CONTRACTED PROVIDERS

Ohio provider manual

Effective date December 1, 2023

sidecar health®

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Introduction

Sidecar Health is working towards making healthcare more affordable across the United States to meet the needs of Members. Our mission is to provide accessible and high-quality healthcare by introducing a new kind of insurance that puts our Members in the driver's seat. We believe in a world where patients have the freedom to choose any Provider they wish, with fully transparent pricing. We offer individuals complete transparency into coverage and costs, plus control over where they receive care. We remove traditional insurance obstacles like prior authorizations or formularies and empower Members to pay cash prices for medically necessary Covered Services from routine checkups to heart transplants.

As Sidecar Health does not have any Provider network, this manual is limited only to Sidecar Health billing practices and only applies to participating Providers that have entered into a billing arrangement with Us. The care You provide is between You and Your patients. If those patients are Members of Sidecar Health, this manual will provide instructions on how to bill the Member's health plan or accept their Sidecar Health VISA Benefit Card for cash payment at the point of service. This manual is effective December 1, 2023 and is subject to change.

Terms and definitions as used in this guide:

- **Benefit Amount** indicates the maximum amount Sidecar Health will pay for Covered Services.
- **Sidecar Health VISA Benefit Card** indicates the Sidecar Health VISA Benefit Card that is provided to all Members.
- **Cost Sharing Amount** indicates the share of costs that Sidecar Health Members pay.
- **Covered Services** indicates medical, laboratory, clinical, or other healthcare services for which a member may be entitled to receive benefits through their relationship with Sidecar Health.
- **Member** indicates an individual who may be eligible to receive benefits for Covered Services through their relationship with Sidecar Health.
- **Sidecar Health Member Portal** indicates the Sidecar Health Member Portal located on our website.
- **Sidecar Health, Us, Our** indicates to Sidecar Health Insurance Company and its affiliates.
- **You, Your, or Provider** indicates any healthcare Provider subject to this manual.

Eligibility

Verifying member eligibility

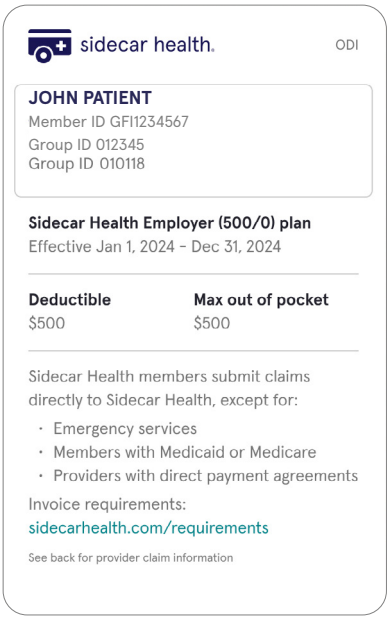
Providers are responsible for verifying Member coverage before providing any non-emergency services or treatments. Every Sidecar Health Member is given a copy of their digital Member Identification Card (ID), which can be requested by the Provider. If a Member is not covered by Sidecar Health on the date of service, We will not pay the claim.

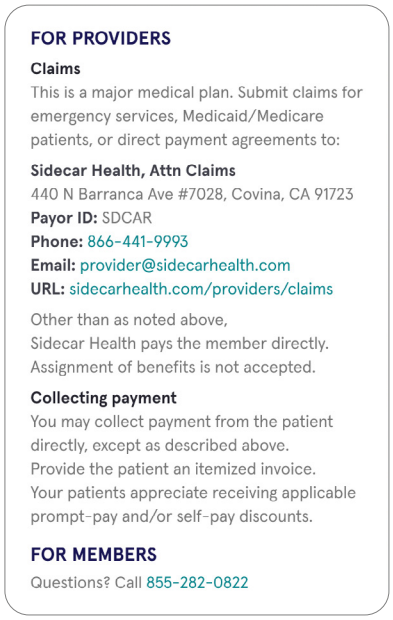
Sidecar Health supports the industry standard 270/271 transactions set for eligibility inquiry and response.

Sidecar Health does not require prior authorization and claims will not be denied on the grounds that care was not authorized prior to being provided. Providers are encouraged to verify benefits prior to rendering care. Member benefits can be verified through our Provider portal, You will need to contact us at provider@sidecarhealth.com to learn more about getting access.

Member identification cards

Every Sidecar Health Member is provided with a Member Identification Card (ID). The following information can be found on all Sidecar Health Member ID cards.





1. Member first and last name
2. Effective date with plan
3. Member ID number
4. Cost to the member, before and after, deductibles
5. What to charge
6. How to submit a claim
7. Medical invoice requirements
8. Contact information for Member Care

**Please note Member IDs may vary in appearance depending on plan type.*

Claims submission and payment

Providers may elect to either charge Our Member at the point of service or submit a claim in accordance with this manual. If only a partial payment is collected from the Member at the point of service the claim submitted to Sidecar Health must reflect the amount already paid by the Member and whether the Member paid using their Sidecar Health VISA Benefit Card or some other payment method.

If the entire charge is collected from the Member, You must furnish the Member with an itemized medical invoice for the services.

Claims submission instructions

Claims can be submitted to Us electronically or by mail. Sidecar Health encourages Providers to submit their claims electronically through our partnership with The SSI Group. When submitting a claim through mail, Sidecar Health requires Providers to use the CMS-1500 Form for all professional services and the UB-04 Form for facility services.

Claims submitted by mail should be sent to SHIS at:

Sidecar Health Insurance Solutions, LLC
440 N Barranca Avenue
Suite 7028
Covina, CA 91723
Attention: Claims Department

Electronic claims filing

Sidecar Health uses The SSI Group to facilitate the electronic transfer of both institutional and professional claims. SSI has communicated to their vendor partners of the availability of the connection. Please reach out to Your EMR and Clearing house vendors for any questions on how to submit and ensure Sidecar Health's payor ID is in their system. Verify with Your vendor that You can send to SSI and that You have the following set up:

Payer Name: Sidecar Health
Payer ID: SDCAR
Transaction: 837i & 837p

If your Clearinghouse is not connected with SSI, please contact Sidecar Health and we will get you connected with our clearinghouse vendor.

Timely filing of claims

We must receive notice of a claim within ninety (90) days from the date of service or as soon as reasonably possible. Claims are not fully adjudicated by Sidecar Health until care has been received and a claim has been submitted to Us. All benefit determinations, including Adverse Benefit Determinations, are therefore made retrospectively and Providers are encouraged to complete a benefit verification to ensure payment.

Incomplete claims

Sidecar Health will pay claims within 30 days of receipt. If a claim is missing critical information such as invalid CPT Codes, NPI, date(s) of services, etc. it will be rejected and returned to the Provider for correction before the end of the first 30-day period, together with a notice explaining the additional information needed. You will have 45 days to supply the missing information. If We receive the requested information We will notify You of Our decision 45 days after We have received Your claim, not counting the days between when We notified You of the information needed to make Our decision and the date We received the information.

Correction of claims

When You submit an incorrect or incomplete claim, You must re-submit an updated claim to correct the initial submission. Claims that are corrected must follow the same procedures as timely filing for the initial submission listed above, which is thirty (30) days from the date(s) of service.

Overpayments

If a claim has been overpaid or paid in error, We have the right to recover the amount overpaid or paid in error by any of the following methods:

1. A request for lump sum payment of the amount overpaid or paid in error; or

2. Reduction of any proceeds payable under this Plan by the amount overpaid or paid in error.

When we notice an overpaid claim, Sidecar Health will begin the process to collect the overpayment. A refund request will be sent to the Provider in the form of an invoice. The Provider must pay the invoice within thirty (30) days of the invoice date. During the thirty (30) day period, the Provider can pay the invoice by check, appeal the overpayment adjustment, or allow the invoice due date expire. If the invoice due date expires without an appeal or payment, Sidecar Health will offset the balance amount against future payments.

Denial of claims

Any denials for non-coverage of service(s) will be based on the Member's plan. If a claim is denied, Sidecar Health will send remittance advice through the clearing house with an Explanation of Benefits (EOB), which will outline the reason for denials and an explanation of appeal rights.

Cost Sharing Amounts

A Provider is permitted to directly bill a Member or any other financially responsible person for the Member for any Cost Sharing Amounts.

Conformity No Surprises Act

The Federal No Surprises Act and applicable state law establish certain patient protections including out-of-network providers' surprise bills ("Balance Billing") for emergency care and other specified items or services. As this is not a network contract, but a billing arrangement to facilitate claims submission and payment, we may consider you an out-of-network provider for purposes of complying with state and federal requirements when we process claims for emergency services and any other claims subject to surprise billing laws.

Additional information requests

When a claim is undergoing the determination process, Sidecar Health may request additional information from the Provider, such as medical records, acquisition invoices, and itemized medical invoices to determine whether the services from the submitted claim should be reimbursed.

Appeals & claim payment disputes

Internal claims and appeals

A Provider may file the appeal for a Member, in writing, either by email, mail, or fax.

Fax Number:	(866) 376-2053
Email Address:	grievances@sidecarhealth.com
Mailing Address:	Attn: Grievances, 440 N Barranca Avenue #7028, Covina, CA 91723

Please include in Your written appeal or be prepared to tell Us the following information:

- Name, address, and telephone number of the insured person
- The insured's health plan identification number
- Name of health care Provider, address, and telephone number
- Date the health care benefit was provided
- Name, address, and telephone number of an authorized representative (if appeal is filed by a person other than the insured)
- A copy of the notice of Adverse Benefit Determination

When You request an appeal, We will review our decision and provide You with a written determination. If We continue to deny the payment, coverage or service requested or You do not receive a decision within thirty (30) days, You may be able to request an external review of Your claim by an independent third party, who will review the denial and issue a final decision.

Time limits for filing an internal claim or appeal

Sidecar Health does not utilize or require prior authorization. Claims are not fully adjudicated by Sidecar Health until care has been received and a claim has been submitted. All benefit determinations, including Adverse Benefit Determinations, are made retrospectively. You may appeal any Adverse Benefit Determination within 180 days of the initial notice of Adverse Benefit Determination. You must file the internal appeal within 180 days of the receipt of the notice of claim denial (an Adverse Benefit Determination). Failure to file within this time limit may result in the company's declining to consider the appeal.

We will review Your Appeal and notify You of Our decision as soon as possible but no later than 60 days after We have received Your Appeal. If an extension is necessary due to matters beyond Our control, We will contact You prior to the expiration of the initial 60 day period. We will explain the reasons why We need more time and the date when We expect to have a decision for You. This extended date will be no later than 15 days after the expiration of the initial 60 day period. If We need more time to make a decision because You have not given Us necessary information, You will have 45 days from the date We notify You to give Us the information. We will describe the information needed to make Our decision in the notice We send You. If We do not receive the requested information within 45 days, We reserve the right to dismiss Your Appeal. You will have the right to appeal again within 180 days of the receipt of the initial notice of Adverse Benefit Determination. If We receive the requested information We will notify You of Our decision 75 days after We have received Your Appeal, not counting the days between when We notified You of the information needed to make Our decision and the date We received the information.

External review

Under certain circumstances, You have a right to request an external review of Our adverse benefit decision by an independent review organization or by the superintendent of insurance, or both. If You have filed internal claims and appeals according with the procedures of this manual, and We have denied or refused to change Our decision, or if We have failed to provide You with a final determination of Your Appeal within the time permitted, or if We waive, in writing, the requirement to exhaust the internal claims and appeals procedures, You may make a request for an external review of an Adverse Benefit Determination.

All requests for an external review must be made within 180 days of the date of the notice of Our final Adverse Benefit Determination. Requests for an external review must be provided in writing. As all Adverse Benefit Determinations are made after receipt of the healthcare service or services in question, no expedited external review is available.

Request for an external review

We will initiate an external review within 5 days after it receives Your written request if Your request is complete. We will provide You with notice that it has initiated the external review that includes:

1. The name and contact information for the assigned independent review organization or the superintendent of insurance, as applicable, for the purpose of submitting additional information; and

2. A statement that You may, with 10 business days after the date of receipt of the notice, submit, in writing, additional information for either the independent review organization or the superintendent of insurance to consider when conducting the external review.

If Your request is not complete, We will notify You in writing and include information about what is needed to make the request complete.

If We deny Your request for an external review on the basis that the Adverse Benefit Determination is not eligible for an external review, We will notify You, in writing, the reasons for the denial and that You have a right to appeal the decision to the superintendent of insurance.

If We deny Your request for an external review because You have failed to exhaust the Internal Claims and Appeals Procedure, You may request a written explanation, which We will provide to You within 10 days of receipt of Your request, explaining the specific reasons for its assertion that You were not eligible for an external review because You did not comply with the required procedures.

Request for External Review to Superintendent of Insurance. If We deny Your request for an external review, You may file a request for the superintendent of insurance to review Our decision by contacting Consumer Services Division at 800-686-1526 between 8:00 a.m. and 5:00 p.m., Eastern Standard Time or by sending a written request addressed to: Consumer Services, The Ohio Department of Insurance, 50 West Town Street, Suite 300, Columbus, Ohio 43215. Information about external reviews is also available on the Department's website: insurance.ohio.gov.

If Superintendent Upholds Our Decision. If You file a request for an external review with the superintendent, and if the superintendent upholds Our decision to deny the external review because You did not follow Our internal claims and appeals procedures, You must resubmit Your Appeal according to Our internal claims and appeals procedures within 10 days of the date of Your receipt of the superintendent's decision. The clock will begin running on all the required time periods described in the internal claims and appeals procedures when You receive this notice from the superintendent.

If Our failure to comply with its obligations under the internal claims and appeals procedures was considered (i) de minimis, (ii) not likely to cause prejudice or harm to You (claimant), (iii) because We had a good reason or Our failure was caused by matters beyond Our control (iv) in the context of an ongoing good faith exchange of information between We and You (claimant) or Your Authorized Representative and (v) not part of a pattern or practice of Our not following the internal claims and appeals procedures, then You will not be deemed to have exhausted the internal claims and appeals requirements. You may request an explanation of the basis for Our asserting that its actions meet this standard.

Independent Review Organization. An external review is conducted by an independent review organization (IRO) selected on a random basis as determined in accordance with Ohio law. The IRO will provide You with a written notice of its decision to either uphold or reverse Our Adverse Benefit Determination within 30 days of receipt of a standard external review (not urgent). The IRO's decision is binding on the company. If the IRO reverses the health benefit plan's decision, We will immediately provide coverage for the healthcare service or services in question.

If the superintendent or IRO requires additional information from You or Your healthcare Provider, We will tell You what is needed to make the request complete.

If We Reverse Our Decision. If We decide to reverse its adverse determination before or during the external review, We will notify You, the IRO, and the superintendent of insurance within one business day of the decision.

Review by the Superintendent of Insurance. If We have made an Adverse Benefit Determination based on a Plan issue (e.g., whether a service or services are covered under Your Certificate), You may request an external review by the superintendent of insurance.

If the IRO and Superintendent upholds Our decision, You may have a right to file a lawsuit in any court having jurisdiction.

Coordination of benefits

Sidecar Health coordinates payment for Covered Services in accordance with the terms of The Member's plan. Providers shall bill primary insurers for items and services they provide to a member before they submit claims for the same items or services to Sidecar Health. Any balance due after receipt of payment from the primary payer should be submitted to Sidecar Health for consideration and the claim must include information verifying the payment amount received from the primary plan. Coordination of Benefits (COB) information can be submitted to Sidecar Health by an EDI transaction with the COB data completed in the appropriate COB elements. If We are primary, You will need to send Us a 835 or Electronic Remittance Advice (ERA). If We are the secondary Provider, You will need to send a 837 File that contains all patient information.

Have questions?

Provider services phone:	(866) 441-9993
Provider services email:	provider@sidecarhealth.com
Provider website:	sidecarhealth.com/providers