coverage, termination may be immediate. EHN communicates investigation outcomes and resulting actions directly to the network professional involved. All complaint records are maintained confidentially and reviewed during the re-credentialing process.

Appeals Process for Professionals Terminated or Rejected from the Network
EHN complies with all state and federal mandates with respect to appeals for providers terminated or rejected from the network(s). Terminated or rejected providers may submit a request for an appeal as outlined in the letter of rejection/termination sent by EHN. In addition, the request for appeal must be received by EHN within thirty (30) days of the date of the rejection/termination letter. Upon receipt of the letter by EHN, the appeal is forwarded to the EHN credentialing committee for review.

The appeal is conducted on the basis of any written information submitted by the terminated or rejected provider, in conjunction with any information previously in possession of or gathered by EHN. The provider may appear in person or via web conference at the appeal hearing with a legal representative, may bring or submit ahead of time additional documentation for review, and may bring witnesses to testify on his or her behalf.

In the event that EHN upholds a decision to terminate a provider upon appeal, the original effective date of the termination is upheld unless otherwise determined by the credentialing committee. If the credentialing committee reverses a termination decision, the network professional's participating status is reinstated as of the date of the initial adverse decision, unless otherwise determined by the appeals committee.

Recognition of Authorized Logos

As a network professional, you agree to recognize each name and/or logo identified as an authorized logo when displayed on identification cards, explanation of benefits (EOB) forms, or other forms of identification as evidence of the payor, TPA, or member's right to access you as a network provider and to reimburse you at the contract rates for covered services rendered to members. EHN may update the list of authorized logos included in Appendix A of this handbook by posting such modifications to the EHN website; however, network professionals should refer to the participating provider agreement for specific access.

Payors and/or TPAs furnish members with a means of identifying themselves as covered under a program with access to the network. Such methods of identification include but are not limited to: affixing an authorized logo on an identification card, an EHN phone number identifier, written notification by TPA of an affiliation with EHN at the time of benefits verification, an EHN authorized logo on the explanation of benefits form, or other means acceptable to EHN and the network provider.

assets with respect to policy, payment, interpretation, practices, or procedures. Be sure to notify members of restrictions and/or limitations identified after contacting the payor.

Utilization Management

Network providers are required to participate in and observe the protocols of payor or TPA utilization management programs for health care services provided to members. Utilization management requirements may vary by payor, TPA, or by the member's benefit plan. Programs generally include, but are not limited to, pre-certification, concurrent review, and retrospective review. Utilization management programs may also include case management, chronic disease management, maternity management, mental health management services, and related programs designed to improve member health by the promotion of evidence-based health care protocol.

Prior Authorization/Pre-Certification

Most utilization management programs used by payors and TPAs require prior authorization or pre-certification for certain services or procedures. Plan providers must verify any precertification or other utilization management requirements at the time of verification of benefits and eligibility. As part of the certification process, please be prepared to provide the following information by telephone, fax, or through any other method of communication acceptable to the payor's utilization management program:

- Group policy number or name
- Policyholder's name, unique ID or social security number, and employer (group name)
- Patient's name, sex, date of birth, address, telephone number, and relationship to policyholder
- Network professional's name, specialty, address, and telephone number
- Facility name, address, and telephone number

- Scheduled date of admission/treatment
- Diagnosis and treatment plan
- Significant clinical indications
- Length of stay requested
- You may be required to obtain precertification from the utilization management or utilization review program for the following:
    - Inpatient admissions, outpatient surgery, and other procedures identified by the network payor. To obtain precertification for these procedures, call the telephone number provided on the back of the member identification card. To facilitate timely review, initiate the precertification process a minimum of seven to ten (7-10) business days before the date of service for all non-urgent or non-emergency services.
    - Emergency admissions: Certification of all admissions following an emergency room visit is usually required within forty-eight (48) hours after the admission or as soon as is reasonably possible.
    - Length of stay extensions: In the event a length of stay extension is required for health care services initially requiring certification, you may be required to obtain additional certification from the utilization management program prior to the last certified day.

Concurrent Review

Network professionals must participate in the utilization management program of concurrent review. A nurse reviewer performs concurrent review to document medical necessity and facilitate discharge planning.

Case Management

Case management identifies those members whose diagnoses typically require post-acute care or high level and/or long-term treatment. The case manager works with providers and family members to formulate a plan that efficiently utilizes health care resources to achieve the optimum patient outcome. Case management services are provided for members who may benefit from

- Change in intensity of care
- Arrangements for ancillary services
- Coordination of complex health care services

Before completing the certification process, always contact the payor to obtain eligibility information. In cases where multiple procedures are performed, be sure to confirm benefit eligibility from the payor or TPA for each procedure.

Maternity Notifications

The member or participating provider should contact the company providing utilization management services for the benefit program early in the pregnancy with the expected date of delivery. The utilization review personnel will work closely with the physician to monitor the pregnancy for potential high risk. If the pregnancy is determined to be high risk, the case may be referred to care management for potential intervention. The utilization management provider should be notified when the member is admitted for labor and delivery. Any other admissions prior to delivery, such as complications of pregnancy, require separate notification. The utilization management provider should also be notified if the baby is not going to be discharged with the mother.

Outpatient Surgery

The company providing utilization management will review selected procedures for recommendation of outpatient surgical setting. When a call is received to pre-certify a surgical procedure and hospital stay, the utilization management department checks all medical information against established medical criteria to determine whether the procedure may be provided safely on an outpatient basis. The utilization management department personnel will then discuss the possibility of using an outpatient facility with the member's network physician.

Referrals to Other Network Providers

To help members avoid a reduction in benefits, you are required to use your best efforts to refer members to network providers within the same respective network, when medically appropriate, and to the extent these actions are consistent with good medical judgment. When required services are not available or medically appropriate within the same network, you are required to contact utilization management for the benefit program. For assistance in finding other providers for referral purposes who are participating in the network or an available wrap network under the member's benefit program, contact the utilization management for the benefit program of provider services at 469-825-4825 or providers@ehnllc.com.

In the event a member requires hospitalization and you do not have hospital privileges with a facility within the same respective network, you agree to exercise best efforts to refer the member to another network professional with hospital privileges at a facility within the same network. Network providers are required to inform the member whenever a referral is made to an out-of-network provider.

Appeals Process for Utilization Management Decisions

The appeals process may vary by the payor or TPA's utilization management program and/or as mandated by state or federal law. In the event you or a member do not agree with a non-certification determination made under the utilization management program, you or the member has the right to appeal the determination in accordance with the payor or TPA's utilization management program appeals process. To obtain details of the payor or TPA's utilization management program appeals process, please contact the appropriate EHN Network payor or TPA.

Failure to observe the protocols of the utilization management program may also result in a reduction of benefits to the member. You are responsible for notifying the member of any potential financial implications associated with failure to observe the utilization management program protocols.

Waiting Times for Members

As a network professional, you agree that the expected waiting time for members to schedule an appointment shall not exceed the following:

- Four (4) weeks for specialty care appointments
- Six (6) weeks for routine appointments

REIMBURSEMENT AND BILLING REQUIREMENTS

Network providers should bill for services for a member at the normal retail rate. The EHN payor will reimburse once applicable fee schedules and plan benefits are applied. You will receive an explanation of payment (EOP) detailing payment. You may not charge a member for covered services beyond copayments, coinsurance, or deductibles as described in their benefit plans.

You may charge a member for services that are considered as non-covered under the applicable benefit plan, provided you first obtain the member's written consent. Such consent must be signed and dated by the member prior to rendering the specific service(s) in question. Retain a copy of this consent in the member's medical record.

Each network payor's plan may exclude or reduce benefits for some types of medical care. Again, please verify a member’s plan design by calling the appropriate network payor. Members should be billed directly for services which are not covered by the network payor's health benefits plan design. If an error has been made in the adjudication of a member's benefits, please contact the appropriate network payor listed on the member's ID card or EOP.

Multiple Procedures

When multiple surgical procedures are scheduled, please obtain benefit information from the network payor regarding rules and payment methods for each covered service procedure. Also, please check your specific network agreement for any contracted rates particular to your practice and reimbursement arrangements.

Coordination of Benefits

Members are sometimes covered by more than one benefit plan. Always obtain complete benefit information from each payor when verifying a member's health plan benefit.

EHN Payor is Primary
When an EHN payor is primary under the Coordination of Benefits (COB) rules, the payor will pay, or arrange for member to pay, for covered services according to the member's benefit program (e.g., applicable deductible, copay, or coinsurance amounts, if any) and pursuant to the contract rate.

EHN Payor is Secondary
Except as otherwise required by law or the member's program, if a payor is other than primary under the COB rules, the payor will pay, or arrange for member to pay, a reduced amount only after the network professional has received payment from the primary plan. Please refer to your participating provider agreement for the specific terms related to payment when a payor is other than primary under the COB rules.

As a network professional, you are required to cooperate fully with EHN and/or network payors in supplying information about other entities providing primary medical coverage or otherwise having payment responsibility for services rendered to members, and in all other matters relating to proper coordination of benefits. Note: payment may vary based on state or federal law when Medicare is a primary or secondary payor.

Timely Payment of Claims

Payors understand the importance of timely payment of clean claims. Please refer to your participating provider agreement for specific requirements regarding timely payment of clean claims. Any payments due by payor shall be reduced by applicable copayments, deductibles, and/or coinsurance, if any, specified in the member's benefit program and/or any service for which the member's benefit program does not provide coverage. Payment by payor shall be subject to industry standard coding and bundling rules, if any.

Submission of Claims

Claims should be sent as usual by following the instructions on the back of the member's ID card. As a network provider, you agree to submit claims for payment within at least ninety (90) days of furnishing healthcare services (or as otherwise required by state or federal law or your participating provider agreement). All claims should be submitted using your billed charges and the appropriate procedure code per American Medical Association (AMA) and Center for Medicare and Medicaid Services (CMS) standards.

Claims must be submitted to the address found on the member's identification using a HCFA-1500 or CMS-1500 claim form. Clean claims that are mailed shall be deemed to have been received by the payeror TPA five (5) calendar days following the deposit of such clean claim in the U.S. Mail, first class postage prepaid, and addressed to the payor or TPA at such address set forth on the member's identification.

PLEASE NOTE: Do not submit claims to EHN's address; only submit claims to the TPA address listed on the member's card

Submitting Claims Electronically

All claims may be submitted electronically through transaction networks and clearinghouses in a process known as electronic data interchange (EDI). This method promotes faster, more accurate processing than paper claims submitted by mail, and is required by federal benefit plans. We encourage you to exercise your best efforts to implement electronic claims submission capability as soon as reasonably practicable. Clean claims that are transmitted electronically shall be deemed to have been received by the payor or TPA on the date that such clean claim is transmitted to the payor or TPA. The national provider identifier (NPI) is a required identifier on all electronic health care transactions. EHN recommends that you submit your NPI information as part of your standard submission of practice information updates. EHN supplies this information to payors and/or TPAs for use in electronic transaction processing.

Disputing a Claim

As a network provider you and the payor, TPA, or member have the right to dispute a claim. When a problem arises, contact EHN Network Operations at 469-825-4825 as soon as possible, as required by your participating provider agreement, and provide all information pertinent to the problem. If the issue can't be resolved on the call, it will be escalated to a provider service representative who will conduct an inquiry contacting the payor, TPA, and/or EHN provider relations specialist as appropriate.

If you discover that a claim you sent to a payor or TPA was meant for another payor or TPA, or the claim had incorrect information, please notify the payor or TPA.

If a payor or TPA receives a claim that is not a clean claim containing all complete and accurate information required for adjudication or if the payor or TPA has some other stated dispute with the claim, they will provide you with written notification prior to payment of the claim. The payor or TPA will pay, or arrange for member to pay, all portions of the claim not in dispute. Please provide complete and accurate information requested within thirty (30) business days of the payor or TPA's request (unless otherwise specified in your participating provider agreement).

Following your receipt of payment from the payor or TPA, you may challenge payments made to you during the timeframe as specified in your participating provider agreement (unless otherwise required by law); otherwise, such payment shall be deemed final.

Balance Billing

Please be sure to review the explanation of benefits (EOB) form sent to you by the payor or TPA to determine the amount billable to the member. At the time of the visit, you may collect any copayment or encounter fee specified in the member's program. Following the receipt of an EOB, you may also bill for deductibles and co-insurance, if any, as specified in the member's program, and/or payment for non-covered services. In the event that you collect fees from the member that exceed the member's responsibility, you must refund those fees to the member promptly upon notice of overpayment.

Benefit Maximums

As previously mentioned, members cannot be billed for the difference between billed charges and the contract rate for covered services, whether the payor is primary or secondary. In instances where the cumulative payment by a payor has met or exceeded an annual or lifetime benefit maximum for a particular type of covered service rendered to a member, network providers may not "balance bill" members for the difference in billed charges and the contract rates. However, you may bill the member for the contracted rate once the member has reached the benefit program maximum. A benefit maximum limits the payor's cumulative responsibility for payment of a select set of services to some annual or lifetime dollar amount or service count. This prohibition will remain in effect as long as the patient remains a member under a program. When a particular type of care, treatment, or supply is considered a "major medical exclusion" pursuant to the program and/or does not qualify under any circumstance as a covered service for the member, network providers may bill the member at the network provider's billed charges for the "excluded" service.

Administrative Fees

When fees are negotiated for covered services pursuant to the participating provider agreement, it is recognized that such covered services may include an administrative and maintenance component. As a result, the fees paid for covered services pursuant to the participating provider agreement include payment for administrative, oversight, overhead, and/or similar charges related to the provision of any covered service rendered. You may not separately bill or collect from the member any additional amount for administrative, oversight, overhead, and/or similar charges related to the provision of such covered services.

Professional Fees

EHN requires that all network providers use the nationally recognized coding standards set by the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association for all services performed. We refer to CMS reimbursement methodologies to help us develop our provider reimbursement structure for the services you render at approved clinical, institutional, and non-institutional settings.

You may bill a professional fee when you have specifically provided a professional service to a member. You may not bill a professional fee for a computer-generated report.

Since we apply the industry standard code sets (CPT, ICD, and HCPCS), we recommend you verify that all services performed have a signed physician order, are medically necessary, and are coded correctly. EHN encourages all contracted providers to maintain a current charge master or fee schedule and to verify that the codes and descriptors used match the services performed. For further documentation, please refer to your participating provider agreement with EHN.

Fragmentation (Unbundled Billing)
Individual CPT codes may include more than one associated procedure. It is inappropriate to bill separately for any of the procedures included in the value of another procedure.

Please be sure to review the explanation of benefits (EOB) form sent to you by the payor or TPA to determine the amount billable to the member. At the time of the visit, you may collect any copayment or encounter fee specified in the member's program.

Maintenance of Practice Information

EHN requires that you provide all tax identification numbers (TINs) currently in use, including the name of the owner of each TIN, for each of your practice locations. If a TIN is not recorded with EHN, members' benefits may be reduced, and your payment may be delayed. Please inform EHN promptly of any change in TIN, practice location, telephone number, or billing address. Failure to provide updated information may result in a delay or error in payment of claims for covered services rendered to members.

Report all practice information updates to Employers Health Network via US mail, e-mail, or fax as follows:

- Mail: Employers Health Network, 1212 Corporate Drive, Suite 225, Irving, TX 75038
- Attn: Network Operations
- Email: providers@ehnllc.com
- Fax: 843-936-6554

EMPLOYERS HEALTH NETWORK STATEMENT OF MEMBER RIGHTS AND RESPONSIBILITIES

Patient Rights:

- A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
- A right to be treated with respect and recognition of their dignity and their right to privacy.
- A right to participate with practitioners in making decisions about their health care.
- A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- A right to voice complaints or appeals about the organization or the care it provides.
- A right to make recommendations regarding the organization's member rights and responsibilities policy.
- A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
- A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.
- A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

PAYOR CLAIMS SUBMISSION AND CONTACT INFORMATION

EHN Health Plan Clients have varying claim submission addresses. Always check the member's ID card for accurate claim submission information.

Employers Health Network

EDI Payor ID: IHS07

Claims Mailing Address:
Employers Health Network
P.O. Box 507
Arnold, MD 21012

EDI Payor ID: 75261

Claims Mailing Address:
WebTPA
P.O. Box 99906
Grapevine, TX 76099-9706

Payor Contacts for Concerns, Authorization, and Claims Issues:
WebTPA
P.O. Box 1808
Grapevine, TX 76099-1808
844-380-4548

EDI Payor ID: 44273

Claims Mailing Address:
Health Plans Inc
PO Box 5199
Westborough, MA 01581

Payor Contacts for Concerns, Authorization, and Claims Issues: 800-532-7575
Authorization handled by MedWatch: 877-532-5220
Authorization handled by CMS: 877-906-5730

Claims Mailing Address:
HealthSmart Benefit Solutions, Inc.
PO Box 16327
Lubbock, TX 79490
Verify Eligibility & Benefits through HealthSmart

EDI Payor ID: 37283
For Claims Status and Check Eligibility: 833-780-3891

For Claims Status, Benefits and Check Eligibility: 888-216-6533

For Claims Status, Benefits and Check Eligibility: 855-999-6810

For Claims Status, Benefits and Check Eligibility: 800-278-0703

www.employershealthnetwork.com