Evry Health
A Globe Life Company

Provider Manual

Evry Premier Network

Updated January 2025

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INTRODUCTION

Welcome to Evry!

Evry Health is not your standard health plan.

We're on a mission to help make health insurance more affordable and improve patient outcomes by leveraging the latest technologies, efficient business processes, innovative insurance products, and unparalleled customer service. Part of this mission means getting back to being a good partner for our providers, and working together to ensure the health and wellbeing of our members.

This document serves as a guide on how to work with Evry Health with the most up-to-date version available on our website.

What Evry Health Does

Evry is a commercial health insurer and managed care plan that contracts with physicians, hospitals, and other healthcare providers to deliver care and deliver service to Evry's members. Additionally, Evry promotes the health and wellbeing of its members as well as the delivery of high quality care through its various programs, including care plans, care management initiatives, and chronic condition management.

Our Beliefs

We created Evry Health to help change healthcare for the better, including providing expanded coverage and reduced premiums for our members. We realize that great providers are the bedrock of a great health plan, and that requires being the best partner possible for our physicians and health systems.

We want to ensure your relationship with us is as simple, helpful, and collaborative as possible so that you can focus on providing world-class care.

Questions, Comments, or Concerns?

We're happy to help.

Phone	Email	Mail	Hours of Operation
1(855) 579-3879	**support@evryhealth.com**	**PO Box 571208 Dallas, TX 75357**	**Mon-Fri 9am-5pm CST**

Evry Overview

Mission

- To improve the state and quality of healthcare in the United States by making healthcare affordable, easily accessible, and transparent.

Vision

- Healthcare should be consistent, convenient, and cost effective.

Values

- Efficiency
- Honesty
- Credibility
- Authenticity
- Results-Oriented
- Passionate about Change

Our Pillars

- Members: Provide the best experience navigating care.
- Providers: Be the best payer. Alleviate work-flow issues.
- Employees: Create the best work experience to maximize engagement and wellness.
- Quality: Contribute to better patients' outcomes.
- Innovation: Be the leaders in insure tech for healthcare plans.
- Strategic Growth: Increase our access to more members and providers.

How to get Involved

One of Evry's goals is to improve and expand the ways that providers and insurers work together. We encourage all providers who are interested to contact us to learn more about how they can get involved directly with Evry. Whether that means serving on our Utilization Management Committee, working with us on Quality Improvement initiatives, providing feedback on value-based options, discussing clinical guidelines, working together to improve how we collaborate with providers, or something else entirely, we want to talk and find a way to get you involved.

EVRY AT A GLANCE

Evry Health offers EPO and PPO plans.

The main difference lies in their coverage for out-of-network visits. Preferred Provider Organizations or PPO plans cover both in-network and out-of-network providers, whereas an Exclusive Provider Organization or EPO plan only covers in-network care, except for emergencies or urgent care situations.

The EPO plans are built around networks that combine the flexibility of a PPO with the cost savings of an HMO. An enrollee in the EPO plan, does not need to choose a primary care doctor or ask for referrals with in-network providers. There is no out-of-network coverage. Care is covered by doctors and facilities only in-network (except for emergency services).

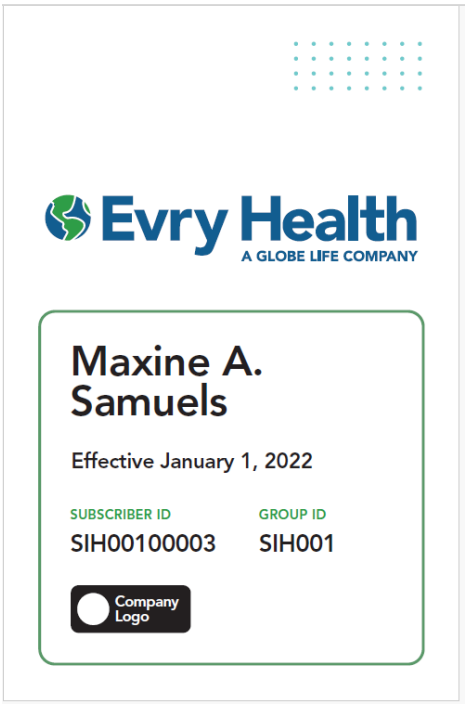
The PPO plans cover in-network and out-of-network visits, offer more freedom and choice in healthcare providers, and members do not need to choose a primary care doctor or ask for referrals. There is out-of-network coverage which may have a higher cost share or meet a separate out-of-network deductible.

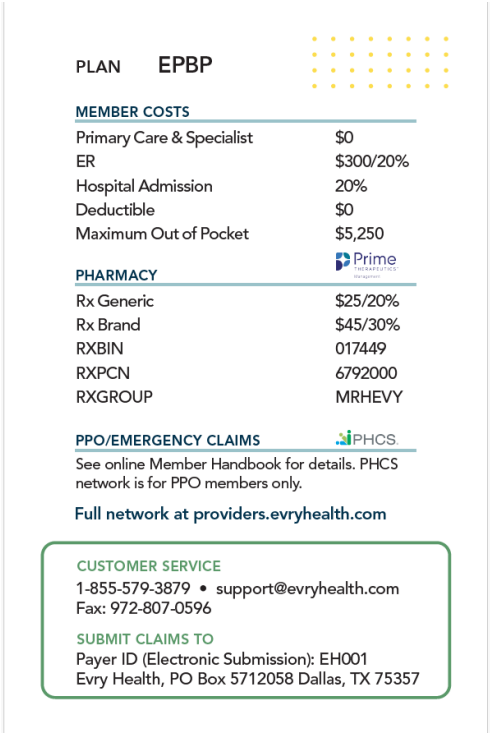
Below is a quick summary of how to work with us.

Check Eligibility and Benefits

1. Call **1(855) 579-3879** between the hours of **9am-5pm** Central Standard Time.
2. Check electronically through Availity. Electronic Payor ID: EH001

Sample Member ID Card





Care Management

For diabetes/hypertension care, cardiac care, asthma/COPD, maternity care, wellness or complex care management, refer patients to call us at **1(855) 579-3879**. Our Member Care Guide Team is standing by to provide dedicated support to patients. This is free and voluntary. Patient participation does not replace provider care and is intended to be an extension of provider services.

Care Plans

As part of our offerings, members will be enrolled directly in one of the following care plans:

- Wellness and Fitness
- Heart and Lung Health
- Bone and Joint Health
- Cancer Prevention and Treatment
- Pregnancy and Maternity

Evry's care plans will present educational content, digital health programs, incentives and rewards to support the health of our members at no additional cost. They will also provide useful options for chronic disease management. If you want to hear more about your member's care plan, call us at: **1(855) 579-3879**. Please review the Telemedicine Section for care options and contact Evry Care Coordination team to determine if your patient is eligible or appropriate for one or more of these .

Chronic Disease and Lifestyle Modification Partners

We have hand-selected different options to help address at-risk behaviors and chronic diseases. These programs will be available to our members at no additional costs after ensuring that they meet eligibility criteria. Please feel free to discuss with your patients and call us if you have any questions such as how to refer to a specific program at **1(855) 579-3879.**

Find In-Network Partners

In-network providers, labs, pharmacies, surgery centers, hospitals, and more can be found in a separate Provider Directory. Visit www.evryhealth.com/providerdirectory for the latest and most accurate provider directory or contact Evry Health.

Pharmacy

Prime Therapeutics manages our pharmacy benefits, including:

- Processing prescription claims.
- Managing clinical pharmacy customer support.
- Coverage reviews for prior authorization of pharmacy requests.
- Specialty pharmacy services.

For drug authorizations and any pharmacy related questions, please call or fax Prime Therapeutics directly at **1(833) 605-0625**.

Drug formulary Link: https://www.evryhealth.com/formulary

The link below will provide a searchable list of in-network pharmacies:

https://web.primetherapeutics.com/member/find-a-pharmacy/

24/7 Access to Virtual Telehealth Visits through Evry Health App

There may be times when a member may have a medical problem after hours or on weekends which doesn't require an emergency room visit. Evry members have access to 24/7 board certified physicians and mental health providers for everyday and urgent care, behavioral health, specialty care which can be an extension of services when members are not able to access their primary care or specialty provider. We encourage our members to share with their provider and care team services received through the Evry Health App. Reach out to Evry Health to learn more about our this service for our members.

Laboratory

Evry partners with Quest Diagnostics and BioReference/GeneDx for in network services. These options provide lab availability at home, in office or at a lab facility.

Home | Quest Diagnostics

BRLI (careevolve.com)

Meet Scarlet | Scarlet Health

Patient Portal | BioReference Laboratories

All molecular diagnostic and genetic lab testing requires prior authorization.

Prior Authorization

EPO members:

- require prior authorization for *all* out-of-network non emergent care services;
- and for certain services rendered by in-network providers.

PPO members:

- *may* require prior authorization, for some out-of-network non emergent care services which depend on the service being rendered;
- and for certain services rendered by in-network providers.

Learn about our prior authorization process and get helpful information to request coverage approval for your patients. Prior Authorization occurs before planned inpatient

admissions and select healthcare services on the prior-authorization requirements list below or see https://www.evryhealth.com/pre-authorization for more information.

Please fax or email the prior authorization request form to request prior authorization. Please call to check the status of an existing authorization or inquire if a procedure requires pre-authorization. A list of services that require pre-authorization is included in the Utilization Management section of this document.

For information on the *prior authorization for pharmacy benefits*, see https://www.primetherapeutics.com/providers-and-physicians.

Submit Claims

Claim Type	Network	Submit to:
In-Network Medical Services	Evry Premier	Electronic Payor ID: EH001 Evry Healthcare, Inc. PO Box 571208 Dallas, TX 75357
Out-of-Area Medical Services	Multiplan PHCS	Electronic Payor ID: EH001 Evry Healthcare, Inc. PO Box 571208 Dallas, TX 75357

OUR PROVIDERS

We want working with Evry to be simple and painless. To that end, this Provider Manual is intended to help provide direction and guidance around the basic operational processes for providers and provider organizations. We encourage you to reach out at **1(855) 579-3879** without delay if there is anything at all we can do for you.

Please note that provider organizations are responsible for distributing copies of this Provider Manual to their in-network providers.

Provider and Support Staff Training

All contracted providers and provider organizations are required to provide appropriate training for employees and applicable subcontractors within **90 days** of hire and annually. Such training shall cover compliance programs that may include, but are not limited to, Fraud, Waste, and Abuse (FWA), Potential Quality Issues (PQI), and the Health Insurance Portability and Accountibilty Act (HIPAA).

Provider Review Requirements

Providers must give regulatory and accrediting bodies the right to audit, evaluate, and inspect books, contracts, medical records, patient care documentation, other records of contractors, subcontractors or related entities for services provided on behalf of Evry Health for the time period required by applicable law following the termination of the contract or the completion of an audit, whichever is later.

Provider Insurance Requirements

Throughout the term of the contract, providers must maintain malpractice, general liability and any other insurance and bond in the amounts usual and customary for Covered Services provided by a licensed managed care company admitted to do business in the State and acceptable to Evry Health. In the event providers procure a “claims made” policy as distinguished from an occurrence policy, providers must procure and maintain prior to termination of such instance, continuing “tail” coverage or any other insurance for a period not less than five (5) years following such termination. Providers must immediately notify Evry of any material changes in insurance coverage

or self-insurance arrangements and must provide a certificate of insurance coverage to Evry upon request.

Compliance with the Americans with Disabilities Act (ADA)

Evry Health's employees, business partners and contracted provider organizations must comply with ADA requirements, including compliance with Section 504 of the Rehabilitation Act which requires that electronic and information technology be accessible to people with disabilities and special needs. Web pages, portals, and other electronic forms of communication are compliant with these standards. Any documents provided on member portals are compliant with the Section 504 standards allowing the use of assistive reading programs.

If you or your patients have any comments or questions about content and accessibility, please contact Evry's Member Services department toll-free at **1(855) 579-3879**.

Language Assistance for Persons with Limited English Proficiency (LEP)

Evry Health assesses the linguistic needs of its enrollee population to ensure members have access to translation and interpretation services for medical services, customer services, and health plan administrative documentation, as needed and according to state regulations. Evry also ensures member access to translated or alternative format documents and communication as necessary, including for the visually and hearing impaired. Members requiring interpreter services can contact Evry's Member Services department at **1(855) 579-3879** for access to the Language Line. Delegated providers are required to follow the policies and procedures established by Evry Health to ensure members with limited English proficiency receive appropriate interpretative and translation services.

Confidentiality and Protected Health Information (PHI)

Evry Health and its provider organizations are considered "Covered Entities" under the Privacy Rule implemented pursuant to HIPAA and require compliance with the strictest applicable federal and state standards for the use and disclosure of PHI. Evry and its affiliated providers are required by federal and state laws to protect a member's PHI and are also required to report any breach in confidentiality immediately. Evry maintains physical, administrative, and technical security measures to safeguard PHI; it is important that any delegated entities maintain these safeguards of PHI as well.

OUR NETWORK PARTNERS

Overview

Evry Health offers EPO and PPO plans. EPO members must use doctors, specialists, or hospitals in the plan's network. Out-of-network care is not a covered benefit, except in cases of an emergency service. PPO members have out-of-network benefits as well as a larger in-network provider network.

For prescription and specialty pharmacy services, telehealth, behavioral health, and home health services, Evry engages with the network partners listed below. Providers of these services must be in the respective partner's network, and claims must be submitted to the electronic or physical address listed. The network partners also handle contracting and credentialing, and some providers do utilization management and review for these services.

Claim Type	Network	Submit to:
Prescription & Specialty Pharmacy Services	PrimeTherapeutics (formerly MagellanRx) Drug formulary Link: https://www.evryhealth.com/formulary For information on prior authorization for pharmacy benefits, see this website https://www.primetherapeutics.com/providers-and-physicians	Prime Therapeutics Attn: Claims Dept. 11013 W. Broad St., Suite 500 Glen Allen, VA 23060
Infusion Services	ARJ Infusion https://www.arjinfusion.com/	Electronic Payor ID: EH001 or Evry Healthcare, Inc. PO Box 571208 Dallas, TX 75357

Telehealth and Telemedicine *Please review the Care Management/Care Plans section for available options and contact Evry Care Coordination team to determine if your patient is eligible or appropriate for one of these programs.	Doctors on Demand/Included Health through Evry App (Included within the benefit plan using Evry Premier Network)	Electronic Payor ID: EH001 or Evry Healthcare, Inc. PO Box 571208 Dallas, TX 75357
Behavioral and Mental Health	Evry Premier	Electronic Payor ID: EH001 or Evry Healthcare, Inc. PO Box 571208 Dallas, TX 75357
Home Health Services & Hospice	Encompass Home Health and Hospice Care (214) 503-7700	Electronic Payor ID: EH001 or Evry Healthcare, Inc. PO Box 571208 Dallas, TX 75357
Durable Medical Equipment	Apria Apria | Home Healthcare For Sleep Apnea, COPD, Wound Care, Diabetes	Electronic Payor ID: EH001 or Evry Healthcare, Inc. PO Box 571208 Dallas, Tx 75357
Pathology and Lab Services	Quest Diagnostics Home | Quest Diagnostics Customer Service Number: 1-866-697-8378 Bioreference Labs/GeneDx Innovative Diagnostic Solutions | BioReference Laboratories Main Number: (800)229-5227	Electronic Payor ID: EH001 or Evry Healthcare, Inc. PO Box 571208 Dallas, Tx 75357

PROVIDER RESPONSIBILITIES

General Responsibilities

The following is a summary of what Evry Health expects from contracted providers. Providers should also reference their specific agreements with Evry.

Please note that these apply to all providers, including primary care physicians, specialists, hospital, and ancillary providers.

- Providers will cooperate with all Evry programs as outlined in this manual and other Evry policies.
- Providers will comply with all applicable authorization procedures for the validation and payment of covered services.
- Providers will coordinate the member's care with the referring provider.
- Providers will be available for or provide on-call coverage through another source 24 hours a day for management of member care.
- Providers will utilize only Evry Health's network of contracted providers unless necessary services cannot be performed by an in-network provider.
- Providers will maintain adequate medical and general liability coverage as prescribed in each provider's agreement with Evry and all licenses, certifications, accreditations, and practice privileges required by law. Providers will furnish proof of such credentials to Evry upon request.
- Providers will fully comply with Evry Health's credentialing requirements and will immediately notify Evry of any material changes in licensure, certification, accreditation, or practice privileges.
- Providers will furnish services in accordance with each provider's legal qualifications and professional capabilities in a manner consistent with recognized standards of healthcare.
- Providers must provide Evry with all identifying information (phone numbers, group affiliations, National Provider Identifier, tax identification number, billing address, etc.) When possible, providers must provide advanced notice of any change.
- Providers will treat Evry members in the same manner and with the same quality of care as they treat other patients. Providers will refrain from discriminating against any Evry member on the basis of membership, source of payment, sex, age, ethnicity, race, color, religion, national origin, ancestry, marital status, sexual preference, or any factor related to health status, including but not limited to, medical condition (including conditions arising

out of domestic violence), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability or handicap, or any other prohibited federal law.

- Providers will communicate with patients about all treatment options they feel are relevant regardless of any limitations in benefits coverages in their policies.
- Providers will look only to Evry Health for payment of covered services and will accept Evry Health's payment as payment in full for covered services. The only exception is that providers can pursue payments from other responsible payors when appropriate.
- Providers will maintain timely and accurate patient records for Evry members in accordance with applicable state and federal laws. Providers will also ensure the confidentiality of those records and access to those records by authorized Evry representatives, peer reviewers, and government representatives upon request.
- Providers will, to the extent possible and legally required, promote the use of health information technology.
- Providers will allow Evry Health to use provider performance data for quality improvement activities.
- Providers will submit claims for covered services in accordance with Evry specified formats, designated claims forms, and with the provider's NPI.
- Providers will comply with all applicable state and federal legislative, regulatory, and legal requirements.
- Other than the appropriate discharge of a patient, providers are expected to refrain from withholding care, appointment access, medication, prescriptions, or treatment of any kind for any reason.
- Providers will comply with and adhere to the American Medical Association Principles of Medical Ethics (Code of Medical Ethics and Conduct) in the care and treatment of Evry Health members.
- Contracted providers shall not use any financial incentive or accept any reimbursement that either directly or indirectly is an inducement to deny, reduce, limit, or delay medically necessary and appropriate services.
- Providers will comply with all obligations outlined in their contracts and in any amendments to those contracts.

Other Responsibilities

- Coordinate with the member's primary care physician or with their Evry Health Care Guide in all situations involving the delivery of medical care or services to an Evry Member.
- Except in the case of emergencies, provide only authorized and covered services.
- Provide a timely written report to the member's primary care physician or Evry Health Care Guide for inclusion in the member's medical record.
- Use only Evry contracted agencies and facilities for tests or services provided to members, unless otherwise authorized by Evry Health.

ENROLLMENT AND ELIGIBILITY

Employees of a business that have contracted with Evry for insurance are eligible for coverage. Evry quotes business to, and will in enter into contracts with, companies that have between 50-2,000+ employees and that are located within the plan service area.

The insured's spouse or domestic partner and all dependent children, including those who qualify under a "Qualified Medical Child Support Order", may also be eligible to enroll with Evry at the same time.

Open Enrollment Period

The annual open enrollment period is designated by the member's employer. During this period, individuals may enroll in an Evry Health plan or switch from one Evry plan to another.

Special Enrollment Period

Individuals may also enroll outside of this period if they are a new hire or lose existing benefits coverage. An individual may enroll outside of the Open Enrollment Period if they experience a qualifying life event or changes in eligibility.

Verifying Eligibility

It is ultimately the provider's responsibility to verify eligibility prior to delivering any non-emergency services or treatments.

Providers can confirm eligibility by calling Evry's Provider Services Department at **1 (855) 579-3879**, or electronically through Availity using the Payor ID: **EH001**.

All Evry members receive a Member Identification Card (Member ID Card) with the name of their plan, their member ID number, their first and last name, and contact information for the Member Services Department. The member should present to you this card, or a digital copy of the card, prior to delivery of non-emergency services.

Evry Health will not pay any claims for members that are ineligible at the date of service or for individuals not covered and in good standing with Evry Health.

Grace Periods

Evry maintains the following grace period unless otherwise specified by applicable state and federal law.

Evry Health provides a grace period of **31 days** to groups and/or individuals who have previously paid at least one full month's premium during the benefit year. The policy remains active for all insureds during this grace period. Coverage will be terminated as of the end of the period for which premiums have not been paid if any outstanding premium is not paid by the end of the grace period.

Any payments made by Evry to a provider on behalf of a member who loses coverage due to non-payment of premiums will be refunded by the provider to Evry within thirty (30) days of receipt of written request by Evry Health.

Any refund amounts not paid within thirty (30) days of receipt of notice from Evry may be deducted from future payments by Evry to the provider, for the same or different Members, with an explantion of the action taken and without further action required by the provider.

After Evry has confirmed that the grace period expired without premiums being paid in full, Evry will deny claims that are received and not processed with dates of service starting on the last day the premium was paid. If the member pays in full during the grace period, claims will be processed as usual.

CLAIMS AND PAYMENT

This section describes Evry Health's claims policies and procedures. Please call **1(855) 579-3879** for any questions or concerns relating to claims.

Providers may submit claims electronically or via mail for verified, eligible members. Electronic submissions are greatly preferred. In-network providers are reimbursed according to the rates outlined in their Provider Agreements.

For situations where multiple contracted rates apply to a claim or that contracted rates exceed billed charges, Evry may pay the claim at billed charges or in accordance with the agreement with the lesser reimbursement rate solely at its discretion.

Claims Submission

Evry prefers and recommends submitting claims electronically via Availity or Change Healthcare. Evry does not currently work directly with other clearinghouses, such as Eligible.

If you experience any issues setting up electronic claims submission to Evry via Availity or Change, please contact your billing vendor to ensure they have Evry Health's Payor ID stored in their system.

Evry's Payor ID for electronic medical claims is: **EH001**

In the event that a medical claim cannot be submitted electronically, please submit a paper UB-04 or CMS-1500 to:

Evry Healthcare, Inc.
P.O. Box 571208
Dallas, TX 75357

Please note that Evry does not currently offer dental or vision coverage for adults or children.

Timely Filing of Claims

Providers should reference their own contracts with Evry for timely filing deadlines when submitting claims. Unless otherwise stated in the contract, please submit a clean claim no later than **95 days** from the date service was delivered.

Changes to a previously submitted claim must be received 95 days from the date the service was delivered, or the date specified in the contract.

Note that different filing deadlines can apply if a provider enters into a formal dispute resolution process with Evry. Please refer to the Dispute Resolution Section of this manual.

All claim submissions must be properly completed itemizing the services or supplies received as well as the charges. Only claims that are considered a “Clean Claim” as defined by applicable Texas law and regulation will be accepted and processed.

Evry will not be liable for claims that are not properly submitted as complete or clean within these time periods.

Claims Forms

For claims that are submitted via mail, Evry Health requires the following forms:

> **CMS-1500 Form**: Required for all physician professional services claims. The International Classification of Diseases (ICD-10) diagnosis codes and HCPCS/CPT procedure codes must be used. All field information is required unless otherwise stated.
>
> **UB-04 Form**: Required for all institutional facilities claims. All field information is required unless otherwise stated.

These forms are available at https://www.evryhealth.com/forms.

Miscellaneous, T codes or unlisted codes are not covered, unless otherwise stated in the provider’s contract.

Requests for Additional Information

Evry will occasionally ask a provider for additional information while adjudicating a claim. This information includes, but is not limited to: medical records, itemized bills, and acquisition invoices. Any information requested will be used to better determine financial liability and whether the charges should be covered.

Evry will make any requests for additional information within **30 days** of receiving the claim. Providers are expected to submit the requested information, along with the original claim and a copy of the request letter, within **30 days** of receipt of the request.

The requested information can be submitted to:

Evry Health
P.O. Box 571208
Dallas, TX 75357

The claim will be processed before the timely payment deadlines specified by the Texas Department of Insurance (TDI) once all necessary and requested information is received and the claim is deemed clean.

Timely Processing of Claims

While Evry endeavors to process and pay claims as quickly as possible and well in advance of legal requirements, all claims for preferred providers will be processed by state-mandated deadlines. These deadlines are:

30 calendar days for clean claims submitted electronically, or **45 calendar days** for clean claims submitted in a non-electronic format.

If the claim is an electronically submitted pharmacy claim, it will be paid within **18 days** after the claim is affirmatively adjudicated. For a non-electronically submitted pharmacy claim, it will be paid within **21 days** after the claim is affirmatively adjudicated.

Preferred Provider Late Payment Penalties

Evry Health will pay a late penalty for all clean claims that are not paid within the state-mandated deadlines.

Evry Health will pay an underpayment penalty for all clean claims where Evry processes and pays a portion, but not all, of the contracted rate.

The amounts of these penalties are listed below as stipulated by the Texas Department of Insurance (TDI).

Penalty Type	Days After Deadline	Amount of Penalty
Late Claim	1-45 days	Lesser of $100,000 OR 50% of the difference between contracted rate and billed charges.
Late Claim	46-90 days	Lesser of $200,000 OR 100% of the difference between contracted rate and billed charges.
Late Claim	91+ days	Lesser of $200,000 OR 100% of the difference between contracted rate and billed charges plus 18% annual interest.

Penalty Type	Days After Deadline	Amount of Penalty
Underpaid Claim	1-45 days	Lesser of $100,000 OR 50% of the underpayment amount.
Underpaid Claim	46-90 days	Lesser of $200,000 OR 100% of the underpayment amount.
Underpaid Claim	91+ days	Lesser of $200,000 OR 100% of the underpayment amount plus 18% annual interest.

These penalties are calculated for each day past the timely payment deadline from either the original date the clean claim was received.

In institutional cases, **50%** of the penalty, including interest, is due to the provider and **50%** is due to the Texas Department of Insurance (TDI). In accordance with TDI regulations, Evry Health will aggregate payments owed to TDI at the end of each month.

For amounts of penalties for late and underpaid claims of 91+ days, interest accrues beginning on the date the claim payment was due and ending on the date the claim and penalty are paid in full.

Good Faith Payments

Solely at its discretion, Evry may determine that it has denied or reimbursed a claim correctly but agree to overturn the denial or issue additional payment on behalf of the member. In these situations, these “Good Faith Payments” will not be eligible for any interest or late payment penalties.

Incomplete Claims

Claims that are submitted with missing or incorrect information, such as invalid CPT codes, will be denied. These claims will need to be resubmitted with the missing or correct information in order to be adjudicated.

Claim Denials

Evry will notify members in situations where the member could be financially liable for a claim denied by Evry. This notification will include an explanation for the denial as well as an explanation of their appeal rights. Providers may submit a corrected/replacement or voided claim within the timely filing period.

For paper claims, providers should use a corrected or voided bill type when resubmitting a UB-04 claim, and populate the applicable resubmission code on a CMS-1500 claim. Corrected claims submitted without replacement or voided bill types/resubmission codes may be rejected or denied.

For electronic claims, submit a claim via EDI, in the applicable loop and segment location:

Loop 2300 (Claim Information)

Segment: CLM

Element: CLM05-3 (Claim Frequency Type Code)

For UB-04 Claims Enter the four-digit code, the first of which is a zero, and use a 7 (the “Replace” billing code) in the fourth position to identify it as a corrected or replacement claim.

Enter the four-digit code, the first of which is a zero, and use an 8 (the “Void” billing code) in the fourth position to identify it as a voided claim.

For 1500 claims Use a 7 (the “Replace” billing code) to identify it as a corrected or replacement claim

Use an 8 (the “Void” billing code) to identify it as a voided claim

Emergency Services Claims

Emergency services do not require prior authorization. All unplanned hospital stays require notification and length of stay review for medical necessity within 72 hours of hospital admission. All out-of-network facilities are required to request authorization for further care or treatment needed within 24 hours after the stabilization of an emergency medical condition.

Claims Overpayment

If Evry Health determines it has overpaid a claim, Evry will provide a written request for a refund to the provider. This request will include the patient’s name, member ID number, date(s) of service, amount to be refunded, any interest and/or penalties related to the overpayment, and an explanation of how we determined the claim was overpaid.

Evry will make any refund requests within **180 days** of the date the claim was paid. Please note that this deadline will not apply to recovery efforts in situations where **fraud, abusive billing, or intentional miscontent** is believed to have occurred.

Upon receiving the refund request, providers must issue the payment or submit a written response officially contesting the overpayment within **45 days** of receiving a request for refund from Evry. The provider must provide specific reasons if a provider chooses to contest an overpayment refund request and must identify the specific portion of the overpayment that they are contesting.

Refund checks or written notices contesting the refund for overpayment request can be sent to:

Evry Health
P.O. Box 571208
Dallas, TX 75357

If the provider fails to issue the refund payment or written notice of contestation to Evry within 45 days, the amount of overpayment may be deducted from future claim

payments, for the same or different members, with an explanation of the action taken until Evry has been fully reimbursed.

Collection of Cost Share

Covered services provided to Evry's members may be subject to a deductible, a copayment amount, or a coinsurance amount. The member is responsible for reimbursing the provider the relevant amount.

Coinsurance and copayment amounts for common services will be listed on the member's ID card. These amounts, as well as the member's deductible, can also be verified by calling Evry's Provider Service Department at **1(855) 579-3879**.

Evry encourages providers to collect copayments from the member at the time of service, but to not collect coinsurance amounts or deductibles until the claim has been adjudicated by Evry and the provider has received an Explanation of Payment (EOP). If the provider elects to collect the coinsurance amounts or deductibles upfront, the provider should check with the member whether or not they anticipate other medical or prescription spending to occur in the same day. If further spending is expected, Evry encourages the provider to account for those amounts in the upfront collection.

If a provider collects an amount upfront at time of service that exceeds the member's cost share as indicated in the Explanation of Payments (EOP), Evry Health requires the provider to issue a refund to the member within **10 business days** of receipt of the EOP.

Coordination of Benefits and Subrogation

Coordination of Benefits (COB) rules apply when a member has coverage from more than one health plan. They determine the order in which plans pay claims and benefits. COB or Health Order Liability (HOROL) is the member's responsibility to provide other insurance information to Evry. Members who do not update their other insurance information may have their claims denied and be responsible for the charges. Providers may bill members for services that were denied for lack of other insurance information.

Providers should bill for coordination of benefits only if the member is covered by more than one plan and Evry Health is secondary, or the primary carrier has been billed and a remittance advice has been received showing a balance remaining.

To the extent provided by applicable state and federal law and the applicable benefit plan, Evry reserves the right to recover benefits paid for a member's healthcare services when a third-party causes the member's injury or illness.

Balance Billing

With the exception of deductibles and copayments, providers must not balance bill or invoice Evry members for the difference between Evry's reimbursement and the provider's billed charges. Furthermore, members may not be held liable for payment if providers are not compliant with this manual, the terms of their contract with Evry Health, or state regulations (e.g. prior authorization checks, timely filings, etc.).

Providers are expected to comply with the Texas Department of Insurance's (TDI) mediation process for eligible out-of-network claims.

This mediation process is available to members who receive medical services and/or supplies provided by in-network hospitals by the following types of out-of-network hospital-based physicians:

- Radiologists
- Anesthesiologists
- Pathologists
- Emergency department physicians
- Neonatologists
- Assistant surgeons

If Evry Health receives a mediation request from TDI for a qualifying claim or event, Evry will notify the provider and schedule a teleconference call or in-person meeting to resolve the dispute. Evry will schedule this call or meeting no later than **30 days** after the date that the mediation request is submitted to TDI. The provider and member will be notified of the date and time for the call or in-person meeting by Evry. It will be Evry's responsibility to provide a toll-free conference line or meeting location.

Evry will submit a request to TDI for formal mediation in the event that the hospital-based physician and member cannot settle the dispute during the teleconference call or in-person meeting.

Evry asks providers to only refer members to an in-network provider or facility. A list of in-network providers, labs, pharmacies, surgery centers, hospitals, and more can be

found at https://www.evryhealth.com/providerdirectory or by calling Evry's Provider Service Department at **1(855) 579-3879.**

Out-of area mediations will be handled by Evry's out-of-area partner, Multiplan.

More information on TDI's mediation process can be found at: https://www.tdi.texas.gov/consumer/cpmmediation3.html.

Reimbursement Policies

Evry processes reimbursements for in-network providers in accordance to the organization's policies, which are available upon request by contacting support@evryhealth.com.

Evry reserves the right to modify or change its reimbursement policies at any time by publishing new versions to the website and providing appropriate notice of changes to providers as required by applicable state law.

UTILIZATION MANAGEMENT

Evry Health is committed to enabling sustainable, high quality, efficient, and affordable outcomes for its members through its Utilization Management (UM) Program and Utilization Review (UR) actions. Evry's utilization management process of certain health services is to determine whether the services are or were medically necessary for a covered benefit, or experimental/investigation. This process is called utilization review. This review process results in a service being prior authorized or denied as a non-covered benefit. The UM program outlines policies and procedures which Evry uses to determine medical necessity, appropriateness, access and availability, and efficiency for medical services based on the member's health plan and Evry care plan.

The UR activities include:

Prospective Reviews: This includes prior authorization or precertification conducted prior to the onset of a service or treatment. The purpose of this is aimed at minimizing members' out-of-pocket costs and improving overall cost efficiencies.

Concurrent Reviews: Performed during the delivery of a service, treatment, or episode of care. This review may include care coordination led by an Evry team discharge planning, and care transitioning. This is intended to support the optimization of an episode of care including inpatient length of stays and recovery times, and ultimately improve patient outcomes.

Retrospective Reviews: This review *may* occur after the service was rendered. This type of review occurs in limited circumstances. This process assesses the appropriateness, location, and duration of services performed and covered under the member's benefit plan. The plan may ask you for the information we do not have.

The process for the UR activities above is to gather appropriate and relevant clinical data for each case, apply case-specific criteria based on medically accepted best practices and standards, and to notify both providers and members of utilization decisions. Evry will use individual member information, such as age, family medical history, comorbidities, complications, progress of treatment, psychosocial siutation, and home or environmental information when applicable, biometric information, and other sources to inform its decision making during the review process.

Prior Authorizations

See List of Services requiring prior authorization section for more information.

Benefits of prior authorization:

- to assure members health benefits are administered appropriately
- members receive treatments that are proven to be safe and effective for the condition being treated
- members and their appointed representatives will know coverage decisions before procedures, services or supplies are provided
- identification of members to pair them with specialty programs with case management and disease management

Evry Health works together with providers and facilities to ensure a requested healthcare service is a covered benefit of the member's health plan. It is important to call Provider Services to verify Benefits and Eligibility with Evry Health for all services. Some services may require clinical review and prior authorization before a service is delivered. For these services, authorization should be obtained prior to the delivery of certain elective and scheduled services. Authorization will be provided when the requested service is a covered benefit of the member's health plan, considered medically necessary, and represents the most effective and efficient manner in which to deliver care.

Emergency services do not require prior authorization. All unplanned hospital stays require notification and length of stay review for medical necessity within 72 hours of hospital admission. And *all out-of-network facilities* are required to request authorization for further care or treatment needed within 24 hours after the stabilization of an emergency medical condition. The facility is responsible for timely authorization and notification. For more information see section on notification and admissions, post-stablization below.

All planned admissions require pre authorization, this includes admission to an inpatient facility, intensive outpatient (IOP), partial hospitalization (PHP), and residential treatment center (RTC) that are not directly from an emergency room.

Prior authorization may be required for PPO members, for some services rendered by an out-of-network provider which is dependent on the service being rendered; and for certain services rendered by in-network providers. PPO members may have a higher cost share or meet a separate out-of-network deductible for services out-of-network. Prior authorization is required for EPO members, before the provision of ALL non-

emergent services rendered by an out-of-network or out of area provider; and for certain services rendered by in-network providers.

Prior authorization is required before the provision of all non-emergent healthcare services, supplies, equipment and physician administered drugs delivered by a non-preferred provider for an EPO member and may be required for a PPO member. It is the responsibility for the rendering, ordering or referring provider to initiate the request for prior authorization for non-emergency, non-preferred provider healthcare services.

Visit https://www.evryhealth.com/pre-authorization for more information on preauthorization requirements or call Evry Health.

Evry Health may, at its sole discretion, rely on vendors, consultants, and other third-parties with expertise in overseeing determinations for coverage and utilization. For these situations, these parties will be managed in accordance with the processes outlined in the Delegation and Oversight section of this manual.

Pre-authorization requests may be submitted to Evry by fax, email or online through Evry's website. Refer to www.evryhealth.com for more details or fax at the number listed below:

Phone: Provider Services Department at **1(855) 579-3879**

Fax: **(325) 603-0541**

You may check the status of an existing authorization request by calling the Provider Services Department at **1(855) 579-3879 (EVRY)**. For all requests, providers may use Evry's standard Authorization Request Form, available online at https://www.evryhealth.com/forms.

To avoid potential delays in the delivery of care to Evry's members, please submit prior authorization requests within the timeframes listed below:

Number of Days Prior	Service
Minimum 5 days	Prior to an elective outpatient physical health or behavioral health services.
Minimum 5 days	Prior to any scheduled or planned admission for physical health, behavioral health, or chemical dependency admissions, including elective surgical procedures, acute, non-acute, rehabilitation, skilled nursing facility, and hospice.
Minimum 5 days	Prior to the commencement of home health care services.
Minimum 30 days	Prior to the initial evaluation for organ transplant services.
Minimum 30 days	Prior to receiving clinical trial services.

Authorization Decision Timeframe for Notification & Determination

Evry works to provide authorization decisions as quickly as possible. On receipt of a request from a participating provider for prior authorization, Evry Health shall review and issue a determination including whether the health care services are authorized. Any expediated review which meets the criteria for non-urgent may be reclassified to a non-urgent timeframe by a physician reviewer. It may be necessary to obtain additional information to determine medical necessity for approval, which would extend the determination timeframe. The preservice requests for authorizations are approved or denied within 3 days of request and all information received.

A facility or provider may request an urgent/expediated review for a patient with a life-threatening condition, or for a patient who is currently hospitalized, or to authorize treatment following stabilization of an emergency condition for a date of service less than 3 days in the future. You may also request an urgent review to authorize treatment of an acute injury or illness, if the provider determines that the condition is severe or painful enough to warrant an expedited or urgent review to prevent a serious deterioration of the patient's condition or health.

Type of Request	Timeframe for Notification
Pre-Service/Urgent/Expediated	Determination within three calendar days
Pre-Service/Non-Urgent/Standard/Routine	Determination within 5 calendar days
Concurrent/Urgent/Expediated	Determination within 24 hours
Concurrent/Non-Urgent/Standard/Routine	Determination within 24 hours
Post Service/Retrospective	Determination within 45 calendar days
Pharmacy Benefits Routine	Determination within 3 calendar days
Pharmacy Benefits Concurrent	Determination 30 days before discontinuance of the medication drug or intravenous infusion

Clinical Criteria

All Utilization Management programs and Utilization Review actions are overseen by Evry's Chief Medical Officer (CMO) with input, as necessary and required by law, from Evry's Utilization Review Committee, which consists of medical providers with a wide range of specialties and backgrounds, as well as Evry's UR staff. The parties develop and approve the clinical criteria, medical policies, and medical protocols for the determination of medical necessity and appropriateness of care.

Additional criteria from vendors or partners is either listed below or made available to providers and members upon request. In the event of an adverse determination, the relevant clinical criteria are summarized in determination notice sent to the provider and member. All clinical criteria are evidence-based, developed in accordance with the current standards of national accreditation entities, based on nationally-recognized standards, and developed to ensure quality of care and access to necessary healthcare services. These criteria are reviewed and updated at least annually.

Evry Health currently relies upon:

- State and Federal Guidelines
- Proprietary Medical Policies
- MCG Guidelines
- American Society of Addiction Medicine Criteria (ASAM) Criteria
- Standards for Reasonable Cost Control and Utilization Review for Chemical Dependency Treatment Centers Texas Administrative Code (state.tx.us)

In addition to the above, Evry may cite or utilize clinical evidence from other established and reliable sources that are clinically relevant. MCG provides evidence-based standards of medical necessity and best practice care as they constantly evolve based upon MCG's transparent assessments of the latest research and scholarly articles and with input from licensed healthcare providers. Their standards are based upon generally accepted medical standards. Evry utilizes the current edition of MCG's criteria, interim updates as they are released, as well as various software services and modules provided by MCG.

Evry has partnered with an outside vendor or third-party for the services listed below. These parties are overseen by Evry's UM staff. These partners may have their own specialty criteria, which are reviewed and approved at least annually by Evry's Chief Medical Officer.

Delegate	Service Categories Delegated for UR
Prime Therepeutics	Pharmacy benefits including home infusions and prescription medication

Evry gives consideration to the local provider network and delivery systems available to members with specific needs, such as skilled nursing facilities, subacute facilities, and home health agencies. As part of its care management processes, Evry reviews an

individual member's unique needs and provides specific guidance tailored to the member and their special circumstances, if any.

Requests and Communications

Providers should call Evry's Provider Services Department at **1(855) 579-3879** to confirm requirements by service, procedure, code, bundle, or episode.

For any services where Evry delegates utilization review, you will be transferred to the appropriate external party or given the necessary contact information. All determinations, or requests for more information in order to make an initial Utilization Review determination, will be made within a timeframe appropriate for the member's condition and specific medical need. These timeframes will not exceed the applicable requirements imposed by the State, URAC, NCQA, and/or federal laws and regulations.

Determination decisions will be communicated in writing as well as verbally to providers, and will be communicated to members in writing or verbally. If Evry Health, or an agent of Evry Health, has given written or verbal authorization prior to the provider performing the service for a covered person, Evry will not reverse a UM approval except in cases where there is fraud or a material misrepresentation.

Program Staff

Evry's Chief Medical Officer has an administrative license in Texas. This Chief Medical Officer is ultimately responsible for Evry's UM Program and all UM activities, such as implementation, supervision, oversight, and evaluation of the Program. Utilization review decisions are made in accordance with generally accepted clinical practices, taking into account special circumstances of each case that may require an exception to the standard. The clinical screening criteria are used for review of medical necessity of the requested service. If medical necessity of a prior authorization cannot be confirmed by clinical staff, a Texas licensed physician/medical director reviews the case, which includes the opportunity for a peer discussion with the rendering or ordering provider prior to issuing any adverse determination. Adverse determinations are only made by a licensed physician. Consequently, the Chief Medical Officer has ultimate oversight and accountability for all adverse determinations relating to members in an Evry health plan within the state of Texas, regardless of whether or not the determination was made by an Evry employee or delegated review agent.

Authority levels for applicable Evry staff members is listed below.

Type of Staff	Participation in UM Program	Authority to issue Adverse Determination?
Licensed Physicians	Review, approve, and/or deny UM requests based on plan documents, policies, procedures, and established clinical critiera. Communicate with members and providers.	Yes
Licensed Nurses	Review and approve UM requests based on plan documents, policies, procedures, and established clinical criteria. Escalate non-approvals for physician review. Communicate with providers and members.	No
Clinical Operations Staff	Oversee UM operations to ensure compliance and that necessary resources are made available to clinical staff. Contribute to quality oversight and reporting.	No
Board-Certified Physician Consultants	Apply domain expertise where a specialty review is required. Provide determination recommendation to Evry's licensed physicians.	No
Non-Clinical Intake Staff	Provide clerical support for inpatient, outpatient, and case management areas, including: data entry; creation of letters, reports and files; verification of member eligibility and benefits; and, serving as the initial point of contact for members and providers for UM activities.	No

Evry works to ensure consistent application of its review criteria across its UM staff through both regular internal audits of determinations made by its clinical UM staff and inter-rater reliability testing (IRR). During IRR testing, clinical UM staff are given scenarios and asked to demonstrate their decision-making so that differences in determinations can be identified and used for the purposes of remediation and training.

Prior Authorization Process

Evry's UM staff is available **eight (8) hours per day** during normal business hours, at a minimum, as well as outside of normal business hours for urgent requests. When initiating or returning UM related calls, the UM staff will identify themselves by name, title, and organization name. Language assistance and TDD/TYY services are available for callers at any valid Evry business number.

Evry Health's Utilization Management Program affirms the following:

- Practitioners or other individuals are not specifically rewarded for denials of coverage.
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization.
- UM decision-making is based solely on appropriateness of care and service and existence of coverage.

Prior authorization can be submitted by phone, fax or online through Evry's website. See https://www.evryhealth.com/pre-authorization provider resources for more information. All prior authorizations requests should include supporting documentation to ensure that the medical necessity review can be timely processed for determination.

The following information should be included with each prior authorization request:

- Member information (member name, member DOB, member Evry ID number); and,
- Provider information (Rendering provider name, NPI, TIN); and,
- Physician signature/Physician order; and
- Specification and description of service, supply, equipment, or Physician-Administered Drugs procedural/service code(s) and description (CPT, HCPC, NDC); and,
- Pertinent diagnosis/conditions that relate to the need for the service (ICD-10); and,
- Objective clinical information (eg. Pertinent notes, radiology reports, and lab findings) necessary to support medical necessity for the requested service; and,
- Start and end date(s) of service; and,
- Frequency and duration

- Depending on the request, specific clinical documentation and information may also be required to complete the medical necessity review.

List of Services Requiring Prior Authorization

It is important to verify Benefits and Eligibility with Evry Health Plans for all services, call Provider Services for more information. The Services listed below may be governed by Evry Health Plans Medical Policies, which may impact coverage decisions. Prior authorization is not a guarantee of benefits or payment. The terms of a member's plan control the available benefits.

Please note that the services listed below within each category may not be exhaustive and apply to both EPO and PPO members. Note: Any services not listed and are non emergent out-of-network or out-of-area services *require prior authorization for EPO members.*

Please call or check the website if you are uncertain whether a prior authorization or referral is necessary or to see if a provider is participating in network. Providers are encouraged to check Evry's website or call **1(855) 579-3879** to confirm requirements for specific codes or services.

- **Admissions**:
    - All **planned** or **scheduled** inpatient medical, inpatient behavioral, or inpatient chemical dependency and surgical admissions, including acute, rehab, skilled nursing facilities requires prior approval. *Except* for maternity admission for vaginal delivery or C-section where notification is required within 24 hours or one business day of the admission.
    - All **unplanned** admissions require *notification* within 72 hours or three calendar days of the admission.
        - An inpatient stay longer than 48 hours for a vaginal delivery or 96 hours for a cesarean delivery will require prior authorization.
    - All **Inpatient hospital/facility stays**: the length of stay must have prior approval.
        - The provider may request additional days to be authorized, if needed.
    - All **transfers** to another hospital or to or from a specialty unit in a hospital require prior approval.

- **Advanced imaging**: CT, CTA, MRI, MRA, PET Scan, Angiogram, Arteriogram
- **Behavioral Health**: All inpatient services for substance use disorder, developmental/cognitive screening and testing, neuropsych/psych testing, transcranial magnetic stimulation, intensive outpatient program (IOP) services, partial hospitalization program (PHP) services, residential treatment center (RTC) services
- **Clinical Trials**: All clinical trials including cancer and clinical innovation.
- **Dental services**: All services for inpatient oral maxillofacial/craniofacial services, such as orthognathic surgery, TMJ surgery. Medical plan generally does not cover dental related services.

- **Dialysis**: All services
- **Durable Medical Equipment (DME) & Supplies** that will cost over $1000, including implants, new technologies, and replacement of devices every 36 months. ***Evry's in network provider for DME is Apria.***
    - This can include:
        - Braces, orthotics, prosthetics
        - Bone growth stimulators
        - Cranial molding helmets
        - Cochlear implants
        - Diabetic supplies: implantable continuous glucose monitors, therapeutic continuous glucose monitors
        - Hearing devices: Hearing aids
        - Hospital beds and accessory equipment
        - Implantable DME: including ocular/corneal implants
        - Mobility devices: wheelchairs, power operated vehicles, gait trainers and lifts
        - Pneumatic Compressors
        - Wound care devices
- **Gene therapy and molecular diagnostics**: Genetic testing, genomic, pharmacogenetic, pharmacogenomics, and pharmacodynamic testing. *(In network providers includes Quest, Bioreference/GeneDx offers in home lab or office, fully integrated digital platform providing access to on-demand specimen collection and Quest Diagnostics)*
- **Habilitative services:** Physical therapy (PT), occupational therapy (OT), speech therapy (ST) may require prior authorization and have benefit limitations.
- **Hematology and Oncology:** Cancer treatment including chemo, radiation, and surgery
- **Home Services**: (***In network provider Encompass Health & ARJ Infusion for Specialty Services)***
    - Home care: skilled nursing, non skilled nursing, extended home care, hemodialysis, home medical visits, ST/OT/OT services
    - Home Infusion therapy services: hydration, nutrition, medications including antibiotics
    - Hospice services (inpatient and home services after first 6 months)
    - Medical foods or enteral nutrition: oral foods generally not a covered benefit

- **In-Office Procedures**: Required for services greater than $1000.00 ***(see lab for lab services)***
- **Non Emergency Transportation/Transfer**: Land transportation or transfer (ambulance, taxi, car service) and air ambulance.
- **Ophthalmology**: All medical eye condition treatments except for cataracts and Yag laser are covered without authorization.
- **Other Services (see provider directory for in network providers)**:
    - For wound care including, but not limited to hyperbaric oxygen, negative pressure wound therapy, wound care specialty supplies
    - Photodynamic therapy
    - Plan specific services, may not be a covered benefit:
        - Infertility services and erectile dysfunction treatment: IUI, IVF, Embryo Transfer, FET, GIFT, ZIFT, ICSI, Donor Egg Procedures, Donor Sperm/Embryos, Cryopreservation of Sperm, Sperm Storage/Banking, PGD, MESA, and TESE, Penile Implants
        - Transgender services including hormone therapy
        - Bariatric surgery initial and/or revisional

  Out-of-Network Services/Out-of-Area Care: It is the responsibility for the rendering, ordering or referring provider to initiate the request for prior authorization for non-emergency, non-preferred provider healthcare services.

    - **EPO members:** Prior authorization is required before the provision of all non-emergent healthcare services, supplies, equipment and physician administered drugs delivered by a non-preferred provider for an EPO member. Out-of-network/out of area non emergent care is not a covered service for members with an EPO plan.
    - **PPO members:** Prior authorization may be required for some services rendered by a non-preferred provider. PPO members do have coverage for non emergent out-of-network care.
- **Rehabilitative Services**: Chiropractic care, acupuncture, physical therapy (PT), speech therapy (ST), occupational therapy (OT), cardiac rehab, pulmonary rehab may require prior authorization and have benefit limitations.
- **Surgical Procedures and services**: All non-emergent surgical procedures and services.

  - Breast procedures
  - Cardiac surgeries
  - Eye surgeries
  - Ear, Nose and Throat surgeries: Nasal/endoscopy, tonsillectomy & adenoidectomy, tympanostomy, myringotomy
  - Gene therapy
  - Gastrointestinal surgeries
  - Intradermal fillers
  - Musculoskeletal and Spine Surgical procedures: eg. spinal surgeries, back procedures (ESI, RFA, MBB, Facet), joint surgeries (knee, hip, shoulder, hammertoe, bunionectomy), joint injections, trigger point injections
  - Nerve blocks
  - Neurostimulator implants
  - Reconstructive and cosmetic procedures
  - Transplant services: Solid organ and stem cell
  - Varicose veins treatment (surgical and invasive)

- **Pathology and Laboratory Services**: Drug testing, genetic testing and molecular diagnostics, miscellaneous and unlisted codes. Check website or call to check specific code. ***(In network provider for lab and diagnostics includes Quest Diagnostics, Bioreference/GeneDx)***
- **Pharmacy** and specialty pharmacy, medications, devices and/or new technologies: See MagellaxRx contracted provider managing these requests on behalf of Evry.
- **Physician administered pharmaceuticals** included but not limited to:
  - Biologicals and certain biosimilars, botulinum toxins, chemotherapy and supportive care drugs, gene therapy, injectable medications with miscellaneous billing codes, intravenous immunoglobulins, intravitreal injectable medications for opthalmology use, viscosupplementation
  - Refer Evry's website for specific requirements and/or exclusions
- **Experimental and investigational** services, procedures and medications, not delegated to the IPA/medical group, are not covered per plan design. If you are interested in a particular treatment plan reach out to Evry to discuss options.

Generally Excluded Services

The items below are items that the plan generally does not cover.* Members should check their policy or plan document for more information and a list of any other excluded services. This list is provided solely to help provide transparency into Evry's process and limit the burden on our physician partners. Providers are encouraged to call Evry's Provider Service Department at **1(855) 579-3879** to confirm requirements for specific codes or services.

- Abortion (except for a pregnancy, that as certified by a physician, places a woman in danger of death or serious risk of substantial impairment of a major bodily function unless an abortion is performed)
- Cosmetic surgery or procedures only to improve appearance (except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or disease when medically necessary)
- Infertility and erectile dysfunction treatments
- Experimental and investigational treatments
- Gene therapy
- Long-term care
- Non-emergency care when travelling outside the United States
- Private duty nursing
- Routine eye or dental care for children and adults
- Routine foot care (except in connection with diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency
- Transgender services including hormone therapy
- Weight loss surgery

*Note: Some employer groups may elect to opt for or opt out of particular covered benefit options which include: rehabilitative and habilitative services for child development delays, home health, treatment of mental or emotional illness or disorder when confined to a hospital or psychiatric day treatment facility, in-vitro fertilization, speech and hearing assistance, transgender services, and bariatric initial and revision/repeat surgery services. Please call customer service or check plan documents for more information for benefits.

Other Covered Services

The items below are covered services where limitations may apply. This is not an inclusive list.

- Acupuncture and chiropractic care up to 5 visits per calendar year.
- Home health care up to a 60 visits per calendar year combined modalities.
- Rehabilitative & Habilitative services up to 35 per calendar year combined modalities (includes cardiac, pulmonary, ST, OT, PT services)
- Skilled nursing care up to 25 days per calendar year.
- Telehealth virtual visits to see a board certified physician or therapist up to 12 visits per quarter.
- Weight loss programs through Care Plan or up to 5 visits per calendar year with registered dietician.

Emergency, Urgent, and Ambulance Services

Emergency room services do not require prior authorization including emergency ambulance. Evry encourages its members to use the 911 emergency response system where available in situations where they reasonably believe an emergency response is needed to reach the nearest appropriate facility, or to be transported between facilities when a higher level of care is required to stabilize and treat an emergency medical condition. The health plan also offers 24/7 access to board certified physicians for virtual visits to address medical concerns which can also be utilized when a member is not certain if an emergency or urgent service is needed.

Members with health plan benefits which exclude out of network coverage seen at an out-of-network facility and require inpatient admission after emergency screening and stabilization require authorization and review for length of stay and medical necessity within 24 hours of hospital admission. The member will not be responsible for in-network facility charges where the facility failed to request timely authorization and notification for inpatient and length of stay review. Notification is the responsibility of the facility providing the service.

All unplanned hospital stays require length of stay review for medical necessity within 72 hours of hospital admission. Out-of-network facilities are required to request authorization after emergency screening and stabilization of services within 24 hours. For instructions on submission see “How to Submit Notification of Admission and Extension of Services Request” https://www.evryhealth.com/admission-notification

All hospitals are required to notify Evry of an emergency/urgent inpatient admission within 72 **hours** following admission, unless otherwise specified in your contract. Out-of-network facilities are required to request authorization for further care or treatment needed within **24 hours** after the stabilization of an emergency medical condition.

Notification may be submitted to Evry by phone or fax at the numbers listed below:

Phone: Provider Services Department at **1(855) 579-3879**

Prior Authorization & Notification Fax: (**325) 603-0541**

Failure to comply with these notification requirements will result in administrative denial of claims. Members are not financially liable for claims denied for failure of participating providers to notify Evry.

Notifications and Admissions

Inpatient admission notification isn't a substitute for prior authorization. Some services require prior authorization in addition to notification of admission and some services don't require notification at all. It all depends on the type of admission and facility. See Prior Authorization Resources for more information https://www.evryhealth.com/pre-authorization.

All hospital stays require inpatient notification. If the service has already been prior authorized, the prior authorization will serve as notification. You do not have to submit a separate notification for those same services.

All unplanned hospital stays require length of stay review for medical necessity within 72 hours of hospital admission. *Out-of-network facilities are required to request authorization after emergency screening and stabilization of services within 24 hours.* Notification is the responsibility of the facility providing the service.

For instructions on how to submit notification of admission and extension of services request see ***"How to Submit Notification of Admission and Extension of Services Request"*** at https://www.evryhealth.com/admission-notification.

The following services require notification for admission within 72 hours and notification of discharge within 24 hours:

- Unplanned Admissions: ALL medical, maternity, and surgical inpatient admissions
- Observation Stays resulting from ER visit over 23 hours
- Observations Stays, unanticipated after surgery or other procedure over 23 hours

- Maternity admission for vaginal delivery or C-section

Out-of-network facilities are required to request authorization after emergency screening and stabilization of services within 24 hours.

Concurrent Review

Concurrent review of services must be submitted to Evry Health via fax at 325-603-0541 in a timely manner for length of stay review can be conducted.

When submitting length of stay request, please include the following information:

- All physician, nursing, and specialty provider notes since the previous authorization
- Vital signs, physical assessments
- Medication list, labs, imaging, or other diagnostic testing that was performed
- Estimated discharge date, discharge plan, and any foreseen barriers to discharge
- Length of stay request/ next anticipated review date

Please note, failure to submit the appropriate documentation and lack of timely delivery may result in a denial of coverage. If facility fails to meet time requirements, the member cannot be billed for these services.

Post Stabilization

In addition to notification, *all out-of-network facilities are required to request authorization after emergency services and stabilization within 24 hours.* Authorization for length of stay review and medical care after stabilization of an emergency services at an out-of-network facility will be reviewed for medical necessity, appropriateness of care, level of care and benefit determination. Notification is the responsibility of the facility providing the service. Out-of-Network facilities may hold members responsible for facility charges associated with services provided after emergency care and stabilization.

The post-stabilization service is automatically authorized if Evry does not respond to the request within **one hour**.

Requests may be submitted to Evry as listed below:

Phone: Provider Services Department at **1(855) 579-3879**

Prior Authorization & Notification Fax: (**325) 603-0541**

Retrospective Review

Retrospective review is the process of determining coverage after treatment has been given. The plan performs retrospective reviews in limited circumstances.

Circumstances in which a retrospective authorization after treatment has been given will be considered when:

- If the plan has authorized the initial inpatient request, subsequent requests will be reviewed up to 72 hours after the last approved day.
- For outpatient medical services, the request must be received within 5 business days of the date the service has been given.
- Additional services needed: the service is directly related to another service for which prior approval has already been obtained but need for the new service was revealed at the time the original authorized service was performed. The request must be received within 5 business days of the performed service.
- An enrollee is discharged from a facility and insufficient time exists for institutional or home health care services to receive approval prior to the delivery of the service.

Retrospective review is not available when claims are for:

- Elective ambulatory or inpatient services on the preauthorization list for which preauthorization did not occur before providing the service. In the case of additional services needed, see above regarding additional services.
- Emergency inpatient services on the previously mentioned preauthorization lists that did not meet notification requirements (notification of inpatient admissions is required within 72 hours of admission date).
- Services not on the preauthorization list.
- Services that do not require preauthorization under the terms of a member's plan.

Retrospective review does not include a preferred/in-network level of benefits determination for routine or scheduled services performed by a nonparticipating provider when the member does not have out-of-network coverage.

Circumstances not meeting the criteria for a retrospective review, may be denied for failure to obtain prior authorization and result in an administrative denial of the services without review, claim non-payment and provider write off.

In certain instances, when no authorization is on file, the claim will be denied for not obtaining authorization approval.

Experimental Treatments

Evry is responsible for all decision-making related to financial coverage of experimental, investigative, or unproven services. Evry Health, at its sole discretion, may deny benefits for any service, treatment, therapy, procedure, device, or drug that is experimental or investigational in nature or utilized in a way that is not consistent with standard medical best practices or medical research.

If benefits are denied, an appeal may be submitted. This appeal should include the patient medical record as well as any supporting medical evidence to justify the benefit. These requests will be reviewed in accordance with Evry's clinical criteria.

Delegation and Oversight

Evry may, at its discretion, contract with vendors, consultants, or other third-parties for certain services or products related to Utilization Review actions. In these situations, Evry's UM staff is responsible for overseeing the delegated vendor, consultant, or third-party for operational and clinical purposes. The Chief Medical Officer of Evry Health has final authority and oversight over any UR determinations and may overturn any recommendation made by a delegate.

UM Monitoring and Reporting

In accordance with state and federal law and regulation, Evry maintains UM policies and procedures as specified within the UM Plan. Providers may contact Evry with any questions about the UM Plan and the related policies and procedures. This may include:

- Case management records.
- Evidence of appropriate licensure for physicians and other clinical staff responsible for performing utilization review actions.
- The UM Plan itself and associated policies and procedures, such as clinical criteria and guidelines.
- Utilization records, such as pre-authorization approval and denial letters.

Appeals Process

The member or someone acting on the member's behalf, and the provider of record have the right to appeal an adverse determination in writing. Appeal rights include the right to submit written comments, documents, or other information relevant to the appeal. This additional information, along with your written statement of disagreement with the previous determination, will assist us in evaluating the basis for your disagreement and, potentially, make a different decision. If we do not receive the additional information, we will process the appeal with the information we have available and will issue our written determination to all the involved parties in accordance with all appeal requirements and within the required appeal deadlines.

Adverse Determination Appeal Process: If a prior authorization is denied for medical necessity or experimental/investigational issue, the member, or an authorized agent for the member, and the provider of record may appeal the decision in writing or orally up to (180) days after the date of issuance of the adverse determination. If new or additional information has been submitted with initial appeal request and original determination remains after reconsideration, then Evry will acknowledge receipt of adverse determination appeal in writing within five (5) business days. This appeal will go through a formal review process with a physician who was not involved in the original determination. All appeals will be resolved in a timely manner but not to exceed 72 hours for urgent appeals and thirty (30) calendar days for standard appeals. If we deny the appeal, the provider of record may request a specialty appeal, which requests that a provider of a specific type of specialty review the case. The provider must request this type of appeal in writing within 10 working days from the date the appeal was requested or denied. We will complete the specialty appeal and send our written decision to the

enrollee or the person acting on the enrollee's behalf and the provider within 15 working days of receipt of the request for the specialty appeal. No new evidence may be introduced on second level appeal. The request will be reviewed and a specialty review will be completed within 15 working days of receipt of the request.

In the state of Texas, if the enrollee has a life-threatening condition or receives a denial for prescription drugs or intravenous infusions for which they are currently receiving benefits, the patient, or someone acting on the patients' behalf, and the provider of record can request an immediate review by an independent review organization (IRO) and is not required to follow our internal appeal procedures.

Administrative Determination Appeal Process: This request is about decisions made that involve something other than medical details. These include decisions based on policy and procedure or claim payment issues. Disputes about any other non-clinical aspect of our business' functions. The appeal of a denial of such a service that is not covered per the member's plan is considered a "complaint" and is resolved via the compliant process.

Our deadlines to resolve the appeal and send a written decision to the enrollee or someone acting on the enrollee's behalf and the provider of record are:

- Standard Appeal: 30 calendar days of receipt of the appeal.
- Expedited Appeal: One working day from the date we receive all information necessary to complete the appeal. We may provide the determination by telephone or electronic transmission but will provide a written determination within three working days of the initial telephonic or electronic notification.
- Retrospective (Claim) Appeal: 30 calendar days after receipt of appeal. However, we may extend this deadline once for a period not to exceed 15 days.
- Acquired Brain Injury Appeal: Not later than three business days after the date on which an individual requests utilization review or requests an extension of coverage based on medical necessity or appropriateness, Evry will provide notification of the determination through a direct telephone contact to the individual making the request. This subsection does not apply to a determination made for coverage under a small employer health benefit plan.

We will not require exhaustion of our internal appeals process if: (a) we fail to meet our internal appeal process timelines, or (b) the claimant with and urgent care situation files an external review before exhausting our internal appeal process, or (c) we decide to waive the appeal process requirements.

Independent Review Process

The purpose of the external independent review is to find out if our decision was right on our decision to uphold the denial of an appeal. The member or someone acting on the member's behalf and the provider of record have the right to request a review by an independent review organization (IRO) if we have upheld an initial appeal request. There is a standard external review and, for emergent and urgent cases, an expedited (faster than usual) external review. The external review may be for denials that involve medical necessity, appropriateness, health care settings, level of care, and effectiveness of a covered benefit, whether treatment is experimental or investigational, and any other matter that involves medical judgment. It is also available for determining if surprise billing protections are applicable.

QUALITY MANAGEMENT

Evry's mission to improve U.S. healthcare includes facilitating the highest quality of care delivery and a world-class experience for our members. One of the ways we do so is through an emphasis on the use of care plans for our members, care coordination and disease management programs, improved quality reporting and analytics, data collection and management, and compliance related activities. These all serve to improve patient outcomes and safety, better control costs, and reduce medical errors.

Evry Health has a Quality Improvement (QI) and Quality Management (QM) structure in place known as Quality Management and Performance Improvement (QM/PI). The overall structure is designed to evaluate and continuously improve the quality, safety and services of care delivered to Evry Health's members and their covered dependents.

All contracted providers and provider organizations are required to participate in Evry's QM/PI Program. This includes submission of encounter data, accurate and complete coding, evaluation of data and their performance and participation in reviews of potential quality issues and programs. Evry Health may use this data for public reporting to consumers, for determining preferred status in its provider network (through tiering), and/or for setting cost sharing thresholds for using preferred providers.

QI and Performance Improvement

Evry Health's QM/PI program improves outcomes and controls costs by ensuring members have access to affordable, appropriate, and timely healthcare services by measuring provider compliance with established evidence-based standards. This is done by accessing relevant data, leveraging proven management and measurement methodologies, and continually analysing and improving operational processes that are related to the delivery of medical care.

This program provides a framework to evaluate the delivery of healthcare services to Evry's members. This framework is based upon the philosophy of Continuous Quality Improvement and includes the following considerations:

- Quality issue identification, oversight, corrective action plan assignment, and follow-up.
- Oversight and monitoring of internal programs.
- Tracking and trending identified plan and provider issues.
- Utilization and medical management plans.

- Management of Protected Health Information (PHI).
- Credentialing of healthcare and other providers.
- Oversight of delegated entities for quality and medical management.
- Disease management.
- Case management.
- Clinical practice guidelines.
- Member Rights and Responsibilities.

Evry's QM/PI program is designed and managed by Evry's QM/PI Committee. This committee seeks to work in a collaborative partnership with providers and provider groups. Providers are encouraged to contact Evry about participating in the planning, design, implementation, and review of the QM/PI program. Any in-network contracted provider may be involved in the QM/PI program and/or attend and advise through involvement with clinical subcommittees.

If you are interested in participating in Evry's QI program, please email quality@evryhealth.com or call the Provider Services Department at **1(855) 579-3879.**

Evry audits medical records randomly for information related to standards of clinical practice which include, but may not be limited to:

1. Each page in the record contains the patient's name or ID number.
2. Documentation of allergies or No Known Drug Allergies (NKDA) and adverse reactions are prominently displayed in a consistent location.
3. All presenting symptom entries are legible, signed, and dated, including phone entries.
    a. Dictated notes should be signed or initialed to signify review. If initialed, a signature sheet for initials is noted.
4. The important diagnoses are summarized and highlighted.
5. A problem list is maintained and updated for significant illnesses and medical conditions.
6. A medications list or reasonable substitute is maintained and updated for chronic and ongoing medications.
7. History and physical exam identifies appropriate subjective and objective information pertinent to the patient's presenting symptoms, and the treatment plan is consistent with findings.
8. Past medical history is documented, including significant illnesses, accidents, and operations, and prenatal and birth information for pediatric members.
9. Each visit notation includes the following:
    a. Subjective Data: Chief complaint or reason for visit.

   b. Objective Data: Focused (problem specific) physical examination.
   c. Assessment: Diagnosis or impression.
   d. Plan: Treatment plans, goals.
10. Laboratory tests and other studies are ordered, as appropriate, with results noted in the medical record. The clinical reviewer should see documentation of appropriate follow-up recommendations and/or non-compliance to care plan.
   a. Follow-up care is scheduled for abnormal findings.
11. Referrals to specialists are clearly documented.
   a. Follow-up report received and acknowledged when referred specialist care was obtained.
12. Documentation of Advance Directive or Living Will or Power of Attorney discussion in a prominent part of the medical record for adult patients is encouraged.
   a. Should the member decline an Advance Directive, the member's decision shall be documented.
13. Continuity and coordination of care between the primary care physician, specialty physician(s) (including BH specialty) and/or facilities if there is reference to referral or care provided elsewhere. The clinical reviewer will look for a summary of findings or discharge summary in the medical record. Examples include, but are not limited to, progress notes/reports from consultants, discharge summary following inpatient care or outpatient surgery, physical therapy reports, and home health nursing/provider reports.
14. Age appropriate routine preventive services/risk screenings are consistently noted (i.e childhood immunizations, adult immunizations, mammograms, pap tests, etc.) or the refusal by the patient, parent, legal guardian, of such screenings/immunizations, in the medical record.

Furthermore, we will request evidence that:

- Medical records are stored securely and only authorized personnel have access.
- There is evidence of annual staff confidentiality training.

Quality Data and Reporting

Evry Health captures and analyzes data to ensure its benefit plans, programs, and providers optimize care, including but not limited to:

- HEDIS data to measure performance on areas of care and service.
- CAHPS data to measure member satisfaction and the experience of care.

- Internal data from HRAs and other sources, including service utilization, cost, and quality.
- Complex case and disease management related logs and notes.
- Provider performance and effectiveness of incentive programs.

While Evry does not delegate its QM/PI program, it may delegate certain QM/PI activities. If QM/PI activities for an Evry plan is delegated to an approved entity, the plan will:

- Establish a written delegation agreement outlining the scope of the delegate's responsibilities and how it will be monitored by Evry.
- Through a pre-delegation audit and annual oversight audits thereafter, assess the delegate's ability to fulfill its responsibilities, including adminsitrative capacity, technical expertise, and budgetary resources.
- Maintain written oversight procedures in place to ensure providers are fulfilling all delegated responsibilities.

Delegated organizations and providers must provide quality metrics for review by the QI Committee, including, but not limited to, periodic reporting of:

- Complex case management summary.
- Disease management summary.
- Utilization management.
- Performance improvement initiatives, findings, and corrective action.

Preventive Health and Wellness Initiatives

Evry's goal is to meet or exceed all the highest clinical and customer quality standards and reporting requirements, specifically the utilization and quality measures of Healthcare Effectiveness Data and Information Set (HEDIS), and Consumer Assessment of Healthcare Providers and Systems (CAHPS survey).

Clinical Practice and Preventive Health Guidelines

Clinical practice guidelines, preventive health guidelines, and other internal criteria provide direction and standards for preventive, acute, and chronic care health services relevant to Evry's enrolled membership. Guidelines address a range of clinical needs, focusing on high-volume and high-risk conditions and are reviewed, updated, and approved by the Quality Management Committee at least once annually. Performance and compliance with guidelines is monitored annually to ensure adherence and to

identify educational opportunies for improvement. Clinical practice guidelines are reviewed against UM criteria and member education materials to ensure consistency and alignment with appropriate medical recommendations.

Evry Health is committed to the philosophy that Evidence Based Guidelines are known to be effective in improving health outcomes. Evry has compiled a group of recognized resources that promulgate Evidence Based Clinical Practice Guidelines.

Agency for Healthcare Quality and Research

Home | Agency for Healthcare Research and Quality (ahrq.gov)

National Guideline Clearinghouse

www.guideline.gov

U.S. Preventive Services Task Force

The Guide to Clinical Preventive Services includes U.S. Preventive Services Task Force (USPSTF) recommendations on screening, counseling, and preventive medication topics and includes clinical considerations for each topic.

http://www.uspreventiveservicetaskforce.org/

National Heart, Lung and Blood Institute

The EPR-3 Summary Report 2007 provides key information from the full report on the diagnosis and management of asthma. Summary information is provided on measures of assessment and monitoring, education for a partnership in asthma care, control of environmental factors and comorbid conditions that affect asthma, and medications.

https://www.nhlbi.nih.gov/node/80397

Professional Associations for Primary Care Providers

American College of Physicians Resource for Clinical Practice Guidelines from the Annals of Internal Medicine.

http://annals.org/

The American Congress of Obstetricians and Gynecologists (ACOG)

https://www.acog.org/

American Academy of Family Practice

Compendium of AAFP endorsed clinical practice guidelines from multiple professional medical associations, including the American Academy of Pediatrics, American Hospital Association (AHA), and the American Medical Association (AMA).

https://www.aafp.org/

American Academy of Pediatrics

Evidence-based decision making tools for managing common pediatric conditions.

https://www.aap.org/

Disease Management

Evry offers disease management programs related to diabetes, cardiac disease, and complex conditions. Providers should refer members to call Evry's Member Services Department toll-free at **1(855) 579-3879** to learn more.

Health Management and Education

Evry understands the value of education for improving and navigating the healthcare system. To this end, Evry engages in a variety of activities aimed at supporting the health education of its members. This includes, but is not limited to: providing tools and resources to stay healthy, knowledge about common and chronic conditions as well as

their treatments, behaviors for better self-management of health issues, and content and resources intended to promote prevention and early detection of illnesses.

These outreaches, tools, and educational material are made available through targeted phone and text messaging outreaches, online content, Evry's mobile app(s), and other mediums.

Evry evaluates outcomes using several mechanisms, such as HEDIS surveys, utilization statistics, pharmacy data, and program particiant surveys.

Member and Provider Satisfaction

The satisfaction of our members and providers is a high priority for Evry Health. Satisfaction levels are assessed and evaluated for improvement regularly.

Member satisfaction may be assessed by several sources, including but not limited to, satisfaction surveys, appeals, grievances. Member complaints and appeals are assessed by reason category, provider, region, and delivery system.

Provider satisfaction may be assessed by satisfaction surveys, provider services complaints, and direct feedback offered by providers and provider organizations. Satisfaction issues are categorized and assessed by prevalance and severity of the issue. Issues not meeting standards or performance benchmarks are identified and a Corrective Action Plan for resolution, correction, and follow-up monitoring is implemented.

Potential Quality Issues

Definitions:

> **Potential Quality Issue (PQI)**: is a suspected deviation from provider performance, clinical care, or outcome of care which requires further investigation to determine if an actual quality of care issue exists.
>
> **Quality of Care Issue (QOC)**: is defined as a confirmed adverse variation from expected clinical performance, clinical care, or outcome of care, as determined through the PQI process.

Clinician or Provider: is any individual or entity engaged in the delivery of healthcare services licensed or certified by the State to engage in that activity, if licensure or certification is required by State law and regulation.

Corrective Action Plan (CAP): is a plan approved by the appropriate quality improvement committee or group to help ensure that a related quality issue does not occur again in the future. CAPs contain clearly stated goals and timeframes for completion.

Corrective Action Plan (CAP): is a plan approved by the appropriate quality improvement committee or group to help ensure that a related quality issue does not occur again in the future. CAPs contain clearly stated goals and timeframes for completion.

Process for Potential Quality Issues

Evry Health has a systematic process for the identification, reporting, and processing of Potential Quality Issues (PQI) in order to determine opportunities for improvement in the provision of care and services to members, as well as to direct actions for improvement based upon the frequency and severity of the PQI.

It is Evry's policy to accept a PQI referral through a variety of sources. These include, but are not limited to: internal referrals from Grievances and Appeals, members, contracted providers, Evry employees, and affiliated parties.

All PQIs which are identified will be tracked in the PQI log for the purpose of monitoring patterns to identify any potential trends or significant sentinel events.

All information obtained during and used in a quality of care investigation will be held in strict confidence in accordance with Plan confidentiality policies and all relevant State and Federal Peer Review laws and regulations.

A designated medical professional reviews all referred PQIs to identify whether a true Quality of Care (QOC) issue exists after which the case will be assigned a severity score. Some cases will be referred to the Peer Review/Credentialing Committee based on Evry's policy. Based on the Credentialing Committee's review, a provider may be placed on a Corrective Action Plan (CAP) or may be required to submit a CAP. The CAP will request follow-up and evidence from the provider in question to demonstrate that the corrective actions have been implemented as specified.

All PQI outcomes are trended on a continuous 36 months' basis. Any identifiable trends, regardless of outcome to the member, will be referred to the Quality Improvement Committee on a quarterly basis for potential action or educational opportunities.

Reporting for Potential Quality Issues

To report a PQI, you may complete the PQI Referral Form included in the Forms section of this manual and mail or fax it to Evry at the location and number below. This form can be submitted anonymously.

Evry Healthcare, Inc.
P.O. Box 571208
Dallas, TX 75357

Fax: **(325) 603-0541**

PHARMACY

Evry Health contracts with Prime Therapeutics (formerly MagellanRx) to provide and coordinate outpatient prescription drug benefits. Prime Therapeutics is responsible, on behalf of Evry, for managing the pharmacy network, formulary, and all aspects of outpatient prescription drug benefits, including any related medication management programs, approvals, denials, and appeals. Prime Therapeutics adjudicates prescription claims at the point of sale.

Drug Formulary

Evry's formulary is a dynamic document. Medications included in Evry's formulary generally remains consistent throughout any coverage year, but new medications and generics that become available are evaluated by Evry and individual medications may be added to or removed from the formulary.

Please refer to the drug formulary at https://www.evryhealth.com/formulary, which provides tools and resources to Prime Therapeutics Management, for precision formulary status and drug authorization guidelines.

Drug Authorization

For drug authorizations and any pharmacy related questions, please call or fax Prime Therapeutics Pharmacy Solutions directly at **1(833) 605-0625**.

For more information on prior authorization for pharmacy benefits, refer to: https://www.primetherapeutics.com/providers-and-physicians.

ACCESS TO CARE

Evry is dedicated to providing access to high quality providers and strives to ensure strong network coverage for all members and their health needs. Evry continues to work with members and providers to ensure members have access to appropriate, timely, and continued care.

Availability of Providers

Evry currently offers two EPO plans (EPO and EPO HDHP) and two PPO plans (PPO and PPO HDHP) in Texas. Services must be provided by participating providers for EPO plan members.

Members in the EPO and EPO HDHP do not have out-of-network benefits except for emergency services.

> **EPO**: For the EPO product, members can see any in-network primary care provider and are not required to designate a specific primary care provider. However, members are encouraged to select a main healthcare provider and report their name to Evry for the purposes of clinical teaming and enabling better coordination of care. The in-network list of providers by state can be located on Evry's website.
>
> **EPO HDHP**: For the EPO HDHP product, members can see any in-network primary care provider and are not required to designate a specific primary care provider. However, members are encouraged to select a main healthcare provider and report their name to Evry for the purposes of clinical teaming and enabling better coordination of care. The in-network list of providers by state can be located on Evry's website.

Members in the PPO and PPO HDHP have out-of-network benefits for emergent and non emergent care.

> **PPO**: For the PPO product, members can see any in-network or out-of-network primary care provider and are not required to designate a specific primary care provider. However, members are encouraged to select a main healthcare provider and report their name to Evry for the purposes of clinical teaming and enabling better coordination of care. The in-network list of providers by state can be located on Evry's website.

PPO HDHP: For the PPO HDHP product, members can see any in-network or out-of-network primary care provider and are not required to designate a specific primary care provider. However, members are encouraged to select a main healthcare provider and report their name to Evry for the purposes of clinical teaming and enabling better coordination of care. The in-network list of providers by state can be located on Evry's website.

In the event an Evry member does not make a choice for a specific primary care provider, Evry may work with members to recommend a primary care provider based on a member's previous relationship with a provider, geographic proximity of provider to member residence, or appropriate provider type such as a pediatrician, internist, family medicine, or obstetrician. Pregnant members should be encouraged to select a pediatrician or other appropriate provider for their newborn baby during their 1st or 2nd trimester of pregnancy.

Termination of Providers

The following may be grounds for a provider's termination from Evry Health's network:

- No admitting privileges to an in-network hospital.
- Admitting members to out-of-network hospitals.
- Performing procedures at out-of-network facilities.
- Referrals to out-of-network providers (including laboratories).
- Quality of care concerns.
- Lack of cooperation with Evry.
- Unsatisfactory utilization management.
- Behavior inconsistent with Evry Health's healthcare objectives.
- Failure to comply with recredentialing standards.
- Evidence of fraud.
- Other appropriate reasons.

Other grounds for termination may apply, as specified in each provider's contract with Evry.

Availability Standards

Evry maintains its provider network in accordance with State and Federal laws and regulations regarding provider ratios, and monitors the adequacy of the network to ensure provision of quality care and services to its members. The number, type, and

geographic distribution of providers, facilities, and laboratories is monitored on an ongoing basis to ensure adequacy for Evry's members.

Evaluation of network availability may include, but are not limited to, geographic distribution analysis, member-to-provider ratios, member and provider satisfaction surveys, and analysis of member grievance information.

Evry Health follows the accessibility and appointment wait time requirements set forth by applicable regulatory and accrediting agencies, to ensure adequate appointment availability and access to care. Below shows the appointment availability for members:

Appointment Care Type	Access Within
Emergency Care	Immediately (24/7), including at out of network and out of area facilities
Urgent Care Providers (Medical and Behavioral Health)	Within 24 Hours
Routine Care for a Behavioral Health Condition	Within 2 Weeks
Routine Care for a Medical Condition	3 Weeks
PCPs and Specialist Providers Phone Call Service for After Hours Care	Office number answered 24/7 by answering service or instructions on how to reach a physician
Routine preventive care adult	3 months
Routine preventive care child	2 months or sooner based on prevention guidelines

Coordination of Care

Evry Health encourages good communication and effective transition between providers and facilities. The goal is a focus on the total health care needs of the member. Evry sees our team as an extension for members, providers and facilities to help identify and bridge gaps in care. Members and providers are encouraged to share information pertinent to ~~to~~ the healthcare needs of the patient and use Evry Care Coordinators to organize and refer to related services (e.g. transportation, nutrition, physical therapy, etc.). In addition, Evry members have on demand access to virtual care solutions through the Evry app and member portal. Our members can reach out to board certified physicians 24/7 for urgent care and behavioral health needs through Included Health and other telemedicine sponsored programs.

Authorizing Out-of-Network Providers

For members without out-of-network coverage, Evry may approve an out-of-network provider authorization in situations where it is determined that Evry does not have an in-network provider with the appropriate training or experience needed to treat the member. Requests for out-of-network authorizations may be made by an Evry member or member's authorized representative and their in-network provider of record. Contact customer service for more information and to initiate the process.

Approvals will not be made on the basis of convenience for a member or a provider. Evry may not approve the specific out-of-network provider request. If Evry does approve the out-of-network provider, all services performed are subject to a treatment plan approved by Evry in consultation with the member, the member's primary care provider, and the out-of-network provider.

All services rendered by an out-of-network provider will be paid as if they were paid to an in-network provider, and members are responsible for any applicable in-network cost sharing. If Evry does not approve an authorization, then services rendered by the out-of-network provider will not be covered by Evry.

Transitional Care

Evry Health understands that in situations where a provider leaves or are terminated from the plan that members may require coverage for a period of time to ensure continuity of care. Members who are being treated by a provider whose contracted status has been terminated may be able to continue ongoing treatment for covered services for up to **90 days** after the effective date of termination. Additionally, pregnant members in their second or third trimester may be able to continue care with a former in-network provider through delivery and postpartum care directly related to the delivery.

Please note that members must contact Evry's Member Services Department to request this continuity of treatment and it must be authorized prior to service. The terminated provider must agree to render services at the negotiated rate that was in effect prior to the termination. Finally, the provider must agree to provide Evry with necessary medical information related to the member's care and adhere to Evry's policies and procedures, including those for assuring quality of care, authorization, prior authorization, and a treatment plan approved by Evry. In the event that a provider was terminated due to fraud, imminent harm to patients, or a final disciplinary action by a state board or agency that impairs the provider's ability to practice, continued treatment with the provider is not available and will not be approved if requested.

CREDENTIALING

Evry's network credentialing process is designed to provide initial and ongoing evaluation of the provider's ability to render specific patient care and treatment within limits defined by licensure, certification, and/or accreditation.

Evry performs or provides oversight for all aspects of the credentialing process, including primary source verification of provider information and identification of potentially problematic providers. All providers that meet requirements are referred to Credentialing and Peer Review Committee for final approval.

Re-credentialing of providers occurs every three (3) years. Information from Quality Management (QM), Utilization Management (UM), Member Services, Provider Services, Appeals, and Grievances is considered at the time of re-credentialing. Provider status and performance is continuously monitored between credentialing cycles by Evry or Evry's delegated entity. Ongoing monitoring of reports by regulatory agencies of sanctions, limitations on licensure, and complaints are also performed between re-credentialing cycles.

If a reportable quality issue or trend is identified, the Credentialing and Peer Review Committee acts in accordance with Evry's policies and procedures to take the appropriate action. Evry contracted providers have the right to appeal and a formal hearing if Evry decides to alter the conditions of a provider's participation based on quality and/or service issues.

Evry complies with applicable State and Federal requirements and NCQA standards in credentialing and re-credentialing of its providers. Providers must maintain good standing with all applicable regulatory and licensing bodies.

The Credentialing Process

The credentialing process is an integral part of maintaining a high quality network. It serves to ensure Evry's members have access to quality healthcare services and our providers meet certain State and Federal requirements for credentialing and recredentialing.

Evry currently relies upon a third-party firm, Medallion, as our preferred credentialing partner to perform the credentialing verification process.

Credentialing Delegation and Oversight

Evry may delegate credentialing activities to organizations and third-parties that have the capabilities to perform such activities, and meet delegation requirements as demonstrated in a pre-delegation review.

Evry performs, and requires contracted entities to perform, ongoing internal audits to ensure the credentialing status of its providers remains current at all times. Audits include validation of licensure, malpractice, Drug Enforcement Administration (DEA), Office of Inspector General (OIG), and other sanctions, and current status of applicable certification and/or accreditation.

Joining our Networks

Evry Health is developing substantial network capabilities and may, at its discretion, maintain more than one network. Participation in one network does not automatically mean that a provider may participate in every network. Each network may correlate to multiple products. Submission of an application and required documentation does not guarantee admission to a network. Providers are selected to participate in Evry's network(s) based on an assessment and determination of the network's needs. Providers should refer to their contracts with Evry to confirm network participation.

Non-Discrimination Policy

Evry has the following criteria and processes to prevent discriminatory credentialing:

- Tracking and trending of reasons for denial and/or termination.
- Semi-annual audits of files in process for greater than six (6) months to determine compliance with practitioner contact criteria.
- Non-discrimination clause on documents signed by members, staff, and guests of the credentialing committee on an annual basis.
- Non-discrimination statement on the Credentialing Committee attendance sign-in form.

Any delegated entities are expected to similarly comply with the above.

Information submitted to the Credentialing Committee for approval, denial, or termination must not designate a provider's race, ethnic or national identity, gender, age, sexual orientation, payor sources, or type of procedures performed.

MEMBER COMPLAINTS

Evry Health treats complaints from members and providers seriously, and has processes in place for the timely hearing and resolution of complaints in accordance with regulatory guidelines. The Head of Member Success ultimately has primary responsibility for Evry's complaint system.The processing of complaints is not delegated to any other entity or third-party. Evry reviews and analyses complaints to track and trend issues. The results of these analyses are reviewed by the Quality Management Committee and the Continous Quality Improvement Committee, and recommendations are made to improve policies and procedures.

Filing a Member Complaint

Evry provides assistance as needed, including interpretor or language assistance to members seeking to file a complaint, and maintains a location as well as toll-free number that may be used for requesting a complaint form. Members may receive assistance in submitting a written complaint by contacting Member Services.

Evry's Member Services Department:

Local: **1(972) 807-3695**
Toll-free: **1(855) 579-3879**

Complaint forms and a description of the complaint process are available online at https://www.evryhealth.com/forms.

Members may submit complaints via mail, fax, or email following any incident or action that is the subject of the member's dissatisfaction using Evry's Complaint Form. Verbal complaints are not accepted. Please direct these complaints to the following:

Mail	Fax	Email
Evry Healthcare, Inc. Attention Complaint Department P.O. Box 571208 Dallas, TX 75337	Fax: **(325) 603-0541**	support@evryhealth.com

Complaints must be submitted in writing. If a member orally indicates they wish to file a complaint, an ackowledgement letter will be sent within 5 business days and will include a one page document for the member to complete. Evry will resolve all complaints within 30 days of receipt of all necessary written documentation.

For each complaint form received, a written record is made that includes the date received, the plan representative recording the complaint, a summary or other document describing the complaint, and its disposition.

Evry will expedite review of a complaint when the complainant, an authorized representative of the complainant, or attending provider delivers notice to Evry and when the criteria for an expedited review are met.

Evry Health's complaint system addresses the linguistic and cultural needs of its member populations, as well as the needs of members with disabilities or special needs. Evry ensures there is no discrimination against an enrollee or subscriber, including cancellation of a contract, on the grounds that a complaint is filed by the complainant.

Regular and expedited complaints will be assessed and resolved in accordance with state regulations.

PROVIDER INQUIRIES AND DISPUTES

Providers who would like to make an inquiry may do so via phone, web, fax, email, or letter sent to the contact information and address specified on the Explanation of Payment (EOP). Inquiries leading to the submission of adjusted claims or late submissions will be reviewed according to the timelines established in the Claims Submission section.

A provider wishing to file a claim dispute may do so by completing Evry's Dispute Resolution Form and submitting it by mail, email, or fax within 180 **days, unless your contract stipulates otherwise, o**f the Explanation of Payment (EOP) A copy of the Dispute Resolution Form can be found in the Forms section of this manual and on Evry's website.

This submission will trigger Evry's Dispute Resolution Process. Evry will seek to resolve disputes no later than **30 calendar days** or to request additional information needed to resolve the dispute within this timeframe. If Evry requests additional information, , Evry will complete the review within **30 calendar days** from receipt of all required information.

At any time during the Dispute Resolution Process, either party may request a meeting. In the event that the meeting is not effective at resolving the dispute, either party may submit the dispute to Binding Arbitration.

Dispute Resolution Forms, and related communication, should be submitted to:

Mail	Fax	Email
Evry Healthcare, Inc. P.O. Box 571208 Dallas, TX 75357	Fax: **(325) 603-0541**	support@evryhealth.com

Complaints

A Complaint or Grievance is a verbal or written expression by a provider, which indicates dissatisfaction or dispute with Evry's policies, procedure, or any aspect of Evry's functions. Complaints do not include claim payment issues. Evry's logs and tracks all complaints/grievances whether received verbally or in writing. A provider has 30 calendar days from the date of the incident, such as the original Explanation of Payment date, to file a complaint/grievance. After a complete review of the complaint/grievance,

Evry shall provide a written notice to the provider within 30 calendar days from the received date of Evry's decision. To submit a formal written complaint regarding an administrative process (as distinct from a billing or claims dispute), providers can use the Provider Complaints Form available on the Evry Health provider website, www.evryhealth.com/provider. Providers are not required to use this form, but are encouraged to do so.

If a provider submits a complaint verbally, they will be provided this form to submit the complaint in writing. Providers may submit written complaints with or without the use of this form.

Fraud, Waste, and Abuse (FWA)

Fraud, Waste, and Abuse are improper actions that result in inappropriate and unnecessary spending.

> **Fraud** is distinct from waste and abuse in that it is committed when one party knowingly or willingly makes a material misrepresentation or omission with the intend to defraud and obtain a benefit.
>
> **Waste** is the overutilization, extravagant, careless, or unnecessary expenditure of healthcare benefits or services. This is often caused by disorganization or a misuse of resources.
>
> **Abuse** refers to practices that are inconsistent or outside of the bounds of generally accepted practices in the industry, which results in unnecessary services and payments.

Evry Health views all Fraud, Waste, and Abuse (FWA) related activities with special interest and maintains a comprehensive anti-fraud program. Evry's Special Investigations Unit (SIU) handles the detection, prevention, and investigation of FWA in the delivery of healthcare services. The SIU depends heavily upon reports from members, providers, and the public to identify incidents of FWA.

Reporting Fraud, Waste, and Abuse

If providers or provider organizations suspect that FWA has occurred whichrelates to Evry in any form, they must report it to Evry Health immediately.

Please contact Evry's SIU at the following:

Mail	Phone	Email
Evry Healthcare, Inc. Special Investigations Unit P.O. Box 571208 Dallas, TX 75357	Compliance Hotline: **1(855) 579-3879**	fraud@evryhealth.com

Please do not hesitate to call the Compliance Hotline with any questions regarding Evry's Compliance Program, to seek advice on how to handle compliance related

situations at work, or with general compliance related concerns, including reporting violations of the law, regulations, policies, or procedures.

All calls are treated confidentially and callers may remain anonymous if they so choose. Callers may be asked if they are willing to identify themselves for the purposes of Evry following-up on the issue with the caller.

All reports through the Compliance Hotline remain anonymous. Retaliation against anyone who raises a concern is prohibited.

REGULATORY REFERENCES

Texas Insurance Code, Subtitle D, Chapter 1301 Preferred Provider Benefit Plans

28 TAC 3.3701-11, 3.3720-25