2022
PROVIDER MANUAL

EMERGE. EVOLVE. EXCEL. ENCORE.

THE HEALTHCARE GROUP, LLC

CONTENTS

CONTACT INFORMATION

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Provider Relations Service Area Map – see Appendix A

NETWORK PRODUCTS

Encore Health Network is a comprehensive statewide Preferred Provider Organization in Indiana. Encore offers its Payors, Employers and Members three Product options to maximize provider choice and plan savings. For more information on identifying Encore members, please see page 13.

ENCORECOMBINED® NETWORK

With the EncoreCombined® Network, employers and employees get access to one of the largest networks in Indiana. EncoreCombined® providers offer top tier pricing for an open access network product giving members the best of both worlds: savings and access. ***Plan design requirements include a 30% benefit plan actuarial differential between in-network and out-of-network.***

ENCOREPRIME® NETWORK

As our high valued network, EncorePrime is our provider directed product that offers the most competitive pricing in selected markets with statewide access for tertiary care. Currently, the EncorePrime® Network is available only in the Evansville market. Benefit steerage is required for this product. EncorePrime also covers tertiary referrals to Indy and Louisville at top-tier savings. ***Plan design requirements include 30% benefit plan differential between in-network and out-of-network.***

ENCORE HEALTH NETWORK® PPO

The Encore Health Network® PPO is one of Indiana's largest leased PPO networks with access primarily in Indiana and the contiguous states. Understanding the importance of provider choice to our Indiana market, the Encore Health Network® PPO provides the most expansive access. ***Plan design requirements include a***

20% benefit plan differential between in-network and out-of-network.

ENCORE DIRECTED ARRANGEMENTS

Encore Health Network has several Encore Directed Arrangements with groups in which provider participation may vary.

ENCORE WORKERS' COMPENSATION PPO®

As a Preferred Provider Organization (PPO) work comp network, Encore's focus is to give our members access to the finest healthcare providers, facilities, and services available.

No one chooses to be injured on the job. When unforeseen accidents happen, Encore is there, every day, to meet the healthcare needs of Hoosiers throughout the state ensuring members have access to an extensive network of high quality, cost-effective health-care providers. We understand the importance of offering a full spectrum of providers to our members, employers, and payers. Encore's workers compensation PPO offers employees injured on the job, comfort knowing there is a team of dedicated healthcare professionals taking care of them. Employers have the peace of mind knowing that returning their greatest asset, their employees, back to health and work is the goal through high quality, cost-effective care.

GENERAL CONTRACT PARAMETERS

Encore Health Network payors will incorporate financial benefit incentives that direct Payor's members to Participating Providers. The benefit differential can very between network product which are defined with the Provider Agreement as well.

Payors will incorporate at least the following information for Participating Providers to identify participants in the Network programs with the exception of programs such as workers compensation which do not utilize member identification cards.

The Identification Card will contain:

- Identifying logo or name of Payor

- Identifying logo or name of one of the following networks:
  - EncoreCombined® Network
  - EncorePrime® Network
  - Encore Health Network PPO®
- Claims address and telephone numbers for claims information
- Benefit, Customer Service and Utilization Management telephone number(s), if applicable

Payors will reimburse Participating Providers or Participants, as appropriate, for Covered Services provided to Participants in accordance with state law. Where the law does not apply, the Payor shall pay or deny Clean Claims within thirty (30) calendar days of receipt of confirmation if submitted electronically, or forty-five (45) calendar days, or sooner if required by law, of receiving a Clean Claim from the Provider, or if applicable from the Repricer. The parties agree that, for the purposes of this provision, receipt of paper claims, for Clean Claims purposes, shall be determined by the Provider's original mailing date plus three (3) days. Failure of a TPA or Payor to comply with any of the requirements in this Exhibit A (unless an executed Exhibit "A-1" is in place and accepted by Participating Provider in writing) shall constitute a waiver of right to negotiated discount and such TPA or Payor will be liable to pay any penalty as described in state law in addition to Provider's billed charges for all such claims. Participating Provider shall contact Payor directly to request adjustment of reimbursement due to untimely payment.

Payors will identify the name of the THCG PPO Network on the explanation of benefits (EOB). For a list of THCG Networks, please go to page 5 or 12.

DIALYSIS CARVE-OUT: THCG does allow Payors and Plan Sponsors to carve dialysis services out of the THCG network and utilize an alternate pricing approach outside of THCG dialysis provider arrangements.

CONTRACTING QUESTIONS

ENCORE CONTRACTED PROVIDERS

As a contracted provider with Encore, you need to contact your Provider Relations Specialist with any contracting questions and updates including: tax identification number, National Provider Identifier number (NPI), corporation name, practice location, billing address and email addresses.

UPDATES AND CHANGES TO PROVIDER INFORMATION

Please notify Encore or your network of any changes or updates 60 to 90 days in advance, whenever possible, by mailing, faxing or emailing change notifications to a provider relations staff member.

It takes approximately 60 days for any changes to be updated by our payors. Provider updates are sent to our contracted payors once a month and contractually, the payors have 30 days to load this information.

Encore Health Network may use discretion in adjusting provider reimbursement for codes typically not reimbursed by Medicare without provider notification. Reimbursement may take into consideration market prices. This applies to direct contracts between Encore and providers.

Please forward any updates or contracting questions to the attention of your provider relations staff member or at our address below or fax number:

Encore Health Network
Attn: Provider Relations
8520 Allison Pointe Boulevard, Suite 200
Indianapolis, IN 46250-4299

OR

Preferred Fax: (317) 621-2389
Corporate Fax: (317) 621-2388

NETWORK CONTRACTED PROVIDERS

If you participate as part of an affiliate network, you will need to contact your network prior to talking with your Encore Provider Relations Specialist.

MID-LEVEL REIMBURSEMENT

Mid-level practitioners/Allied Health providers are reimbursed at 80% of the physician fee schedule unless indicated otherwise in your Provider Agreement. Mid-level practitioners/Allied Health providers include, but not limited to, Physician Assistants (PA), Nurse Practitioners (NP), Licensed Clinical Social Workers (LCSW), Licensed Mental Health Counselors (LMHC), and Certified Registered Nurse Anesthetist (CRNA).

WORKERS COMPENSATION REIMBURSEMENT FOR PAYORS

(these guidelines are in accordance with Indiana Statue)

- All providers must bill claims on UB's and HCFA's per Medicare guidelines.
- Physician claims are reimbursed at the lesser of PPO rate or the 80th percentile of U&C.
- All work comp payers must pay hospital charges at PPO contracted rate. If there is no PPO contract then at 200% of Medicare.
- Steerage to in-network provider is still allowed. Please note that Encore's payer contracts require payers to steer to in-network providers.
- The work comp network is still identified on the Explanation of Payment.

Encore is excited to include our Workers' Compensation PPO to our full suite of network offerings. Giving members, employers and payers the option to choose the product that best meets their needs for high quality, cost-effective healthcare.

NOTICE OF CHANGE IN CONTRACT PARAMETERS

Should Encore desires to enter into a Payor arrangement on behalf of Provider which does not fall within the Contract Parameters, and which does not constitute an amendment to the standard Contract Parameters then Provider shall be

provided with forty-five (45) days prior written notice describing the proposed unique Payor arrangement. Provider must then notify Encore within fifteen (15) days of the effective date of the notice by signing the applicable exception notice indicating acceptance or rejection then returning a copy to Encore as indicated on the notice. If Provider does not respond to this notice in this time frame, Provider will be deemed to have accepted the Payor arrangement as of the effective date. *See Appendix B – Sample Notification Letter of Change.*

CREDENTIALING & RE-CREDENTIALING PROCESSES

ENCORE CREDENTIALING REQUIREMENTS FOR PROFESSIONAL PROVIDERS

Encore does not subscribe to CAQH. Therefore, unless the provider contract delegates credentialing or the provider qualifies as a non-credentialed provider, Encore must credential providers for participation.

Encore does not credential residents. All professional provider types must have completed residency training in the practicing specialty.

Please e-mail or mail the following applicable supporting documents to your Provider Relations Representative for processing. **Incomplete applications or supporting documents that are invalid or expired may delay provider participation status.**

- Full State Replica CAQH Application. We cannot accept the data summary or just the CAQH number.
    - Must have been attested in the last 6 months.
    - If provider does not have a CAQH application, ask your Encore Provider Relations Specialist for an application.
- Attestation and Release form signed and dated with Current Date
- Copy of State Licenses(s)
- Copy of Federal DEA(s) (if applicable)
- Copy of Controlled Substance Registration (CSR)
- Copy of Board Certification
- Copy of ECFMG Certificate
- Copy of Liability (Malpractice) Insurance Face Sheet
- Education and Training Documents i.e. degree, residency completion certificate or letter, fellowship certificate. **These documents must reflect training has been completed.**
- Detailed malpractice cases within the past five (5) years which are pending or closed
- CV including Work History
- Copy of HCFA or UB sample for billing verification
- W-9 – Tax Identification Number
- Collaborative Agreement if NP, PA, or other allied professional that requires a CA.

The credentialing process takes 60-90 days when a clean application has been received. The provider effective date is determined upon when credentialing has been completed and approved. A letter will be sent confirming effective date.

RE-CREDENTIALING

Providers must be re-credentialed approximately every 3 years. Letters will be sent to the provider's office notifying which provider(s) are due for re-credentialing. There will be a request to submit an application and re-credentialing documentation within a certain time frame. If no response is received, the provider will be terminated for not responding to re-credentialing requirements.

PROVIDER ENROLLMENT FOR NON-CREDENTIALED PROVIDERS

Certain providers can be enrolled as a Participating Provider without going through our full credentialing procedures. They are:

- Anesthesiology (Anesthesiologists, CRNA, Certified Anesthesia Assistants)
- Emergency Room providers
- Radiologists (Radiation Oncologists must be fully credentialed)
- Pathologists
- Hospitalists/Nursing Home Rounding
- Locum Tenens (See below for more information)

Please contact your Encore Provider Relations Specialist if you have any questions and for an enrollment form

LOCUM TENENS ENROLLMENT

Locum Tenens are considered exempt under the current THCG Credentialing Guidelines due to the temporary nature of their assignments.

Because our credentialing process takes 60-90 days to complete, Locums with expected assignments less than 180 days will not be listed in provider directories. However, THCG must have an enrollment form completed accompanied with certain supporting documents to prevent fraudulent practitioners from entering the Network. Please contact your Encore Provider Relations Representative for an enrollment form.

If you wish your Locum to be listed in provider directories, please contact your Encore Provider Relations Representative to discuss criteria. The Locum must be credentialed just like any other provider. It is important that THCG is notified when that provider is no longer employed by your organization to be removed from our provider directories.

Once per year, THCG shall generate a report of all Locums in our system and send notices to contracted entities to confirm Locums status.

If a Locum works for an entity that is **not** contracted, a THCG contract must be executed before enrollment for in-network status.

Please contact your Encore Provider Relations Specialist if you have any questions.

IDENTIFYING MEMBERS

All insurance companies and payors are required by their contracts with Encore Health Network to identify a THCG network on their members' identification cards. The identification of our network will be represented on the identification card by the following:

- the Encore Health Network logos (please see page 5)

The insurance identification card may include the following:

- Member Name
- Member Identification Number
- Member Employer Name
- Group or Policy Number
- THCG Network Identifier
- Address for Claim Submission
- Phone numbers for Precertification, Benefit/Eligibility, Customer Service
- Specific Requirements for Precertification
- Effective Date of Subscriber's Policy
- Payors may also contract for Carved Out Networks for health services. *Example: Pharmacy, Vision*

EncoreCombined provider contracts outside of the Indiana counties of Vanderburgh, Warrick, Posey, and Daviess counties will be considered in-network for EncorePrime® member presenting the EncorePrime® logo at the time of service.

ENCOREPRIME LOGO RECGONITION FOR ENCORECOMBINED® PROVIDERS

EncorePrime is a narrow network offering for employers in Southwest Indiana. Those employers have network needs outside the Southwest Indiana market. As a part of mainstreaming our operations and/to reduce confusion over member ID card logos and plan reimbursement, EncoreCombined® Providers

outside the EncorePrime service area, will accept the EncorePrime® logo. Unless the provider has contractual reimbursement specific to EncorePrime, providers with EncoreCombined® contracts shall view EncorePrime® logo as equivalent to the EncoreCombined® logo and their EncoreCombined®contracts. This will not change your reimbursement for EncorePrime® members. It only adds the EncorePrime® logo recognition to your existing reimbursement.

It is recommended that you copy the front and back of the ID card at each visit.

Payors will identify THCG Network Identifier on their Explanation of Benefits (EOB), which helps you identify which managed care discount applies when posting payments.

Encore Health Network does not determine benefits, eligibility, or benefit availability for persons covered by a payor benefit plan. Providers should make best efforts to contact the contracted payor for this type of information. Please reference the member's identification card for the appropriate telephone numbers.

If Encore Health Network is not on the card, we ask that you do the following:

- **Notify Encore Provider Relations**. You may fax a copy of the front and back of the ID card to Encore at (317) 621-2389 or (317) 621-2388. We will verify if the employer and vendor are Encore participants or if the member is carrying an old card. If the payor has omitted identifying Encore, we will request that new cards be printed or an Encore sticker may be applied to all insurance ID cards.
- If the member states they are participating with the Encore Health Networks, advise them their insurance card is not labeled appropriately. The member should contact their human resources department of their insurance company for a new card.

SAMPLE IDENTIFICATION CARDS

Payors are required to use the Encore Health Network® logo (see page 5 for all logos) on all ID Cards. Tiered networks must have the EncoreCombined® or

EncorePrime® logo along with the Encore Health Network® PPO logo on a participating member's ID card that utilize the tiered network . *See Appendix C – Sample ID Card.*

PROVIDER REFFERALS

In order to minimize the out-of-pocket expense to your Encore Health Network® members, you should make best efforts to refer members to other Encore Health Network® participating providers.

Provider participation can be confirmed by contacting our customer service department at (888) 446-5844 or logging onto our website at www.encoreconnect.com.

If there is a healthcare provider whom you want to nominate for Encore Health Network® members, please contact us at (888) 446-5844 or complete a provider nomination request form located on our website at www.encoreconnect.com.

CLAIM FILING & BILLING

STEPS FOR PROPER CLAIM FILING:

- Request to see the member's current insurance ID card each visit. Copy the front and back of the current card. The card will list the insurance plan and/or payor, claim address, benefit/eligibility and precertification phone numbers.
- Providers must submit claims directly to the payor or its designee for repricing.
- **CLAIM FILING TIME LIMITS**: A 120-day claim filing time limit is in our current payor/provider agreements. Please feel free to contact your Provider Relations Specialist if you have any questions.
- Encore Health Network® providers are required to submit claims for their Encore Health Network® members, regardless of whether a network of Encore is primary or secondary.
- Please list your service location in Box 32 to ensure proper claim processing.
- Bill with the rendering provider NPI in box 24J. Please make sure that the appropriate NPI is used.
- The billing NPI is in box 33a.
- **ANESTHESIA PROVIDERS**: Please include the total amount of minutes in field G on the HCFA claim form.

DEFINTION OF A CLEAN CLAIM

Without the following information on a claim, the repricing company or payor may not be able to identify the member. The claim would have to be returned which will cause delays in processing and reimbursement. In order for a claim to be considered clean and properly completed it must include, but is not limited to, the following information and any additional requested information necessary to adjudicate the claim:

- Enrollee's Name
- Enrollee's Identification Number
- Enrollee's Employer or Group Name. This is a required field for electronic claim submission. (If not on ID card, request this information from the member).
- Enrollee's Group Number. This is a required field for electronic claims submissions. If an identification card does not have a group identification number, please utilize a number such as 99999, XXXXX.
- Insurance Carrier Name. **Please note: Do not list Encore Health Network in Box 11C of the HCFA form or box 50 on the UB-04.**
- Member's full name, age and relationship to enrollee.
- Full name of attending physician, hospital or facility name if billing on a UB-04.
- Tax identification number of attending physician (depending on which is used for typical billing purposes) or tax identification number of hospital or other facility if billing on a UB-04.
- HIPAA Compliant code for each procedure
- ICD-10 diagnosis code
- NPI Number (Rendering NPI)

When submitting claims to Encore Health Network, the Rendering TIN is required to reprice claims. This is not a legacy number and is still required by Encore as an identifier. Some providers have stopped sending the Rendering TIN, which delays the processing and may cause your claim to be repriced as non-par.

IF THE ABOVE INFORMATION IS NOT INCLUDED ON THE CLAIM, THE REPRICING/PAYOR COMPANY MAY NOT BE ABLE TO IDENTIFY THE MEMBER, AND WILL RETURN THE CLAIM, THEREFORE CAUSING DELAYS IN PROCESSING.

BILLING GUIDELINES

PROVIDERS MAY BILL OR COLLECT PAYMENT FROM THE MEMBER FOR THE FOLLOWING, WHICH ARE THE MEMBER'S FINANCIAL RESPONSIBILITY:

- All co-insurance amounts as reported on explanation of benefits;
- Co-payments;
- Deductibles, as reported on the explanation of benefits;
- Penalties imposed on member by payor for member's failure to comply with payor's precertification and/or authorization process, services that are not medically necessary, non-covered services, and services that the payor has failed to pay within the contracted time period.

PROVIDERS MAY NOT BILL OR COLLECT PAYMENT FROM THE MEMBER FOR THE FOLLOWING:

- Medically necessary covered services;
- The difference between provider's billed charges and the negotiated reimbursement schedule, and amounts imposed on providers by payors for any reduction of fees when it is the provider's responsibility to comply with network's and/or payors procedure of utilization management.

In some instances, providers may be responsible for pre-certification and authorization of services for members. Information about this process will appear on the member's identification card. If the member has primary responsibility to pre-certify services according to their benefit plan, then any penalties or payment reduction resulting from a failure of the member to pre-certify or authorize services are the financial responsibility of the member.

Providers may bill for non-covered services to Encore members if they inform and obtain consent in writing that such services are not covered and all reimbursement for such services are the member's financial responsibility.

LIMITATION ON BILLING COVERED PERSONS

Provider agrees that reimbursement will come from Payor for Covered Services.

Provider cannot bill Covered Persons for any amounts not paid due to the following:

- Provider's failure to comply with the requirements of Utilization Management—payor
- Failure to file a timely claim or appeal
- Application of claims coding and bundling rules-payor.

This provision shall not prohibit collection of any applicable Copayments, Coinsurance and Deductibles, or non-Covered Services.

LIMITATION ON PAYMENT DISPUTES (SPECIFIC TO FULLY INSURED PLANS)

Payment by a payor of any claim shall be final twelve (12) months after payment and neither the payor nor the participating provider shall have any further recourse thereafter.

ENCORE MODIFIER REPRICING

Providers must include all required modifiers for services rendered. Encore will apply industry standard logic for the following modifiers:

<u>Modifiers:</u>

AS	26
51	50
53	
80	81
QW	TC

All other modifiers should be applied by the payor. Encore's provider contracts do not prevent the application of industry standard modifier logic by the payor. If a dispute arises, Encore will assist in the resolution of the dispute.

Encore does not perform any claim edits or audit for appropriate modifier billing.

ELECTRONIC FILING

All claims should be mailed to the appropriate claim filing address as indicated on the identification card. If claims will be submitted electronically, our Web MD identification number is **35206.**

All electronically submitted claims must contain the information below. Claims without this information may possibly be returned and will delay claim processing.

- Policy and/or Group Number
- Name of Employer
- Name of Insurer
- Insured's Name, Identification Number and Address
- Member's Name and Date of Birth
- All Provider or Facility submitted on the claim must have their NPI submitted as well

If you are not currently submitting claims electronically and are interested in learning how, please contact Change HealthCare (formerly known as Emdeon, Relay Health or WebMD) Customer Support at (800) 845-6592 or TK Software at (888) 372-2808.

CLAIM PROBLEM NOTIFICATION

If you experience claim issues, please follow the steps below:

- Begin by always contacting the payor regarding any claim issue. This information can be found on each EOB. Payors have sole responsibility and liability for payment of claims.

Payors are required by contract to make timely payment or denial in accordance with appropriate state laws or where law does not apply as stated below:

- Within 30 days if submitted electronically
- Within 45 days from receipt from provider or repricer, if submitted on paper. The expectation of the provider is that "receipt" of a paper claim, from either the provider or repricer, shall be within three (3) days of mailing date.

If a payor fails to meet these requirements, they forfeit the negotiated discount. The provider may contact the payor or repricer for an adjusted reimbursement that includes any penalty described in state law in addition to the provider's billed charges for such untimely payment of claims.

If the issue remains unresolved, contact Encore Health Network

Customer Service Phone Number: (888) 446-5844

Customer Service Fax Number: (317) 621-2388

Please e-mail a copy of the claim, payor EOB, patient ID card, with an explanation of the issue to claims@encoreppo.com.

CLAIMS INQUIRIES AND APPEALS

Please remember the claims@encoreppo.com email box is for inquiries and claim appeals on previously repriced claims. All new claims that need repricing must be submitted to the address on the member ID card presented at time of service.

The contractual time limits for appeals and refunds may be superseded by ERISA if it creates an adjustment based on a beneficiary appeal of an "adverse benefit determination".

CONSOLIDATED APPROPRIATIONS ACT

DIRECTORY INFORMATION. Provider shall develop a business process to timely submit provider directory information to Encore, which information shall include, at a minimum, the following: names, addresses, specialty, telephone numbers, and digital contact information of individual health care providers, and the names, addresses, telephone numbers, and digital contact information of each medical group, clinic, or facility contracted to participate in any of the Payor's networks, hereinafter "Directory Information."

UPDATES TO DIRECTORY INFORMATION. Provider shall provide or transmit, in writing, any material changes (as validated by Hospital) to the Directory Information at least every ninety (90) days or as often as requested by Network. Failure to comply may result in removal from directory. The Parties agree to comply with applicable federal and state regulations as issued or amended from time to time.

COMPLAINT OR GRIEVANCE PROCESS

Complaint or Grievance at any time for any reason.

LEVEL I COMPLAINT

DEFINITION:

A Complaint is the first level of notification by a Provider that there is a disagreement regarding any service offered by Encore Health Network. The notification may be in person, by telephone, or in writing.

Complaints will be directed to the Customer Services Department for review and referrals to the appropriate designee. Inquiries will be responded to within fifteen (15) business days of the receipt of the Complaint.

When a Provider has a Complaint, every effort will be made to resolve the issue informally. In the event the issues cannot be resolved informally, the Provider may request that it be handled according to the Level II - Appeals Process.

LEVEL II APPEALS

DEFINITION:

An Appeal is the second level of notification when a Provider is dissatisfied with the Complaint resolution.

1. A Provider who is not satisfied with a decision made in Level I may file a written Appeal and request a review of the Appeal by The HealthCare Group Vice President. The time for filing an Appeal shall be limited to a period of not more than six (6) months from the date of occurrence or thirty (30) business days following the issuance of a Complaint resolution decision under Level I, whichever is less.

2. The Vice President will issue a written decision within thirty (30) business days from the date of Appeal to include, a statement indicating the decision is binding unless the Provider files a Level III Grievance with the Grievance Committee.

LEVEL III GRIEVANCE COMMITTEE

The Grievance Committee shall act as the final level of review of any Grievance. The

Grievance Committee shall be composed of members who do not have a conflict of interest with party filing the Grievance.

The Provider may request a review by the Grievance Committee if he or she is not satisfied with the Vice President's decision. This request must be in writing to The HealthCare Group, accompanied by the notification received from the Vice President. The HealthCare Group must receive the appeal within fifteen (15) business days of the date of the Vice President's decision. The Provider may submit written materials in support of the appeal and may request the right to present oral argument to the Committee.

The Grievance Committee will review the decision of the Vice President, any written materials submitted by Provider in support of the request for review, and any oral arguments, before issuing a decision.

The Grievance Committee shall issue a decision within thirty (30) business days of receiving a request for review. The decision of the Grievance Committee shall be final unless Participating Provider demands Arbitration as described in your Provider Agreement.

WWW.ENCORECONNECT.COM

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THE HEALTHCARE GROUP, LLC

How to look up an Encore Health Network Providers

Finding an Encore Health Network Provider is as simple as a point and click.

Encore understands that when you need to look up a physician and the office location and phone number, time really does matter. So instead of turning page after page in a print directory to find an Encore Health Network physician near you, make it easy on yourself. Just turn to Encore's Online Provider Directory at www.encoreconnect.com. You can search by doctor name or medical facility – or even by ZIP Code. Hassle-free.

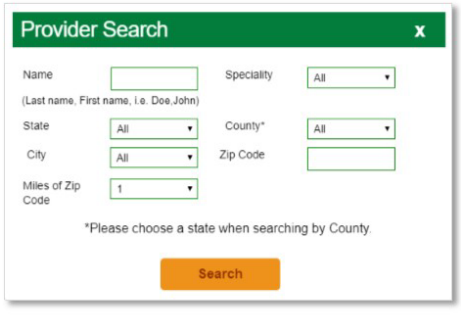
The Steps

1. Visit www.encoreconnect.com
2. Click on the orange Provider Search Ball 

in the center of the page.
3. Click on the logo on your ID Card. 

4. A pop-up box will ask you if you are an employee of several listed Employers, please select "None" and then the click here button. 

5. The next pop-up will be the provider search box and you can begin your search. You can search for a provider by Name, Specialty, City , State, Zip and/or County.



If your provider is not in the network, please feel free to contact us at (888) 574-8180. We will work to recruit them.

APPENDICES

APPENDIX A - PROVIDER RELATIONS SERVICE AREA MAP

PROVIDER RELATIONS TERRITORY MAP

LOGAN JOYCE, RHIA
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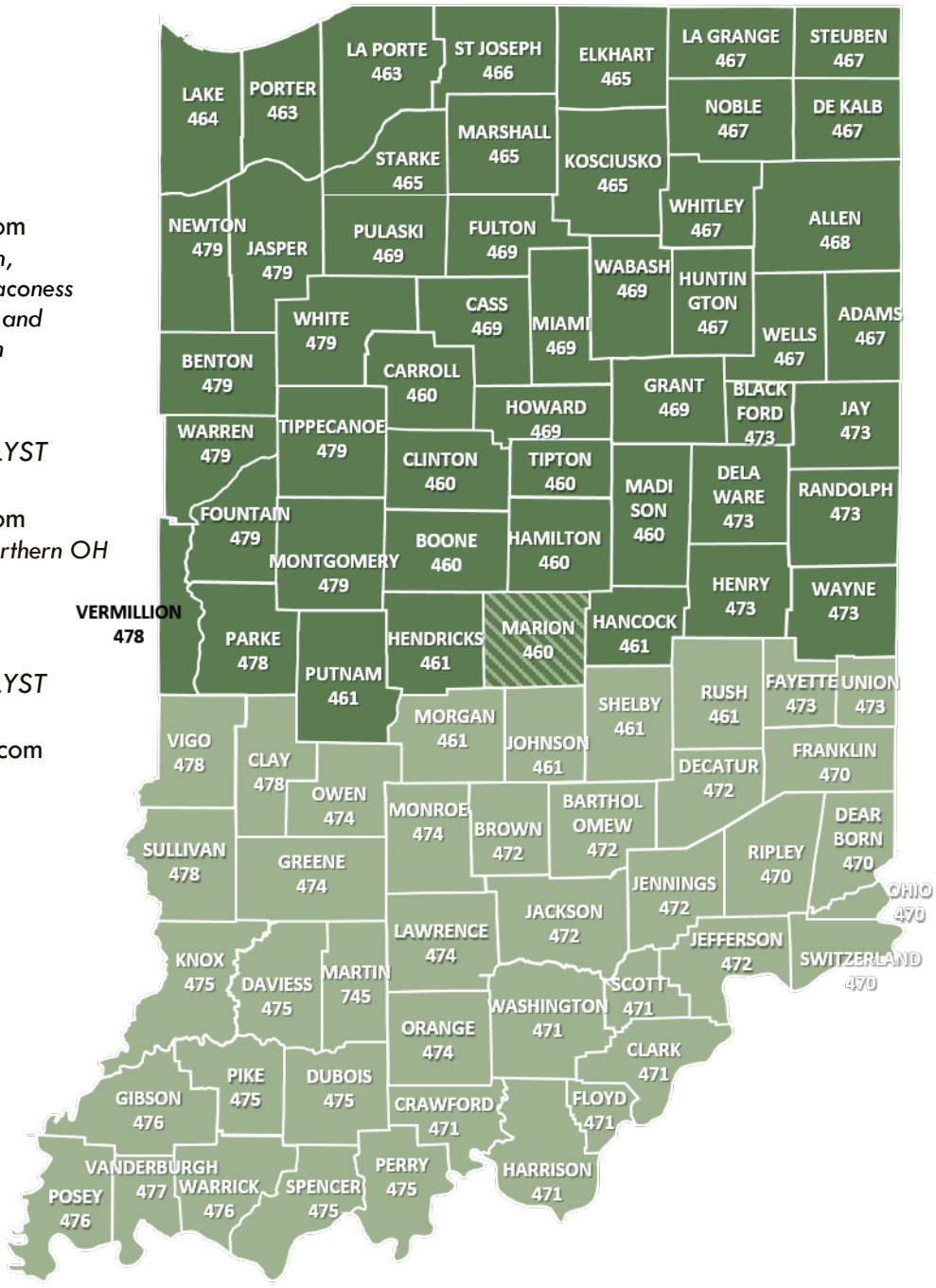


APPENDIX B – SAMPLE NOTIFICATION OF CHANGE LETTER

ENCORE PPO EXHIBIT A-4

ENCORE PPO NOTICE OF EXCEPTION TO CONTRACT PARAMETERS

Encore is notifying Participating Providers of an exception to its PPO Contract Parameters in accordance with Section 2.4 of the Encore Health Network Provider Service Agreement.

This exception notice provides that the Agreement may be utilized for Covered Services for which a Payor or Participant is obligated to pay pursuant to a contract between the Payor and the Employer or Participant. **Such services will include _____.**

In accordance with Section 2.4 of the Provider Services Agreement this shall serve as 45 day notice to Participating Providers of the exception. Providers may notify network within 15 days of the effective date or of the notice or _____ by signing and returning the exceptions notice indicating acceptance or rejection of the exception or provider will have been deemed to have accepted the arrangement.

If you should have any questions please contact _____, via telephone at _____ or by email _____. Please return to the address below, by fax, or by e-mail.

Encore Health Network
Attn: _____
8520 Allison Pointe Blvd Suite 200
Indianapolis, Indiana 46250-4299
FAX_____ _____

The effective date of this exception will be _____.

_____Accept **_____Reject**

Provider

BY: _____
Signature

PRINTED: _____

TITLE: _____

DATE: _____

TAX-ID: _____

GROUP NAME_____

PHONE NUMBER_____

Please keep a copy for your records as one will not be returned to you.

APPENDIX C – SAMPLE IDENTIFICATION CARD

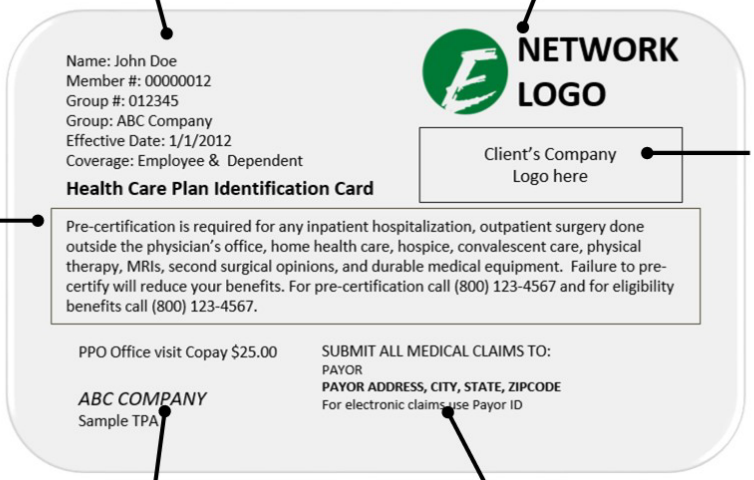
ID CARD REQUIREMENTS

(Encore Health Network must approve the ID Card template prior to the effective date of the employer group. This is just a sample.)

All ID cards must contain the following information:

- *Member name*
- *Member number*
- *Employer Group Name & Group Number*

One of the Encore logos must be on the ID card. Here are the network



The Company logo (if available) should be on the ID card.

ID cards must also have pre-certification and utilization review information on the card as well as the eligibility/ benefits and/or customer service contact numbers. Encore's customer service number is (888) 446-5844

All ID cards must have the claim submission address as well as Web ID address. For electronic submission.

The Company Name and TPA must also be on the ID card.

Encore Health Network does not produce ID cards. This is a responsibility of the payor to provide ID cards to the participants.