Dear Provider:

We want to extend our personal greeting and welcome you to the Sonder Health Plans family.

Attached you will find Sonder Health Plans' Provider Manual which has been specifically designed to meet the requirements to administer our Health Plans' products, services, policies, and procedures and to complement the service agreement. Sonder Health Plans is a Health Maintenance Organization (HMO) and a Preferred Provider Organization (PPO) that has obtained a Medicare Advantage Plan Contract with the Center for Medicare and Medicaid Services (CMS) to provide the health needs of Medicare beneficiaries enrolled with Sonder Health Plans, Inc.

Medicare is a health insurance program for persons aged 65 or older, under age 65 with certain disabilities, and all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

Sonder Health Plans, Inc. will offer an appropriate and accessible range of preventive, primary care, specialty services and ancillary/facility providers to meet the needs of its Medicare enrollees, and maintain a sufficient number, mix and geographic distribution of providers.

We have designed this Provider Manual to support you in learning the processes and responsibilities as a Primary Care Physician (PCP), Specialist, Ancillary/Facility Provider, or vendor. In addition, it will educate you on protocols for prior authorization and referrals, medical necessity standards and practice protocols, including guidelines that address treatment of chronic and complex conditions, covered and emergency services, claims and encounter submissions, member rights and responsibilities and many other important functions and information. It is all outlined for you in the Table of Contents.

There are times when updates to this handbook may be required due to regulatory changes or internal policy revisions or updates. When this occurs, we will advise you if it is a new (add) or revised (replace) change - you will simply have to add or replace the specific information in the handbook.

You may request additional copies of the Provider Manual at no charge from your local Provider Engagement Representative. The Provider Manual is also available on our website at https://www.sonderhealthplans.com/.

Thank you for actively participating in the delivery of quality health care services to our members. We encourage you to contact us if you have any suggestions for improving the services that we provide. We look forward to partnering with you in the care of our members.

Sincerely,

Suzanna Roberts Chief Executive Officer
Sonder Health Plans, Inc.

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PROVIDER QUICK REFERENCE & PLAN CONTACT INFORMATION
Visit our website at https://www.sonderhealthplans.com/ for more Plan information.

DEPARTMENT	CONTACT INFORMATION
Provider Services ***Provider Member Eligibility and Benefit Verifications Provider Participation Status Inquiries*** ***Network Inquires, Claim Status*** ***Hours: 9a-5p Mon-Fri***	Sonder Health Plans, Inc. Attn: Providers Services 6190 Powers Ferry Road, Suite 320 Atlanta, Georgia 30339 Phone: 1 (888) 525-1730 Fax: 1 (888) 216-5210
Provider Engagement Department ***Provider Participation or Demographic Change Requests Provider Training, Education***	6190 Powers Ferry Road, Suite 320 Atlanta, Georgia 30339 1 (470) 563-1855 Fax: 1 (678) 258-9895 Providerrelations@sonderhealthplans.com
Case Management	6190 Powers Ferry Road, Suite 320 Atlanta, Georgia 30339 Phone: 1 (888) 712-7007 Fax: 1 (888) 891-0019
Health Services Department ***Prior Authorization/Referrals Requests and Inquiries*** ***NOTE:*** *Providers must submit all documentation for medical necessity when filing a request for prior auth to allow for prompt and effective reviews and determinations.* *All medically necessary STAT/URGENT or Expedited Requests should be requested by calling the Pre-Certification number to the right and should be identified as an expedited when filing the request to ensure expedited processing timeframes are met.*	6190 Powers Ferry Road, Suite 320 Atlanta, Georgia 30339 Phone: 1 (888) 978-0255 Fax: 1 (888) 217-4320
Health Services Department ***Case Management Services***	6190 Powers Ferry Road, Suite 320 Atlanta, Georgia 30339 Phone: 1 (888) 712-7007 Fax: 1 (888) 891-0019
Health Services Department ***Inpatient Services*** ***Admission Notification, Requests, and Inquiries***	6190 Powers Ferry Road, Suite 320 Atlanta, Georgia 30339 Phone: 1 (888) 974-1546 Fax number: 1 (888) 217-3885
Health Services Department ***General Contact Line***	Phone: 1 (888) 217-4560

Member Appeals & Grievance Department *Member Appeals* *Please reference denial letter issued (i.e. Integrated Denial Notice) for appropriate process when filing on behalf of a member) This is NOT the Participating Provider Reconsideration process.*	Sonder Health Plans ATTN: Member Appeals & Grievance Department 6190 Powers Ferry Road, Suite 320 Atlanta, GA 30339 Phone: 1 (888) 428-2110 Fax: 1 (941) 866-2319 *(note, must include denial letter with request)*
Participating Provider Reconsideration Requests (claims denied for auth notification for failure to provide medical records for an inpatient stay)	Sonder Health Plans ATTN: Provider Reconsiderations 6190 Powers Ferry Road, Suite 320 Atlanta, GA 30339 Phone: 1 (888) 428-2110 Fax: 1 (941) 866-2319 *(note, must include denial notification with request)*
Participating Provider Claim Payment Dispute Requests (Claim underpayments, duplicate claims decisions, timely filing, contracted rate disputes, no auth obtained, etc.)	Sonder Health Plans ATTN: Audit & Recovery Department, Disputes Unit 6190 Powers Ferry Road Suite 320 Atlanta, GA 30339 Via Email: providerdisputes@sonderhealthplans.com Via Fax: 1 (678) 813-5594

DEPARTMENT	CONTACT INFORMATION
Pharmacy Department ***Pharmacy benefit manager*** ***MedImpact***	6190 Powers Ferry Road, Suite 320 Atlanta, Georgia 30339 Phone: 1 (833) 684-7263
Claims Mirra TPA	PO Box 3325 Spring Hill, Fl 34611 Email: claims@mirrahealthcare.com W-9 Request Response can be faxed to 1 352-616-0909Electronic Claims Submission: (Availity) EDI Payer ID: A0339 Availity Claim Submission Technical support: 1 (800) 282-4548 MIRRA Portal: Member Eligibility; Member Details; Member Search; Claims Search and Listing To access the self-registration provider portal, please visit https://pm-sonder.mirrahealthcare.com/. Please have the following information available: • Provider/Facility Address • NPI (group or individual) • Tax ID(group or individual) • User First, Middle and Last Name • Contact Number • Fax Number • Email Address
Non-Emergent Transportation	6190 Powers Ferry Road, Suite 320 Atlanta, Georgia 30339 Phone: 1 (888) 428-4440
Hearing Services ***TruHearing***	Phone:1 (866) 581-9464 Non-contracted Providers, call Sonder Health Plans at 1 (888) 525-1730
Vision Services ***EyeMed***	Phone: 1 (844) 600-1779
Dental Services ***Liberty Dental Plan***	Phone: 1 (844) 844-0893
Gym ***Silver & Fit***	Silver&Fit GA Gym Locations Search Link Daily Fit at Home Workout Schedule Link

OTC ***Sonder Health Plans***		The latest version of the OTC Catalog can be located by accessing member resources at www.sonderhealthplans.com
Lab ***LabCorp***		**LabCorp** 5667 Peachtree Dunwoody Road #250 Sandy Springs, GA 30342 Phone: 1 (404) 418-5952 **LifeBrite Laboratories**

DEPARTMENT	CONTACT INFORMATION
LifeBrite 	9 Corporate Blvd NE, Suite 150 Atlanta, GA 30329 Phone: 1 (678) 433-0607
Quest Diagnostics 	**Quest Diagnostics** 1777 Montreal Circle Tucker, GA 30084 Phone: 1 (866) 697-8378
Durable Medical Equipment (DME) ***Apria*** 	**Apria Healthcare** Phone: 1 (888) 492-7742
Quantum Medical Supply Diabetic Shoes 	**Quantum Medical Supply** Phone: 1 (561) 432-8200
S2 Medical Supply 	**S2 Medical Supply** 2780 Peachtree Industrial Blvd, Suite C Duluth, GA 30097 Phone: 1 (888) 799-3767
Solara Medical Supplies  ***NOTE:*** *Prior auth required for devices/equipment over $500. All DME under $500 requires referral. Referral should be submitted to both vendor and SHP. Fax to SHP:* 1 (888) 217-4320.	**Solara Medical Supplies** Phone: 1 (619) 600-3250
24 Hr Nurse Hotline ***health dialog*** 	***Sonder Health Plans' Members ONLY*** Phone: 1 (888) 317-0079
Acupuncture & Chiropractic Services ***American Specialty Health (ASH)*** 	Phone: 1 (800) 972-4226

DEPARTMENT	CONTACT INFORMATION
Compliance Department ***Compliance and FWA***	Sonder Health Plans ATTN: Compliance & SIU 6190 Powers Ferry Road, Suite 320 Atlanta, GA 30339 ethicsandfraudreports@sonderhealthplans.com

SECTION 1: MANUAL OVERVIEW

Purpose:

The Sonder Health Plans, Inc. Provider Manual is an extension of the practitioner/facility provider contractual agreement and provides participating physicians/facility providers and their respective staff with the policies and procedures that guide their participation with Sonder Health Plans, Inc. A copy of this manual should be maintained in physician/facility provider offices for reference.

This document is intended as a guideline. Situations may arise in which professional judgment may necessitate action, which differs from the guidelines in this document. An explanation of the special circumstances, which justify variation from these guidelines, should be documented and retained in medical records or office files. If a situation arises where deviation occurs, please contact Sonder Health Plans, Inc. for instructions.

In the event of any inconsistency between information contained in this manual and the contractual arrangement between you and Sonder Health Plans, Inc., the terms of the contractual agreement shall govern. Additionally, inconsistency between information contained in this manual and the provision of any state or federal statute or regulation applicable to either Sonder Health Plans, Inc., or a contracted/participating provider, the provisions of the prevailing statute or regulation shall have full force and effect. Also, please note that Sonder Health Plans, Inc. may provide available information concerning an individual member's status, eligibility for benefits, and/or level of benefits. The receipt of such information shall in no event be deemed to be a promise or guarantee of eligibility of any such individuals to receive benefits. In addition, all payment is subject to the terms of the contract under which the individual is eligible to receive benefits.

This manual will be updated, and providers notified, as needed, to incorporate any changes to Sonder Health Plans, Inc. administrative policies and procedures that impact providers.

Confidentiality of Patient Information:

Confidentiality is the responsibility of every Sonder Health Plans, Inc. staff member and participating provider. Sonder Health Plans, Inc. is a "Covered Entity" under HIPAA (the Health Insurance Portability and Accountability Act of 1996). As a participating provider, you are our Business Associate for the purposes of HIPAA. In addition, any provider who conducts any healthcare transactions electronically is also a Covered Entity. As such, you are also required to comply with the HIPAA Privacy and Security Rules, as amended (the HIPAA Security Rule applies to all ePHI (electronic Protected Health Information). The Health Information Technology and Economic and Clinical Health (HITECH) Act, part of the American Reinvestment and Recovery Act of 2009 (ARRA), further adjusted the civil monetary penalties for HIPAA violations, including Administrative Simplification.

In addition, providers must comply with state and federal laws and regulations regarding the confidentiality of patient information, e.g., legislation pertaining to disclosure of mental health/HIV information, data breach notification, etc.

Participating Physicians and Provider:

SHP contracts with entities who furnish and/or provide items and/or services in cost-effective manner that safeguard federal and state funds, as applicable. Participating physicians/providers include but are not limited to physicians, ambulatory surgery centers, diagnostic facilities, hospitals, skilled nursing facilities, pharmacies, and other health care providers such as medical laboratories and home health care agencies.

Primary Care Physicians (PCPs):

Primary Care Physicians (PCPs) are licensed, practicing physicians who have contracted with Sonder Health Plans, Inc. to provide medical services to Sonder Health Plans, Inc. members and are reimbursed for delivery of those services. A PCP is usually one of these disciplines:

- Family Physician & General Practitioner – A physician who specializes in the care of all members of a family regardless of age.
- Internist – A physician who specializes in internal medicine and delivers non-surgical treatment of medical conditions.

The PCP makes diagnoses, provides treatment, performs physical examinations, gives advice on the individual's health and, when necessary, makes referrals to consultants and/or specialists. The PCP is considered our member's medical home.

Contact Addresses:

Provider Engagement:
Sonder Health Plans, Inc.
Attention: Provider Engagement
Department 6190 Powers Ferry Road,
Suite 320
Atlanta, Georgia 30339

Medicare Advantage Program Requirements:

The Centers for Medicare and Medicaid Services (CMS) requires Sonder Health Plans, Inc.'s participating providers and vendors ("first-tier entities") and their employees and contracted individuals and entities to comply with all CMS Medicare Advantage (MA) program requirements. Sonder Health Plans, Inc.'s agreements with its first-tier entities must contain certain specific provisions. In addition, first tier entities' agreements with their downstream entities must also contain these provisions. Therefore, if you (or your organization) subcontracts with a downstream entity, the following provisions must be included in your agreements. Unless otherwise noted, the Medicare Advantage provisions apply equally to members receiving Medicare benefits only as well as those receiving both Medicare and Medicaid benefits.

These provisions are:

1. **Compliance with Law.** Provider agrees to comply with all applicable Medicare laws, rules and regulations, reporting requirements, CMS instructions, and applicable requirements of the contract between Sonder Health Plans, Inc. and CMS (the "Medicare Contract") and with all other applicable state and federal laws and regulations, as may be amended from time to time, including, without limitation Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to applicable provisions of Federal criminal law, the False Claims Act [31 U.S.C. § § 3729-3733]; the Anti-Kickback Statute [§1128B]; the Physician Self-Referral Law (Stark Law) [42 U.S.C. § 1395nn]; the Exclusion Statute [42 U.S.C. § 1320a- 7]; the Whistleblower Protection Act; Beneficiary Inducement Law; the Civil Monetary Penalties Law (CMPL); the Deficit Reduction Act of 2005; the Health Insurance Portability and Accountability Act of 1996 administrative simplification rules at 45 CFR parts 160, 162, and 164. [42 C.F.R. § 422.504(i)(4)(v) and § 422.504(h)(1)]; and The Health Information Technology for Economic and Clinical Health (HITECH) Act.

2. **Member Privacy and Confidentiality.** Provider agrees to comply with all state and federal laws, rules and regulations, Medicare program requirements, and/or requirements in the Medicare Contract regarding privacy, security, confidentiality, accuracy and/or disclosure of records (including, but not limited to, medical records), personally identifiable information and/or protected health information and enrollment information including, without limitation: (1) HIPAA and the rules and regulations promulgated thereunder, (2) 42 C.F.R. § 422.504(a)(13), and (3)

   42 C.F.R. § 422.118; (iv) 42 C.F.R. § 422.516 and 42 C.F.R. § 422.310 regarding certain reporting obligations to CMS. Provider also agrees to release such information only in accordance with applicable State and/or Federal law or pursuant to valid court orders or subpoenas.

3. **Audits; Access to and Maintenance of Records.** Provider shall permit access, collection, inspection, evaluation and audit directly by Sonder Health Plans, Inc. and/or their authorized designee, the Department of Health and Human Services (DHHS), the Comptroller General, the Office of the Inspector General, the General Accounting Office, CMS and/or their authorized designees, and as the Secretary of the DHHS may deem necessary to enforce the Medicare Contract, of Provider's physical facilities and equipment and any pertinent information including books, contracts (including any agreements between Provider and its employees, contractors and/or subcontractors providing services related to the Agreement), documents, papers, medical records, patient care documentation, computers, electronic systems, and other records and information involving or relating to the provision of services under the Agreement, and any additional relevant information that CMS may require (collectively, "Books and Records"). All Books and Records shall be maintained in an accurate and timely manner and shall be made available for such inspection, evaluation or audit for a time period of not less than ten (10) years, or such longer period of time as may be required by law, from the end of the calendar year in which expiration or termination of this Agreement occurs or from completion of any audit or investigation, whichever is later, unless CMS, an authorized federal agency, or such agency's designee, determines there is a special need to retain records for a longer period of time, which may include but not be limited to: (i) up to an additional six (6) years from the date of final resolution of a dispute, allegation of fraud or similar fault; or (ii) completion of any audit should that date be later than the time frame(s) indicated above; (iii) if CMS determines that there is a reasonable possibility of fraud or similar fault, in which case CMS may inspect, evaluate, and audit Books and Records at any time; or (iv) such greater period of time as provided for by law. Provider shall cooperate and assist with and provide such Books and Records to Health Plan and/or CMS or its designee for purposes of the above inspections, evaluations, and/or audits, as requested by CMS or its designee and shall also ensure accuracy and timely access for Medicare Advantage Members to their medical, health and enrollment information and records. Provider agrees and shall require its employees, contractors and/or subcontractors and those individuals or entities performing administrative services for or on behalf of Provider and/or any of the above referenced individuals or entities: (i) to provide Health Plan and/or CMS with timely access to records, information and data necessary for: (1) Health Plan(s) to meets its obligations under its Medicare Contract(s); and/or (2) CMS to administer and evaluate the MA program; and (ii) to submit all reports and clinical information required by the Health Plan(s) under the Medicare Contract. [42 C.F.R. § 422.504(e)(4), (h), (i)(2), and (i)(4)(v).]

4. **Prompt Payment of Claims.** Sonder Health Plans, Inc. agrees to promptly process and pay or deny claims for Covered Services in accordance with the Agreement between

Sonder Health Plans, Inc., and Provider. [42 C.F.R. § 422.520(b).]

5. **Hold Harmless of Medicare Advantage Members.** Provider agrees that: (i) in no event, including but not limited to, non-payment of rendered services or items, Sonder Health Plans, Inc.'s insolvency, or breach of Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Sonder Health Plans' eligible Members for amounts, services, or items that are the legal obligation of Sonder Health Plans. Sonder Health Plans' Medicare Advantage Members shall be held harmless from and shall not be liable for payment of any such amounts. Provider acknowledges, understands, and agrees to comply with all Sonder Health Plan referral and prior authorization requirements. The Advanced Beneficiary Notice of Non-Coverage (ABN), Form (CMS-R-131) does not comply with MA organization determination requirements of 42 CFR, Part 422, Subpart M and, therefore, shall not be used by a Participating provider for that purpose. When a provider wishes to inform an enrollee that a service is not covered, in whole or in part, the standardized denial notice is the Notice of Denial of Medical Coverage or Payment (Form CMS-10003-NDMCP), also known as the Integrated Denial Notice (IDN) that includes the OMB-approved standardized appeal language must be issued. If a provider believes an item, service or Part B drug may not be covered, the provider must advise the enrollee to request prior approval from the MA plan or the provider may request a decision from the plan in order to explain to the member. This also applies to any service the provider intends to provide directly to the member that they know is not covered under the Medicare program and to which they intend to bill the member directly. The failure to contact the plan to issue the CMS required notifications can result in you, the provider, not being able to bill the member for any non-covered service. Please utilize the organization process located in section 9. Provider further agrees that this provision (a) shall be construed for the benefit of Medicare Advantage Members; (b) shall survive the termination of Agreement(s) regardless of the cause giving rise to termination, and (b) supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Sonder Health Plans and/or other impacted parties. This does not apply to the collection of co-pays/coinsurance from Sonder Health Plans' Medicare Advantage Members. [42 C.F.R. § 422.505(g)(1)(i) and (i)(3)(i).]

6. **Accountability**. Provider agrees that Sonder Health Plans, Inc. shall monitor the provision of services by Provider on an ongoing basis and Sonder Health Plans shall be accountable under the Medicare Contract, and, as applicable, a State contract, for services provided to Medicare Advantage Members under the Agreement regardless of the provisions of the Agreement or any delegation of administrative activities or functions to Provider under the Agreement. [42 C.F.R.
§ 422.504(i)(1); (i)(4)(iii); and (i)(3)(ii).]

7. **Delegated Activities**. Provider acknowledges and agrees that to the extent Sonder Health Plans, Inc., in its sole discretion, elects to delegate any administrative activities or functions to Provider, Provider understands and agrees that: (i) Provider may not delegate, transfer or assign any of Provider's obligations under the Agreement and/or any separate delegation agreement without Sonder Health Plans' prior written consent; and (ii) Provider must demonstrate, to Plan's satisfaction, Provider's ability to perform the activities to be delegated and the parties will set out in writing: (1) the specific activities or functions to be delegated and performed by Provider; (2) any reporting responsibilities and obligations pursuant to Sonder Health Plans' policies and procedures, obligations of the Medicare Contract and/or State Contract, and/or the Medicare and State Program requirements; (3) delegation monitoring and oversight activities by Sonder Health Plans including without limitation review and approval by Plan of Provider's processes, procedures, and evidence thereof, as applicable, and audit of such on an

ongoing basis; and (4) corrective action measures, up to and including termination or revocation of the delegated activities or functions and reporting responsibilities if CMS or Sonder Health Plans determines that such activities have not been performed satisfactorily. [42 C.F.R. § 422.504(i)(3)(iii); 422.504(i)(4)(i)-(v).]

Provider/Vendor and any of their downstream contracted associates shall not conduct offshore operations for services related to Sonder Health Plan business without prior notice and written consent from Sonder Health Plans. Provider acknowledges and affirms that prior to Provider or any of their downstream contracted associates conducting Sonder Health Plans business offshore, they shall give Sonder Health Plans a minimum of ninety (90) calendar days prior notice of the intent to offshore services under contractual obligation to allow Sonder Health Plans to conduct required actions in a timely manner as a result of intended changes. Fifteen (15) calendar days from Provider's notification of intent to offshore, Providers must complete and submit to the Plan an Offshore Attestation for each offshore subcontractor that the Provider has engaged to perform Sonder Health Plans Medicare-related work that involves receiving, processing, transferring, handling, storing, or accessing protected health information (PHI) of Sonder Health Plans' Medicare beneficiaries. Provider agrees to supply any additional information in a timely manner related to offshoring as required to ensure continued compliance with prevailing Medicare Program requirements. For the purposes of this requirement, offshore is defined as outside of the one of the fifty U.S. states, the District of Columbia, or one of the United States Territories (American Samoa, Guam, Northern Marianas, Puerto Rico, and the Virgin Islands).

8. **Compliance with Sonder Health Plans' Policies and Procedures.** Provider shall comply with all policies and procedures of Sonder Health Plans, including, without limitation, written standards for the following: (a) timeliness of access to care and member services (refer to Section 5 of this Provider Manual); (b) policies and procedures that allow for individual medical necessity determinations (e.g., coverage rules, practice guidelines, payment policies); (c) provider consideration of Medicare Advantage Member input into Provider's proposed treatment plan; and (d) Sonder Health Plans Compliance Program which encourages effective communication between Provider and Sonder Health Plans' Compliance Officer and participation by Provider in education and training programs regarding the prevention, correction and detection of fraud, waste and abuse and other initiatives identified by CMS.

   Sonder Health Plans' Compliance policies and training shall be disseminated within 90 days of contracting/hiring and annually thereafter. Provider acknowledges, understands, and affirms that timely distribution of Sonder Health Plan's Standards of Conduct and Compliance Policies shall be distributed and/or made available to its employees and/or downstream contracted associates to ensure compliance with Plan compliance policies and procedures and standards of conduct. Compliance Program and Code of Conduct policies are in the Appendix of this Provider Manual, as well as the Plan's Anti-Fraud Plan and annual Compliance & FWA Training.

   The aforementioned policies and procedures are identified in Sonder Health Plans' Provider Manual which is incorporated herein by reference and may be amended from time to time by Sonder Health Plans [42 C.F.R. 422.112; 422.504(i)(4)(v); 42 C.F.R. § 422.202(b); 42 C.F.R. § 422.504(a)(5); 42 C.F.R. § 422.503(b)(4)(vi)(C) & (D) & (G)(3).]
9. **Compliance with Exclusion Screening.** Provider shall comply with CMS exclusion screening requirements and must review the DHHS Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE list) and the General Services Administration (GSA) System for Award Management (SAM) to ensure that any provider, supplier, employee, or staff rendering services or items under the Sonder Health Plans'

Agreement is not excluded by the OIG or GSA. As such, payment for items or services furnished or prescribed by an excluded provider or entity shall be denied and/or recouped. Provider should verify individuals or entities are not excluded from Program participation prior to the hiring or contracting of new hires, board members, or vendors; thereafter, running verifications monthly. Your monthly review should include, at a minimum, the monthly LEIE supplement file and any SAM updates, below are links to both OIG and SAMs. [42 U.S.C. 1320a-7).]

Link to OIG Exclusion Database Search

Link to SAM Exclusion Search, Data Files, and Resources

10. **Continuation of Benefits.** Provider agrees that except in instances of immediate termination by Sonder Health Plans for reasons related to professional competency or conduct and upon expiration or termination of the Agreement, Provider will continue to provide Covered Services to Medicare Advantage Members as indicated below and to cooperate with Sonder Health Plans throughout the transition of Medicare Advantage Members to other Participating Providers in a manner that ensures medically appropriate continuity of care. In accordance with the requirements of the Medicare Contract, applicable laws, regulations, and/or accrediting bodies, Provider will continue to provide Covered Services to Medicare Advantage Members after the expiration or termination of Agreement, whether by virtue of insolvency or cessation of operations of Sonder Health Plans, Inc., or otherwise: (i) for those Medicare Advantage Members who are confined in an inpatient facility on the date of termination until discharge; (ii) for all Medicare Advantage Members through the date of the applicable Medicare Contract for which payments have been made by CMS to Sonder Health Plans, Inc.; and (iii) for those Medicare Advantage Members undergoing active treatment of chronic or acute medical conditions as of the date of expiration or termination through their current course of active treatment not to exceed ninety (90) days unless otherwise required by item (ii) above. [42 C.F.R. 422.504(g)(2) & (3).]
11. **Physician Incentive Plans.** The parties agree: (i) that nothing contained in Agreement nor any payment made by Sonder Health Plans to Provider is a financial incentive or inducement to reduce, limit or withhold Medically Necessary services to Medicare Advantage Members; and (ii) that any incentive plans between Sonder Health Plans, and Provider and/or between Provider and its employed or contracted physicians and other health care practitioners and/or providers shall be in compliance with applicable state and federal laws, rules and regulations and in accordance with the Medicare Contract and Medicare Program requirements. Upon request, Provider agrees to disclose to Sonder Health Plans the terms and conditions of any "physician incentive plan" as defined by CMS and/or any state or federal law, rule, or regulation. [42 C.F.R. § 422.208]
12. **Data Integrity & Record Retention.** Providers agree to maintain compliance with applicable state and federal laws, rules, and regulations and in accordance with record retention requirements and the Medicare Contract and Medicare Program Integrity rules and requirements. Provider agrees to comply with 10-year record retention requirements and to work with and respond timely to requests regarding data integrity program incentives, as defined by CMS and/or any state or federal law, rule, or regulation. [42 CFR 422.504(d) and (e)]

SECTION 2: ORGANIZATIONAL GOALS AND OBJECTIVES

Partnership - The state or condition of being a partner, participation; association; joint interest. We build trusting Engagement that promote teamwork to achieve win-win results for our members.

Stewardship - The careful and responsible management of something entrusted to one's care. We drive a culture of service that values quality, compliance, and accountability to our members.

Leadership - The capacity or ability to guide and direct in the best interest of others. We take responsibility for our actions to deliver excellence in the work that fulfills our purpose and serves our members.

Sonder Health Plans, Inc.is pleased that you have agreed to participate as a network provider. We look forward to working with you to provide Sonder Health Plans' members with quality health care. In this section, we highlight some of the goals and objectives that guide Sonder Health Plans in the provision of care and service to members.

Sonder Health Plans is organized to ensure (1) members' access to quality care, (2) on-going monitoring of appropriate utilization of services, and (3) continuous evaluation and improvement in the quality of care and services delivered by participating providers to Sonder Health Plans embers.

Guiding goals:

- Improve and maintain Plan members' physical and emotional status.
- Promote health and empower members to develop and maintain healthy lifestyles.
- Involve members in treatment and care management decision-making.
- Ensure that the care and treatment provided to members is based on evidenced-based medical/clinical guidelines, standards, and practices.
- Be accountable and responsive to Plan member concerns and grievances.
- Use technology and other resources efficiently and effectively for member welfare.
- Ensure that appropriate care and treatment is accessible to members and provided in a timely manner.

Operational Objectives:

- Enhancing the efficiency of resource utilization, while at the same time ensuring the delivery of high quality and accessible care and treatment.
- Proactive pursuit of methods to improve care and service to members.
- Provision of interventions designed to improve the overall health and productivity of members.
- Providing consistency and continuity of care throughout Sonder Health Plans health and behavioral health network.
- Ensuring systematic identification and follow-up of potential quality/compliance issues.
- Continuously educating our members and providers about goals, objectives, and structure for providing quality, cost-effective, and coordinated managed health and mental health care.
- Promoting open communication and interaction between providers and members.

Sonder Health Plans' Mission: Improve the overall health and well-being of our members while being recognized as a valued and trusted partner in their health care journey.

Sonder Health Plans' Vision: To make healthcare simple, personal, and affordable by delivering on our commitments and holding ourselves accountable.

Being innovative by inventing the future and learning from the past. Eliminate the financial barriers for our members by offering cost effective plan choices.

Sonder Health Plans' Values:

Integrity Compassion Community Partner High Performance Diversity

SECTION 3: OVERSIGHT COMMITTEE STRUCTURE

Sonder Health Plans' committee structure is designed to promote company-wide participation and the involvement of network providers in the development, implementation, and evaluation of quality management and other activities. Sonder Health Plans' standing committees include:

Quality Management Steering Committee (QMSC):

The QMSC is responsible for oversight of the company's Quality Management Program including management and senior management representing various departments, including Health Services, Compliance, Network Management, Operations, Quality Management, etc. The QMSC reports directly to the Sonder Health Plans Board of Directors.

Responsibilities of the QMSC include:

- Providing direction and oversight for the development, monitoring, evaluation, and enhancement of the company's Quality Management Program.
- Establishing and monitoring key performance indicators.
- Establishing and monitoring organizational performance goals for clinical care consistent with HEDIS criteria and national Medicare benchmarks.
- Facilitating and monitoring performance improvement activities.
- Reviewing reports from committees reporting to the QMSC.
- Oversight of delegated entities and approval of delegation decisions; and
- Evaluating the effectiveness of the Quality Management Program at least annually.

Health Services Committee (HSC):

The HSC is a subcommittee of the QMSC and is chaired by a SHP Medical Director appointed by the SHP Board of Directors and/or SHP executive leadership . It includes representation by VP of Health Services and/or Director of Health Services; Physicians from various specialties; Health Equity Representative; and Internal or External Experts; and "As needed", internal or external subject matter experts may be invited to provide additional clinical or operational insight. The HSC is responsible for decision-making related to SHP's Clinical Operations, including Utilization Management and

Population Health (comprised of Case Management and Disease Management), policy development, and performance improvement across all covered services under SHP.

The HSC operates under the delegated authority of SHP's Executive Leadership Team and the Board of Directors. It has the authority to:

- Develop, approve, and review clinical and utilization management policies.
- Make decisions on medical necessity, utilization, and service authorization.
- Approve performance improvement initiatives and monitor quality outcomes.

Peer Review Committee:

The Peer Review Committee is a sub-committee of the QMSC and is responsible for reviewing cases involving the professional competence or conduct of providers which could potentially adversely affect member welfare. It is chaired by a Medical Director and includes representation by Risk Management, Medical Management, and network providers. In addition to being standing members, network providers are invited on an ad hoc basis in order to provide appropriate peer/specialty representation for the case or issue under review based on provider specialty. Responsibilities of the Peer Review Committee include:

- Evaluation of cases, events, or situations with actual or potential impact on quality of care.
- Conducting objective evaluations and making decisions using evidence-based medicine and established standards of care.
- Evaluating committee membership for appropriate health care specialty representation for the case or issue under review.
- Participation in the peer review appeal process.
- Providing input on the re-credentialing process; and,
- Maintaining strict confidentiality practices regarding all information obtained through the peer review process.

Credentialing Committee:

The Credentialing Committee is a subcommittee of the QSMC and is chaired by the Chief Medical Director. It includes primary and specialty care providers. The Credentialing Committee is responsible for the overall direction of the credentialing program. Responsibilities include:

- Providing input on Sonder Health Plans' credentialing program and standards.
- Evaluating applicants, verifying qualifications and credentials in accordance with regulatory requirements, accreditation standards, and plan policy.
- Evaluating applicants' professional license status, history of medical board disciplinary actions, malpractice claims history/cases, complaints filed by Sonder Health Plans members and any other factors included in Sonder Health Plans' credentialing standards.
- Ensuring appropriate clinical peer input when discussing standards of care for a

particular type of provider.

- Approving or disapproving initial and re-credentialing applications for network participation; and,
- Maintaining strict confidentiality practices regarding all information obtained through the credentialing process

Pharmacy and Therapeutics (P&T) Committee:

Sonder Health Plans contracts with a Pharmacy Benefits Manager (PBM) and delegates the function and responsibilities of the P&T Committee to the PBM. The Committee's goal is to promote safe, cost- effective, and quality drug therapy that appropriately reflects community and national standards of practice. The P&T Committee approves Sonder Health Plans' Formulary and promotes clinically appropriate, safe, and cost-effective drug therapy. Committee members meet regulatory and accreditation requirements. The Sonder Health Plan Chief Medical Officer is an active member of the P&T Committee.

Compliance Committee:

The Compliance Committee exists to assist the Board with its oversight responsibilities regarding Medicare compliance. It provides resources, guidance, and assistance to the Compliance Officer in the preparation, implementation, and evaluation of the Medicare Compliance Program. The Committee is chaired by the Compliance Officer and includes senior representative from throughout the organization.

JOIN OUR COMMITTEES!!!

Sonder Health Plans invites and encourages our Network Providers to serve on the Credentialing Committee or the Medical Management Committee and/or its Peer Review Sub-Committee.

If you are interested in learning more about these opportunities, please contact your Provider Engagement for information.

SECTION 4: PROVIDER ENGAGEMENT DEPARTMENT

Provider Engagement Role & Responsibilities

The Sonder Health Plans Provider Engagement Department is responsible for assessing and meeting your needs as Sonder Health Plans' participating providers. The Provider Engagement Department's main responsibilities are as follows:

- Negotiating Contracts
- Managing Contract Terms
- Collecting Credentialing Information
- Conducting Site Surveys
- Training New Providers Through Orientation Sessions
- Offering Training Sessions Upon Request by The Provider
- Distributing and maintaining the Sonder Health Plans Provider Manual
- Providing Updates on Sonder Health Plans' Policies and Procedures

- Distributing Provider Directories and Newsletters
- Processing Provider Changes

Resolving Provider Issues and Complaints Provider Communications

Periodically, the Provider Engagement Department will conduct in-services or workshops for all providers to review Sonder Health Plans' current policies and procedures and provide updates on Sonder Health Plans' programs and services.

Provider Engagement staff are committed to meeting the needs of our physicians/providers. Your Provider Engagement Representative is always available to answer questions concerning Sonder Health Plans. Please contact the Provider Engagement Department at the number below if you do not have the contact information for your local representative.

Provider Engagement Department Contact Information:

Email address: ProviderRelations@sonderhealthplans.com Fax: 1 (678) 258-9895

Quarterly Provider Outreach for Directory Accuracy

Purpose:

To ensure the accuracy of the Sonder Health Plans provider directory through regular quarterly outreach to all contracted providers, in compliance with regulatory requirements and to enhance member access to accurate provider information.

Scope:

This policy applies to all staff involved in the maintenance and verification of the provider directory for the health plan.

Policy Statement:

Sonder Health Plans is committed to maintaining an accurate and up-to-date provider directory. To achieve this, the health plan will conduct quarterly outreach to all contracted providers to verify and update their information.

Procedures:

1. **Quarterly Outreach Schedule:**
    a. Conduct outreach to all contracted providers on a quarterly basis (every three months).
    b. Establish a schedule for outreach activities to ensure timely completion each quarter.
2. **Outreach Methods:**
    a. Work closely with ProviderLenz to access multiple methods for outreach, including phone calls, emails, and online verification forms.
    b. Ensure that outreach communications are clear, concise, and provide instructions for providers to verify and update their information.
3. **Information Verification:**
    a. Verify key provider information, including but not limited to:
        i. Provider name and contact details
        ii. Practice location(s)
        iii. Specialty and services offered
        iv. Office hours
        v. Acceptance of new patients

b. Update the provider directory with any changes or corrections received from providers.

4. **Documentation and Reporting:**
    a. Maintain records of all outreach activities, including the date of outreach, method used, and responses received.
    b. Generate quarterly reports summarizing the outreach efforts and any updates made to the provider directory.
5. **Compliance Monitoring:**
    a. Monitor compliance with the quarterly outreach schedule and ensure that all providers are contacted as required.
    b. Address any issues of non-compliance and implement corrective actions as necessary.

Responsibilities:

- **Provider Relations Team:** Work with ProviderLenz to conduct outreach activities, verify provider information, and update the provider directory.
- **Compliance Department:** Monitor adherence to the outreach schedule and maintain documentation of outreach efforts.

Review and Revision: This policy will be reviewed annually and revised as necessary to ensure ongoing compliance with regulatory requirements and to improve the accuracy of the provider directory.

SECTION 5: PHYSICIAN/PROVIDER RESPONSIBILITIES (Provider Protocols)

Accessibility and Availability of Services

Physicians/Providers are expected to:

a) Be available to provide or arrange for provision of medical services to Members 24 hours a day, 7 days a week.

b) Arrange for on-call and after-hours coverage as well as coverage for other absences (illness, holidays, vacation) by utilizing participating ***and*** credentialed Sonder Health Plans Physician/Providers of similar specialty.

c) Comply with Sonder Health Plans standards for timely access to care and services to as follows:

1. Urgent Care – within 24 hours
2. Routine Care-within one week
3. Well Care – within one month
4. In-office wait time should not exceed thirty minutes (30) from the time of check-in to time at which the Physician/Provider sees the patient.

d) Ensure accessibility of services to members by maintaining a ratio of patients to full-time equivalent (FTE) physicians as follows:

- One (1) physician FTE to 2500 Medicare members.
- An allied health care professional (PA or ARNP) counts as 0.5 physician

FTE for Medicare.

e) Will have hours of operation that do not discriminate against particular needs of Sonder Health Plans members.

Allied Health Care Professionals

Participating physicians may utilize the services of allied health care professionals such as Physician Assistants (PAs), Advanced Registered Nurse Practitioners (ARNPs), and individuals other than physicians who may provide direct patient care within the scope of practice established by the rules and regulations of the State of Georgia and Sonder Health Plans guidelines.

- Sponsoring physicians will assume full responsibility to the extent of the law when supervising allied health care professionals. Sponsoring physicians are also responsible for implementation of written policies (as required) to enforce statutory requirements for licensure, delegation, collaboration, and supervision of these staff.
- Allied health care professionals should clearly identify themselves to patients, as well to other health care professionals.
- Any patient request to be seen by a physician, rather than an allied health care professional, must be honored at all times.

Patient Care Services

Physicians are expected to adhere to the following patient care services guidelines:

- Provide comprehensive health services and care to Sonder Health Plans' members and refer Sonder Health Plans members with problems outside their scope of practice for consultation and/or care to appropriate Sonder Health Plans participating specialists on a timely basis.
- Refer members only to network Physicians/Providers, except when they are not available, or in an emergency. For HMO Plans, a prior authorization should be obtained, unless services are considered urgent/emergent. This will help our member/your patient understand their plan as well as assist with any claims payment issues.
- Submit authorization request information to Sonder Health Plans in a timely manner.
- Admit members only to participating Sonder Health Plans network hospital, SNFs, and other inpatient care facilities, except in an emergency. Contact the plan for assistance with placement.
- Adhere to Sonder Health Plans clinical practice guidelines as made available to participating providers. Clinical practice guidelines can be found on the SHP website at sonderhealthplans.com
- Obtain authorizations as required by Sonder Health Plans and provide appropriate information to the Plan regarding the member.
- Not to discriminate based on a member's health status, race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, or genetic information.
- Not to discriminate in any manner a Sonder Health Plans member from any other patients.
- Council members on follow-up care and provide training in self-care, as necessary.
- Work cooperatively with other practitioners and uphold the standard of ethics for the

health care profession.

- Provide or coordinate health care services that meet generally recognized professional standards and those standards provided by Sonder Health Plans in the areas of operations, clinical practice guidelines, customer satisfaction, and fiscal responsibility.
- Discuss all aspects of a member's health with him/her and be cognizant of the member's health benefits to ensure that conversations about treatment options are comprehensive.
- Understand that the information provided in the Physician/Provider contractual agreement, or the Provider Administration Manual is not intended to interfere with or hinder communications between Providers and Members regarding a patient's medical condition or available treatment options.
- Maintain an environmentally safe office with equipment in proper working order to comply with City, State, and Federal regulations concerning safety and public hygiene.
- Transfer copies of medical records to other Sonder Health Plans Physicians/Providers upon request and at no charge to Sonder Health Plans, the member, or the requesting party, unless otherwise agreed upon.
- Preserve member dignity and observe the rights of members to know and understand the diagnosis, prognosis, and expected outcome of recommended medical, surgical, and medication regimen.
- Fully disclose treatment to members.
- Provide services in a culturally competent manner, i.e., remove all language barriers to those patients with limited English proficiency or reading skills, as well as those with diverse cultural and ethnic backgrounds.
- Meet the requirements of all applicable State and Federal laws and regulations including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, the Rehabilitation Act of 1973, and the Health Insurance Portability and Accountability Act (HIPAA).
- Adhere to all HIPAA guidelines and requirements.
- Ensure all Provider Staff are aware of participation status and are appropriately providing information to Sonder Health Plan members.

Sonder Health Plans Standards

Provide quality, cost-effective health care without compromising patient care.

- Abide by the rules and regulations and all other lawful standards and policies of Sonder Health Plans.
- The PCP agrees to accept Sonder Health Plans members as stipulated by the Physician/Provider contract. The PCP must not refuse new members until such time he/she can reasonably demonstrate to Sonder Health Plans that his/her panel size has reached the maximum for adding new members, or upon mutual agreement with Sonder Health Plans. A 60-day notice is required to close panels.

Expected Professional Conduct during Physical Examinations

Physicians are expected to adhere to the following guidelines for physical examinations of Sonder Health Plans members:

- The Physician/Provider should obtain agreement from the member prior to performing

a genital examination, rectal examination, or female breast examination.

- To decrease the risk of allegations of misconduct, Physicians/Providers examining the other sex should routinely have a chaperone in the room during female breast or pelvic or a male hernia or prostrate examinations. The chaperone should:
    - (1) Remain in the room for as long as the patient is being examined. The chaperone may leave the room once the pelvic or female breast examination is completed, and the patient is properly draped; (2) assume a supportive role in the examination but should not interfere with physician/patient Engagement; (3) preserve physician/patient confidentiality.
- The patient or Physician/Provider may request a chaperone to be present during any office examination. The chaperone may be a family member or friend of the patient or the physician/provider's assistant.

Confidentiality of Specified Member Information and Medical Records

All consultations or discussions involving a Sonder Health Plans member or his/her case should be conducted discreetly and professionally in accordance with professional practice and standards of ethics. All members have a right to confidentiality, and any health care professional or person who deals directly or indirectly with the member or his/her medical record must honor this right. Information regarding the member or his/her case, including medical, financial, and personal information is considered confidential and must be treated as such.

Confidential information includes:

1. Any communication between a member and a physician.
2. Any communication with other clinical persons involved in the member's health, medical care, and mental health care, including:
    a) all clinical data, i.e., diagnosis, treatment.
    b) member transfer to a facility for treatment of drug abuse; alcoholism, and/or behavioral health problem.
    c) Any communicable disease such as acquired immunodeficiency syndrome (AIDS) or Human Immunodeficiency Virus (HIV) testing that is protected under Federal or State law.

Release of Member Information

All Sonder Health Plans members have the right to confidentiality. To protect the confidentiality of members' Protected Health Information (PHI), Sonder Health Plans addresses applicable regulatory requirements in all contracts. As part of our quality improvement and compliance activities, Sonder may engage contracted vendors to assist with medical record retrieval (chart retrieval) for HEDIS, risk adjustment, or audit purposes. These vendors operate under strict confidentiality agreements and are considered business associates under HIPAA. Access to member PHI by these vendors is limited to the minimum necessary to fulfill their responsibilities and is conducted in accordance with applicable privacy and security standards.Except for the purposes of treatment, payment or operations, the member or the member's authorized representative must authorize release of PHI. An authorized representative is an individual designated by a member to make health care and/or personal decisions through a power of attorney, health care surrogate designation, court-appointed guardianship, or designation in a will for minors or incapacitated persons. Please

refer to the Medicare Advantage Program Requirements in Section I for more information.

Reporting Adverse Incidents to Sonder Health Plans

Sonder Health Plans has a risk management program which includes the reporting of Adverse Incidents and quality of care grievances to the Georgia Department of Community Services.

Physicians and other health care providers have an affirmative duty to report any Adverse Incident involving a Sonder Health Plans member occurring at their offices and outside of hospitals, outpatient ambulatory, skilled nursing, and rehabilitation facilities. Adverse Incidents occurring at hospitals, outpatient facilities and rehabilitation facilities are reported by those facilities directly to the Georgia Department of Community Services.

An Adverse Incident is an event over which health care personnel could exercise control, and which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred. Adverse incidents include, but are not limited to:

- Death
- Brain or Spinal Injury
- Surgery on the wrong patient or wrong site
- Medically unnecessary surgery or surgery unrelated to the member's condition/diagnosis
- Surgery to remove foreign objects left from a prior surgical procedure
- Surgery to repair damage from a planned surgical procedure, where the damage was not a recognized specific risk, as disclosed to the member and documented through the informed- consent process
- Permanent disfigurement
- Fractures or dislocation of joints or bones

In addition, participating providers should report other occurrences/events to Sonder Health Plans, including:

- Complication of drug, treatment, or service prescribed.
- Patient dissatisfaction angrily expressed with threats.
- Delay in diagnosis or referral.
- Breach of confidentiality.
- A request for medical records by an attorney other than for motor vehicle accident.
- Actual or potential Quality of Care issues involving a Sonder Health Plans member.
- Hospital-acquired infections.
- Falls occurring in contracted/participating facilities.

NOTE: All Occurrences should be reported to the Sonder Health Plans Risk Manager within three (3) business days, using the Sonder Health Plans Incident Report Form. The form may be found on the website and in the Provider Documents and Forms Section.

The information submitted to Sonder Health Plans is used to investigate potential quality issues and for risk management review. All information reported to Sonder Health Plans will remain strictly confidential in accordance with Sonder Health Plans policies and procedures

on confidentiality.

Fraud and Abuse Plan

Sonder Health Plans has an Anti-Fraud Plan aimed at detecting, investigating, and preventing all forms of fraud, waste, and abuse (FWA), including internal fraud, FWA by pharmacies, providers, prescribers, pharmaceutical manufacturers, vendors, and members. The Anti-Fraud Plan can be located in the Appendices Section of this Provider Manual.

Sonder Health Plans has an obligation to investigate reports of fraud and to report FWA to the State, the CMS Medicare Integrity Contractor, and other government agencies such as the Department of Health and Human Services.

Sonder Health Plans has established mechanisms to assist with detecting incorrect coding, duplicate billing, services not justified by diagnosis, etc. Sonder Health Plans will reject claims that do not meet Medicare criteria and recover amounts for claims previously paid in error as allowed by applicable and prevailing laws and regulations.

Participating Providers are required to adhere to Sonder Health Plans Anti-Fraud Plan. All Providers and their staff are to be educated on their responsibility to notify Sonder Health Plans' Compliance Department immediately in the event fraud, waste, or abuse is known or suspected.

Sonder Health Plans has also established a Compliance and FWA Hotline and email for members, providers, employees, and vendors to report known or suspected misconduct and/or FWA activity. Individuals have the right to report anonymously and without fear of retaliation.

To report or communicate concerns, please contact us via our hotline or by email:

Sonder Health Plans' Compliance

ethicsandfraudreports@sonderhealthplans.com

As stated above, Sonder Health Plans has a strict non-retaliation policy:

No retaliation will be taken against anyone for reporting violations or communicating concerns in good faith.

- Reports may be made anonymously; to the extent allowed by company policy and the law, your name will remain confidential at your request.
- Suspected violations will be investigated.
- Disciplinary action(s) will be taken when violations occur.

Please help us fight FWA by notifying our Compliance Officer immediately if you become aware of any suspected FWA involving a Sonder Health Plans member, vendor, or provider. For example:

- A member who intentionally permits others to use his/her identification card to obtain services or supplies from any Physician/Provider.
- A member knowingly provided fraudulent information on his/her enrollment form that materially affects the member's eligibility.
- Pharmacy FWA such as prescription drug shorting, bait, and switch pricing, altering scripts or data to obtain a higher reimbursement, dispensing counterfeit, or adulterated drugs, dispensing without a prescription, prescription refill errors, inappropriate billing practices, etc.

- Theft of your DEA number or prescription pad
- Kickbacks, inducements, and other illegal remuneration

If, after appropriate investigation, Sonder Health Plans takes action to disenroll a member due to fraud, Sonder Health Plans will seek approval from CMS and notify the member in writing.

Sonder Health Plans provides Compliance and FWA training annually to its employees and first tier and downstream entities. Although Providers may undergo FWA training as part of their Medicare certification training, Providers regardless of certification are provided with Sonder Health Plans Compliance & FWA training upon on-boarding and annually there-after. Providers are responsible to ensure that their employees, staff, agents, and subcontractors providing care or services under their Sonder Health Plans agreement undergo the required training upon hire and annually thereafter.

Covering Physicians

In the event a provider is on vacation, takes a sabbatical, or is temporarily unavailable to provide care or services to Sonder Health Plans members, they must make arrangements with another like specialty participating with Sonder Health Plans to provide services on their behalf. Should a provider have a covering physician who ***IS NOT*** contracted and credentialed with Sonder Health Plans, they must obtain prior approval from Sonder Health Plans. The covering physician must meet CMS screening requirements and may be required to sign an Agreement accepting the contracted rates as payment-in-full for services rendered and agree not to balance bill Sonder Health Plans Members. Contact your Provider Engagement Representative to report coverage changes.

Closing a Physician Panel

A contracted Primary Care Physician desiring to close their panel for "good cause" should contact the Sonder Health Plans Provider Engagement Department with the following information:

- A written request, 60 days prior to the requested closing date, stating the "good cause" reason for closing a panel.
    - Information regarding the status of the closed panel request for example: to new patients only or to all patients including existing patients transferring from another plan.
    - A specific effective date for the re-opening of the panel if known, or description of circumstances under which panel may be re-opened.
    - Effective Date for requested changes.

Please note, a PCP cannot discriminate against Sonder Health Plan Members by closing their panels to SHP Members and not all patients.

Provider Practice or Billing Charges

Prior written notice to your Sonder Health Plans' Provider Engagement Representative or corporate office is required for any Provider contracting and/or demographic changes. Sonder Health Plans requires a sixty (60) day prior notification to process changes under your agreement.

- Tax identification Number changes (require new W-9 and re-contracting or the reassignment of Agreements)

- NPI changes
- Group Name or Affiliation changes (may require new W-9 and/or re-contracting)
- New Practice Address (Site Visit Required for PCPs)
- New Provider (Submission of Credentialing information is Required)

Providers must submit requests timely by submitting requests for changes in writing to their Provider Engagement Representative. Requests in writing should be submitted on Providers company letterhead or sent via company email with company signature. Requests must identify the following, as applicable for the changes being requested:

- Practice Name (on W-9)
- Tax ID Number
- Requested Change(s)
- Requested Effective Date of Changes
- Practice location or Billing Location demographic changes/additions (to include the below):
    - Address
    - Phone
    - Fax
    - Days and Hours of Operations for the practice location
    - If Accepting New Patients at the practice location
    - Languages other than English spoken, if applicable

If more than 1 Provider is impacted by the Practice Group's changes, the Practice may submit a roster identifying all impacted Providers under their group in lieu of documenting each within the written request, referencing instead the attachment.

Sonder Health Plans Provider Engagement will review and process request for changes in a timely and efficient manner while supporting impacted Providers and Members with assistance as needed to ensure a smooth transition of changes.

Effective dates of changes differ based on changes being requested; Plan shall notify Provider of approved effective dates for the changes requested upon completion of processing request.

Encounters and Other Data

Physicians/Providers shall submit all reports and clinical information required by Sonder Health Plans. Capitated Physicians/Providers shall not submit claims for services set forth as capitated services but shall submit encounter information to Sonder Health Plans on standard CMS 1500, or its successor, forms which identify the health services provided to Members and which shall also contain such statistical and descriptive medical and patient data as specified by Sonder Health Plans. Encounter information on capitated Covered Services shall be submitted to Sonder Health Plans within 30 days of the date of service to the Member.

Physicians/Providers that fail to submit encounters and other data as required by Sonder Health Plans may be subject to penalties, such as withholding monthly capitation check(s) until the data is received.

Advance Directives

Sonder Health Plans provides written information to all members at the time of enrollment concerning their rights to accept or refuse medical or surgical treatment. Physicians/Providers are required to comply with Federal and State statutes regarding advance directives. The member's record must indicate whether or not the individual has executed an advance directive, and a copy of such must be retained as part of the medical record of the member. The Statutory Form Georgia Advance Directive for Health Care is included as an Appendix. . In addition, forms can be found on the Sonder Health Plans Website under "For Members," "Member Resources," "Find a Document or Form."

The Medicare Member Grievances and Appeals Process

Note, Contract providers do not have appeal rights under the member appeal provisions. Contract provider disputes involving plan payment denials are governed by the appeals/dispute resolution provisions in the contract between the provider and the plan. Claim Payment Disputes for participating Providers must be handled through the Participating Provider Payment Dispute Process (below).

Providers should refer to the original organization determination notice that outlines the appropriate process that should be followed. It is imperative that the correct process is followed to provide both members and providers due process. For appeals associated with organization determinations where the CMS approved adverse determination notice was issued to the member for specific appeals rights and information located in Section 12 of this manual.

Participating Provider Resolution Process **Participating Provider Complaints**

Participating Provider Complaints are dissatisfactions with any aspect of the Participating Providers interaction with the Plan that are not governed under any of the following Participating Provider processes:

- The Medicare Member Grievances and Appeals Process
- Participating Provider Reconsiderations
- Participating Provider Claims Payment Disputes

Participating Provider Complaints are those issues that are not reconsiderations or disputes but other concerns such as contractual, credentialing, or other feedback on Sonder service. Participating Providers who have a complaint regarding Sonder Health Plans should contact their Provider Engagement Representative or Director directly. For escalated issues, please email ProviderRelations@SonderHealthPlans.com and include all necessary information.

Participating Provider Claim Payment Disputes:

Sonder Health Plans provides a clear process for participating providers to resolve claim payment disputes. This process allows providers to request a review if they disagree with a claim payment decision.

The dispute process is available to any participating provider who wishes to initiate it after a claim has been formally processed. The Sonder Health Plans claim payment dispute process is designed to respect the rights of our Members and our Providers. Examples of claim issues falling within the scope of this dispute process include, but are not limited to, those related to reimbursement and/or cost share errors, denial errors, coding errors, billing provider participation errors, corrected claim requests, and/or other administrative claim issues believed to not be processed per contractual agreement.

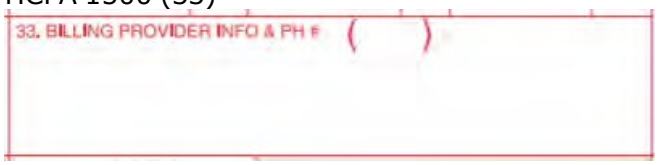
The scope of the Participating Provider Payment Dispute Process does not include denials issued with member liability. Member liability denials are determined when Sonder Health Plans issues the CMS approved Notice of Denial of Medical Coverage or Payment (Form CMS-10003-NDMCP), also known as the Integrated Denial Notice (IDN) that includes the OMB-approved standardized appeal language or those related to actions regarding quality of care and/or member safety issues or changes in participation status related to professional competency or conduct; the Member appeal process and peer review processes are in place to address such disputes and a Provider may file a first-level appeal on behalf of the Member to initiate the reconsideration process for such denials.

For prompt resolution of claim payment disputes, participating providers are encouraged to submit a dispute request within sixty (60) calendar days from the notification of the initial denial. Providers should use the Participating Provider Claim Payment Dispute Form to ensure a thorough investigation.

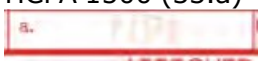
To submit a request for a claim disputes review, participating Providers should be ready to report and/or submit the following information to Sonder Health Plans, Audit & Recovery Department, Disputes Unit for investigation:

A. Claim Details for disputed claim(s):

1. Provider (Group) Tax Identification Number (billing TIN)
2. Group Name (billing practice Name)
   - HCFA 1500 (33)

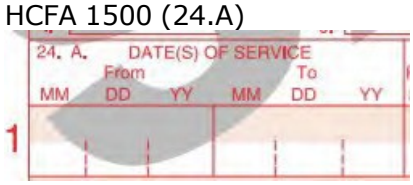


3. Group NPI (billing practice NPI)
   - HCFA 1500 (33.a)



4. Member Name(s)
5. Member ID(s)
   - HCFA 1500 (1.a)

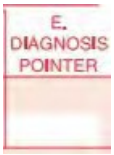
6. Dates of Service (DOS)
   - HCFA 1500 (24.A)



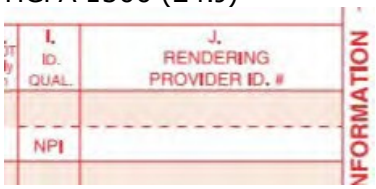
7. Place of Service Code Billed (POS)

- HCFA 1500 (24.B)

8. Diagnosis (DX)
   - HCFA 1500 (24.E)

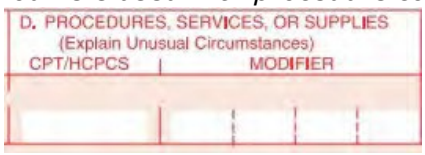


9. Rendering Provider Name
10. Rendering Provider NPI (at the service line level)
    - HCFA 1500 (24.J)



11. Service Code(s) Billed (such as CPT and HCPCS Codes)
    - HCFA 1500 (24.D)

Include Modifiers used with procedure codes billed, if appliable



B. Supporting Documentation
   1. Provide a copy of denial notification(s) (such as the claims Remit)
      - If disputing a claims rejection notification, and not a claim denial, please provide information on clearing-house rejection transaction codes received for investigation.
   2. Provide any other supporting documentation, as applicable (records, contract pages, communications with Plan employees, or any other material to support your request for review and correction.

C. Other Important Information
   1. Providers are encouraged to communicate any identified timeframes to assist with the investigation process.
      - Communicate when Providers first noticed the issue (approximately).
      - Confirm if Provider feels they are continuing to occur or if they have stopped.
        - If stopped, please communicate when the Provider notices the issue stopped.
   2. Providers are encouraged to communicate if they notice any trends that may help the Plan identify root-cause.
      - Are suspected claim errors impacting all the Provider/Group claims or only particular Provider/Provider Types/Billing locations being billed?
      - Are claim errors relating to a particular service or service type?

Providers may present relevant information in conjunction with their request for a claim dispute. Supporting documentation may be remit, notifications, provider written comments, documents, or records. Supporting documentation will be considered during the claim review and dispute process whether or not the information was available or considered during the initial review/determination.

To submit a request for a Participating Provider, Claim Payment Disputes, Providers should submit the following:

- Completed forms and supporting documentation may be submitted to:

Sonder Health Plans, Audit & Recovery Department, Disputes Unit

6190 Powers Ferry Road Suite 320

Atlanta, GA 30339

Via Email: providerdisputes@sonderhealthplans.com

Via Fax: 1 (678) 813-5594

Participating Provider Claim Disputes will be reviewed in accordance with the following timeframes as long as all required information is provided:

- Claim Disputes will be reviewed within sixty (60) calendar days of receipt.

Participating Provider Claim Payment Dispute Process:

- Requests for Participating Provider Claim Payment Dispute are investigated upon receipt by Audit and Recovery Department, Dispute Unit:
    - Investigation timeframes may vary based on the size and elements pertaining to the required review.
        - Audit and Recovery Department, Dispute Unit shall:
            - Ensure review and response times meet contractual and/or regulatory requirements, as applicable; and,
            - Audit and Recovery Department, Dispute Unit findings will be communicated to Provider via a claim dispute resolution letter.
- Providers have the right to withdraw a request at any time by contacting the Audit and Recovery Department, Dispute Unit. Providers must send a written notification to the Audit and Recovery Department, Dispute Unit requesting to withdrawal their previously submitted request.
- Providers may submit a formal written letter on their company letterhead or may send the written notification via an email to the Audit and Recovery Department, Dispute Unit, as long as the email is being sent by a company email (not a personal email account).

Participating Provider Reconsiderations

Participating Provider Reconsiderations are requests to review any claims payment decision where the plan has determined that the submitted billing/coding/request for reimbursement has not been determined/justified based on the information provided.

Adequate medical records will then be required to review in order for the Plan to determine the appropriateness of the services being rendered in accordance with clinical guidelines.

As a Participating Provider, you are obligated to follow the Plans requirements as outlined in Section 9 of this manual.

As a Participating Provider, you are required to provide notification of certain services. Additionally, any request for claims payment must include the appropriate clinical documentation to justify the billing/reimbursement requested/submitted with your claims submission. If your claim has been determined that additional medical records are needed to justify the billing submitted, you have the right to file a Participating Provider Reconsideration directly with Sonder Health Plans. Notices are issued by the Sonder Health Plans Claims Department upon claims processing .

Please note, any request to reconsider a failure to provide notification or obtain Prior Authorization will need to be resolved prior to any medical necessity review being undertaken.

To submit a request for a Participating Provider Reconsiderations, Participating Providers are required to submit the following:

- A Claim for the services in question must have been submitted to Sonder Health Plans.
- All Participating Provider Reconsiderations must be submitted within 60 calendar days of the claims determination.
- A completed Participating Provider Recon form (See Appendix Q)
- A copy of the notice issued by the Sonder Health Plans Claims Department
- All applicable medical records
- Please note – *Sonder Health Plans will not request any additional information, please submit all necessary information at the time of your reconsideration request.*

Completed forms and supporting documentation may be submitted to Sonder Health Plans Participating Provider Reconsiderations Department via Fax: 1 (941) 866-2319 *(note, must include denial letter with request)*

Participating Provider Reconsideration will be reviewed within 60 calendar days of receipt of request unless additional information is submitted that will reset the review timeframe.

Privacy and Confidentiality of Member Medical Records

Physicians/Providers must assure that all individually identifiable member information, whether verbal, written, recorded or otherwise, is reported as confidential information to the extent confidential treatment is provided under State and Federal laws. Such information is protected in accordance with relevant Federal Laws such as Standards for Privacy of Individually Identifiable Health Information (also known as the HIPAA Privacy Rule) and all other State statutes, whenever releasing or disclosing any portion of a member's medical information to any party outside of Sonder Health Plans, including to the member.

Sonder Health Plans strives to protect the privacy of Sonder Health Plans members by maintaining strict compliance with rules governing the release, exchange, and disposal of member individually identifiable information. In addition to adhering to State and Federal laws and regulations, Sonder Health Plans utilizes standards consistent with National Accrediting Organizations throughout the Sonder organization. Physicians/Providers are expected to acknowledge and adhere to those rules and standards.

"Medical Information" means medical information, in electronic or physical form, in possession of, or derived from, a provider of health care or health care service plan regarding a member's medical history, mental or physical condition, or treatment.

"Individually-Identifiable" means that the medical information includes or contains any element of personal identifying information sufficient to allow identification of the member, such as the member's name, address, electronic mail address, telephone number, Social Security number, or other information that, alone or in combination with other publicly available information, reveals the member's identity.

"Mental Health Records" means member/member records, or discreet portions thereof, specifically related to evaluation or treatment of mental disorders, including notes recorded in any medium by a health care provider/mental health professional which document or analyze the content of conversations during private, group, joint or family counseling sessions. "Mental Health Records" also include, but are not limited to, records dealing with alcohol and drug abuse, schizophrenia, schizoid-affective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa and bulimia nervosa.

All member individually identifiable information whether contained in the member's medical records or otherwise, is confidential. Such confidential information, whether oral or recorded in any format or medium, includes, but is not limited to, that which may be created or received by a health care provider, health plan, public health authority employer, life insurer, or health care clearinghouse.

Member individually identifiable materials, information or data means any document or group of records in physical (hardcopy) or in electronic form which displays identifying numbers or symbols, names, condition, identification codes, and data which could permit persons unrelated to member/member treatment, quality of care studies, payment for or administration of health care services, to identify any Sonder Health Plans member.

In general, a member's information means any individually identifiable information in the possession of, or derived from, a provider of health care regarding a member's medical history, mental or physical condition, diagnosis, encounters, referrals, authorization, medication, or treatment, which either identifies the member, or contains information which can be used to identify the member.

Medical information regarding a member will not be disclosed without obtaining written authorization. The authorization must come from the member, the member's guardian, or conservator. If the member signs the authorization, the member's medical record must not reflect mental incompetence. If a guardian or conservator signs, evidence such as a Power of Attorney, Court Order, etc., must be submitted to establish the authority to authorize the release of medical information.

Pursuant to laws which allow disclosure of confidential medical information in certain specific instances, such information may be released without prior authorization to the persons, parties, or entities, or for the purposes indicated below, namely:

- To other providers, service plans, professional or facilities for member diagnosis or treatment, including emergency situations.
    - To an insurer, employer, health care or hospital service or employee benefit plan, or the party responsible for payment, or the governmental authority determining member eligibility for payment.
    - To any facility providing billing, claims management, medical data processing or administrative services for providers or service plans.

- To organized committees, professional societies or medical staffs of licensed hospitals and health care plans, professional standards review or utilization and Federal quality control peer management organization, or those incurring responsibility for or defending professional liability claims in cases of competency, qualifications, necessity for health care services, level and quality of care, or charges justification.
- To any private or public body responsible for licensing or accreditation, but member information must stay on practice or the company premises, unless otherwise provided by law.
- To County Coroner, for death investigation.
- To public agencies, clinical investigators, health care researchers, and accredited non-profit educational or health care institutions for research but limited to that part of the information relevant to litigation or claims where member's history, physical condition or treatment is an issue, or which describes functional work limitations, but no statement of medical cause may be disclosed.
- To employer upon written request and at its expense but limited to that part of the information relevant in litigation or claims where member's history, physical condition or treatment is an issue, or which describes functional work limitations, but no statement of medical cause may be disclosed.
- Unless notified in writing to the contrary, to a sponsor, insurer, group administrator, uninsured plan, or policy where member is seeking coverage from if the information was created as a result of services conducted, upon written request and at the expense of any such requestor, for purposes of evaluating a coverage or benefits application.
- To a health care service plan by its contracted providers and to other contracted providers, for plan administration purposes.
- To an insurance institution, if there is compliance with all requirements of the Insurance Code.
- To Probate Court, in conservatorship cases.
- To organ procurement organizations or tissue banks, to aid member medical transplantation.
- To agencies authorized by law, such as the FDA.
- To State and Federal disaster relief organizations, but only basic disclosure information, such as member's name, city of residence, age, sex, and general condition.
- To third parties for encoding, encrypting or otherwise anonymizing data, but recipient shall not disclose further data to reveal individually identifiable medical information; and
- To any chronic disease management programs, provided member's treating physician authorizes the services and care.
- A valid and completed Disclosure Authorization Form, prepared in plain language, is to be used for releasing member information. The Form includes the following items:
    - Name of the person or institution providing the member information.
    - Name of the person or institution authorized to receive and use the information.

- Member's full name, address, and date of birth.
- Purpose or need for information and the proposed use thereof.
- Description, extent, or nature of information to be released that identifies the information in a specific and meaningful fashion, including inclusive dates of treatment.
- Specific date or condition upon which member's consent will expire, unless earlier revoked in writing, together with member's written acknowledgment that such revocation will not affect actions taken prior to receipt of the revocation.
- Date that the consent is signed, which must be prior to the date of the information to be released.
- Signature of the member or legal representative and his or her authority to act for the member.
- Member's written acknowledgment that member may see and copy the information described in the release and a copy of the release itself, at reasonable cost to the member

- The law may no longer protect member's written acknowledgment that information used or disclosed to any recipient other than a health plan or provider.
- Except where the authorization is requested for a clinical trial, it must contain a statement that it will not condition treatment or payment upon the member providing the requested use or disclosure authorization.
- A statement that the member may refuse to sign the authorization.
- Where use or disclosure of the requested information will result in financial gain to the health plan or provider.

Records containing information pertaining to alcohol or drug abuse are subject to special protection under Federal Regulations (Confidentiality of Alcohol and Drug Abuse Member Records, Code 42 of Federal Regulation, chapter 1, Subchapter A. Part 2). Please note that additional consent forms are required prior to releasing any medical records that contain alcohol or drug diagnosis.

Records pertaining to psychiatric diagnoses and/or treatment are subject to special restrictions on the release of information. Please refer to applicable statutes before releasing records that contain psychiatric information without a specific consent.

When a medical record is provided, only the minimum amount of the information specifically requested should be released to accomplish the purpose for which the request was made.

Members may receive a copy of their own records after completion of a valid authorization form and payment is received to cover reasonable costs of providing the record and/or copies. Reasonable charges will be billed to insurance companies, attorneys, and photocopy services, to cover reproduction costs and clerical costs incurred in locating and copying records.

Information contained in medical records may be provided to Sonder Health Plans legal representatives to protect the interest of Sonder Health Plans. Information contained in the medical records may be provided to Sonder Health Plans employees in the course of completing Sonder Health Plans business (i.e., Member Services, Quality Improvement, and Health Services). All appropriate aspects of member confidentiality will be maintained by those employees/physicians reviewing the records.

A valid authorization form must be completed before releasing medical information to any of

the following:

- Other health care providers currently carrying out medical treatment, payment, or health care operation.
- Medical researchers (when using member-identifiable information).
- Member's employer.
- Sponsor, insurer, administrator of a group insurance plan for purposes of evaluating the member's application for coverage of benefits.
- Member's attorney(s).
- To the Member.

Sonder Health Plans does not require signed authorization before releasing information to the following, subject only to a written request to the Medical Records Department which will process such records:

- Peer reviewers.
- Licensing or accreditation surveyors.
- County Coroner.
- Other health care providers currently furnishing health emergency care to member.
- Public Health Authorities for reporting communicable disease, follow-up abuse or neglect, and vital events such as death.
- Health oversight agencies for purposes of audit, investigation, inspection, civil, criminal, or administrative proceedings or determining beneficiary eligibility.

In general, medical information will always be reported as required by State law. Additional information will be released regarding a member infected with HIV only with an informed consent, which must include at least the following written data:

- Name of individual or institution releasing the information.
- Name of individual or institution or governmental agency receiving the information.
- Member's full name, address, and date of birth.
- Extent or nature of information to be released such as AIDS test results, diagnosis, and treatment, with inclusive dates of treatment.
- Specific date, event, or condition upon which authorization will expire unless revoked earlier.
- Statement that authorization can be revoked, but not retroactively to the release of information made in good faith.
- Date that consent is signed.
- Signature of member or legal representative and relationship to member.

Information released to authorized individuals/agencies shall be strictly limited to minimal information required to fulfill the purpose stated in the authorization.

Any authorization specifying "any and all medical information" or other such broadly inclusive statements shall not be honored and release of information that is not essential to the stated purpose of the request is specifically prohibited.

In response to a subpoena, records on members infected with HIV will be released as required

by State/Federal Law.

Special Consent Releases are also required prior to the disclosure of medical information when requested by any outside third party in the following instances:

- Request by employer for purposes other than paying a claim or managing a Workers' compensation case.
- Request by any third party where the member's medical information relates to evaluation and treatment of the following conditions:
  a) Alcohol or drug use
  b) Psychological/psychiatric evaluation, treatment, and counseling
  c) HIV testing and treatment
  d) Sexually transmitted diseases
  e) Genetic evaluation and testing

Other Regulatory Requirements, Sonder Health Plans Policies and Standards

In addition to the regulations previously mentioned, below are some of the key provisions of Federal Regulations 42 CFR Part 422, that has to be met by Sonder Health Plans and/or its participating providers:

CMS REGULATION - 42 CFR 422
Prohibition against discrimination based on health status §422.110(a)
Provide coverage for ambulance services, emergency and urgently needed care, and post- stabilization care consistent with provisions §§422.112(a)(9); 422.100(b)
Pay for renal dialysis for those temporarily out of service area §422.100(b)(1)(iv)
Direct access to mammography screening and influenza vaccinations §422.100(g)(1)
No co-pay for influenza and pneumococcal vaccines §422.100(g)(2)
Agreements with providers to demonstrate "adequate" access §422.112(a)(1) *Network must be sufficient to provide access to covered services*
Direct access to in-network women's health specialist for routine and preventive services §422.112(a)(3)
Services available 24 hrs./day, 7 days/week §422.112(a)(7)
Safeguard privacy and maintain records accurately and timely §422.118
Adhere to CMS marketing provisions §§422.2260 – §§422.2276
Ensure services are provided in a culturally competent manner §422.112(a)(8)
Document in prominent place in medical record if individual has executed Advance

CMS REGULATION - 42 CFR 422
Directive §422.128(b)(1)(ii)(E)
Provide covered benefits in a manner consistent with professionally recognized standards of health care §422.504(a)(3)(iii)
Payment and incentive arrangements specified between MAO, providers, first-tier, & downstream entities be specified in all contract(s) §422.504(a)(6)
Disclose to CMS all information necessary to (1) administer & evaluate the program (2) establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services §§422.64; 422.504(f)(2)
Comply with medical policy, QM and MM. MAO must develop such standards in consultation with contracting providers §§ 422.202(b); 422.504(a)(5)
Comply with ten (10) year record retention requirements 42 CFR §422.504 [d]
Provide 60 days' notice (terminating contract without cause) §422.202(d)(4)
Comply with Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and the anti-kickback statute (section 1128B(b)) of the Act) and HIPAA administrative simplification rules. §422.504(h)
Prohibits MAO, first-tier & downstream entities from employing or contracting with individuals excluded from participation in Medicare under section 1128 or 1128A of the SSA §422.752(a)(8)
Adhere to appeals/grievance procedures §422.562(a)

Provider Marketing

<u>General Guidance about Provider Promotional Activities:</u>

CMS has issued specific guidelines on provider promotional activities. The term "provider" refers to all providers contracted with the plan and their sub-contractors, including but not limited to, pharmacists, pharmacies, physicians, hospitals, and long-term care facilities.

These guidelines are designed to guide plan sponsors and providers in assisting beneficiaries with plan selection, while at the same time striking a balance to ensure that provider assistance results in plan selection that is always in the best interest of the beneficiary. Providers that have entered into co-branding relationship with plan sponsors must also follow this guidance.

Promotional activities (including provider promotional activities) must comply with all relevant Federal and State laws, including when applicable the anti-kickback statute and the

civil monetary penalty prohibiting inducements to beneficiaries.

Provider Participation in Health Fairs:

Providers may only distribute marketing materials that compare the benefits of different health plans if they accept and display materials from all plan sponsors with which they contract. The use of publicly available comparison information approved by CMS is permitted.

Plan Activities and Materials in the Health Care Setting:

Plan sponsors may not conduct sales activities in health care settings except in common areas. Common areas where marketing activities are allowed include areas such as hospital or nursing home cafeterias, community or recreational rooms, and conference rooms. If a pharmacy counter area is located within a retail store, common areas would include the space outside of where patients wait for services or interact with pharmacy providers and obtain medications.

Plan sponsors are prohibited from conducting sales presentations, distributing, and accepting enrollment applications, and soliciting Medicare beneficiaries in areas where patients primarily intend to receive health care services. These restricted areas generally include, but are not limited to, waiting rooms, exam rooms, hospital patient rooms, dialysis center treatment areas (where patients interact with their clinical team and receive treatment), and pharmacy counter areas (where patients interact with pharmacy providers and obtain medications). The prohibition against conducting marketing activities also applies after business hours in these settings. An example of such activity includes providers sending out authorization for disclosure form information to their members, such as nursing home members, to request that the member give permission for a plan sponsor to contact them about available plan products (through mailing, hand delivery or attached to an affiliation notice).

Provider-Based Activities:

CMS holds plan sponsors responsible for any comparative/descriptive material developed and distributed on their behalf by their contracting providers. The plan sponsor must ensure that any providers contracted (and its subcontractors, including providers or agents) with the plan sponsor comply with the requirements outlined in this chapter.

The plan sponsor must ensure that any providers contracted (and its subcontractors or agents) with the plan sponsor to perform functions on their behalf related to the administration of the plan benefit, including all activities related to assisting in enrollment and education, agree to the same restrictions and conditions that apply to the plan sponsor through its contract. In addition, the plan sponsor (and subcontractors, including providers or agents) are prohibited from steering, or attempting to steer an undecided potential enrollee toward a particular provider, or limited number of providers, offered either by the plan sponsor or another plan sponsor, based on the financial interest of the provider or agent (or their subcontractors or agents). While conducting a health screening, providers may not distribute plan information to their patients since this is a prohibited marketing activity.

CMS is concerned with provider activities for the following reasons:

- Providers may not be fully aware of all plan benefits and costs; and
- Providers may confuse the beneficiary if the provider is perceived as acting as an agent of the plan versus acting as the beneficiary's provider.
- Providers may face conflicting incentives when acting as a plan sponsor representative. For example, some providers may gain financially from a beneficiary's selection of one plan over another plan. Additionally, providers generally know their

patients' health status. The potential for financial gain by the provider influencing a beneficiary's selection of a plan could result in recommendations that do not address all of the concerns or needs of a potential plan enrollee.

Beneficiaries often look to their health care professionals to provide them with complete information regarding their health care choices (e.g., providing objective information regarding specific plans, such as covered benefits, cost sharing, drugs on formularies, Health Services tools, and eligibility requirements for SNPs) to the extent that a provider can assist a beneficiary in an objective assessment of the beneficiary's needs and potential plan sponsor options that may meet those needs, providers are encouraged to do so. To this end, providers may certainly engage in discussions with beneficiaries when patients seek information or advice from their provider regarding their Medicare options.

Providers are permitted to make available and/or distribute plan marketing materials and display posters or other materials announcing plan contractual relationship as long as providers offer this to all plans with which the provider participates.

All payments that plan make to providers for services must be fair market value, consistent for necessary services, and otherwise comply with all relevant laws and regulations, including the Federal and any State anti-kickback statute.

For enrollment and disenrollment guidance related to beneficiaries residing in long-term care facilities (e.g., enrollment period for beneficiaries residing in long-term care facilities and use of personal representatives in completing an enrollment application), please refer to Chapter 2 of the Medicare Managed Care Manual.

Providers should remain neutral parties in assisting plan sponsors with marketing to beneficiaries or assisting with enrollment decisions. Providers not being fully aware of plan benefits and costs could result in beneficiaries not receiving information needed to make an informed decision about their health care options.

Therefore, it would be inappropriate for providers to be involved in any of the following actions:

- Offering sales/appointment forms.
- Accepting enrollment applications for MA/MA-PD or PDPs.
- Directing, urging, or attempting to persuade beneficiaries to enroll in a specific plan based on financial or any other interests.
- Mailing marketing materials on behalf of plan sponsors.
- Offering anything of value to induce plan enrollees to select them as their provider.
- Offering inducements to persuade beneficiaries to enroll in a particular plan or organization.
- Health screening when distributing information to patients, as health screening is a prohibited marketing activity; and
- Accepting compensation directly or indirectly from the plan for beneficiary enrollment activities.

Providers contracted with plan sponsors (and their contractors) are permitted to do the following:

- Provide the names of plan sponsors with which they contract and/or.
- Provide information and assistance in applying for the low-income subsidy.
- Provide objective information on ALL plan sponsors' specific plan formularies,

based on a particular patient's medications and health care needs.

- Provide objective information regarding ALL plan sponsors' specific plans being offered, such as covered benefits, cost sharing, and Health Services tools.
- Distribute all PDPs' marketing materials with whom the provider contracts with, including enrollment application forms.
- Make available and/or distribute plan marketing materials for all plans with which the provider participates (including PDP enrollment applications, but not MA or MA-PD enrollment applications).
- Refer their patients to other sources of information, such as the SHIPS, plan marketing representatives, their State Medicaid Office, local Social Security Office, CMS website at http://www.medicare.gov/. or calling 1-800-MEDICARE; and
- Print out and share information with patients from CMS website.
- The "Medicare and You" Handbook or "Medicare Options Compare" (from http://www.medicare.gov), may be distributed by providers without additional approvals. There may be other documents that provide comparative and descriptive material about plans, of a broad nature, which are written by CMS or have been previously approved by CMS. These materials may be distributed by plan sponsors and providers without further CMS approval. This includes CMS Plan Finder information via a computer terminal for access by beneficiaries.

Provider Affiliation Information:

Providers may announce new affiliations and repeat affiliation announcements for specific plan sponsors through general advertising (e.g., publicity, radio, television). An announcement to patients of a new affiliation which names only one plan sponsor may occur only once when such announcement is conveyed through direct mail and/or email. Additional direct mail and/or email communications from providers to their patients regarding affiliations must include all plans with which the provider contracts. Provider affiliation banners, displays, brochures, and/or posters located on the premises of the provider must include all plan sponsors with which the provider contracts. Any affiliation communication materials that describe plans in any way (e.g., benefits, formularies) must be approved by CMS. Multiple plan sponsors can either have one plan sponsor submit the material on behalf of all the other organizations, or have the piece submitted and approved by CMS for each plan sponsor mentioned prior to use. Materials that indicate the provider has an affiliation with certain plan sponsors and that only list plan names and/or contact information does not require CMS approval.

Comparative and Descriptive Plan Information:

Providers may distribute printed information provided by a plan sponsor to their patients comparing the benefits of all of the different plans with which they contract. Materials may not "rank order" or highlight specific plans and should include only objective information. Such materials must have the concurrence of all plan sponsors involved in the comparison must be approved by CMS prior to distribution (e.g., these items are not subject to File & Use). The plan sponsor must determine a lead plan to coordinate submission of these materials.

NOTE: Plan sponsors may not use providers to distribute printed information comparing the benefits of different plans unless providers accept and display materials from all plan sponsors in the service area that contract with the provider.

Comparative and Descriptive Plan Information Provided by a Non-Benefit/Service

Providing Third-Party:

Providers may distribute printed information comparing the benefits of different plan sponsors (all or a subset) in a service area when the comparison is done by an objective third party.

Providers/Provider Group Websites:

Providers may provide links to plan enrollment applications and/or provide downloadable enrollment applications. The site must provide the links/downloadable formats to enrollment applications for all plan sponsors with which the provider participates. As an alternative, providers may include a link to the CMS Online Enrollment Center.

SECTION 6: PHYSICIAN/PROVIDER CREDENTIALING

Credentialing is the process by which the appropriate peer review bodies evaluate each individual Physician's/Provider's experience, background, training, demonstrated ability, licensure, and health status. In order to become part of the network and provide services to Sonder Health Plans' members, a Physician/Provider must go through the credentialing process.

Initial Credentialing:

All contracted professionals must be credentialed in order to participate with Sonder Health Plans. Additionally, the following list of Health Care Professionals must complete credentialing, either directly or through a delegated agreement, in order to participate:

- Physicians (MD, DO)
- Podiatrists (DPM)
- Dentists (DDS, DMD)
- Advanced Registered Nurse Practitioners (ARNP)
- Physician Assistants (PA)
- Certified Nurse Midwife (CNM) (If Applicable)
- Certified Nurse Anesthetists (CNA)
- Certified Registered Nurse Anesthetists (CRNA)
- Chiropractors (DC)
- Physical Therapist (PT)
- Occupational Therapist (OT)
- Speech Language Pathology (SLP)
- Respiratory Therapist
- Optometrist (OD)
- Psychologist (PhD)
- Licensed Clinical Social Worker (LCSW)
- Masters in social work (MSW)
- Licensed Mental Health Counselor (LMHC)

The following entities will also be credentialed:

- Hospitals
- Ambulatory Surgery Centers (ASC)
- Skilled Nursing Facilities (SNF)
- Independent Diagnostic Testing Facilities (IDTF)
- Inpatient Hospice
- Audiology Centers
- Behavioral Health Facilities
- Clinical Laboratory Facilities
- Comprehensive Outpatient Rehabilitation Facilities (CORF)
- Dialysis Centers
- Durable Medical Equipment Facilitates (DME)
- Home Health Agencies
- Inpatient and Outpatient Services Centers
- Infusion Service Centers
- Mobile Diagnostic
- Rehabilitation Therapy Facilities (PT, SLP, OT)
- Prosthetics & Orthotics Service Centers
- Sleep Study Centers
- Urgent Care Centers

Please Note:

Existing contracted individual physicians and group practices that add physicians **must** ensure that the new physician(s) are credentialed **prior to** providing services to Sonder Health Plans' members.

The Physician/Provider can be credentialed using the information on CAQH or will need to complete an approved Sonder Health Plans application and attach current supporting documentation. Sonder Health Plans will obtain information regarding the applicant from the National Practitioner Data Bank (NPDB), the Health Care Integrity and Protection Data Bank (HIPDB), the State Board of Medical Examiners, malpractice claims and Medicare and Medicaid Administration's List of Parties Excluded from Federal Programs, the Department of Health and Human Services, and the Office of Inspector Generals' List of Excluded Individuals/Entities.

The Physician/Provider must respond to any reasonable Sonder Health Plans request for additional information, including but not limited to, Drug Enforcement Administration (DEA) verification, and a site inspection evaluation. If the information requested is not received within ninety (90) calendar days from receipt of the completed application, and a "good faith" effort was made by Sonder Health Plans to obtain and verify the information, the application will be removed from consideration and the process will terminate.

Sonder Health Plans recognizes the Physician's/Provider's right to review information that is submitted in support of the credentialing application to the extent permitted by law. The Physician/Provider will be notified if any information obtained during the review differs substantially from the information provided by the Physician/Provider. The Physician/Provider has the right to correct any erroneous information received by Sonder Health Plans.

Physicians/Providers may obtain information regarding the status of their credentialing application by calling the Sonder Health Plans Credentialing Department. Information regarding general requirements for participation may also be obtained.

The entire process, including signature on application and attestation as well as verifications, must be completed within one hundred-eighty (180) calendar days prior to credentialing decision. All documents printed from the Internet or received electronically from any source must be dated and initialed by the Credentialing staff. Documentation of verifications obtained by phone will be noted on the checklist, dated, and initialed by the Credentialing staff. The credentialing process includes, at a minimum, the following primary source verifications:

- Verification through the on-line program with the State Medical Board https://medicalboard.georgia.gov/ that the applicant has a valid medical license in good standing. Licensure must be current at the time of the credentialing decision.
- Written verification of copy of DEA Certificate, if applicable. Certification must be current at the time of the credentialing decision. The Credentialing Committee will review any restrictions to the DEA Certificate.
- If the physician is not board-certified, written verification of the highest level of training completed will be obtained directly from the school or programs or through the use of industry-recognized verification sources; Sonder Health Plans accepts organizations recognized by regulatory agencies and URAC, NCQA, AAAHC.
- Curriculum Vitae or summary of work for minimum of five (5) years. The applicant must explain any gaps greater than six (6) months in the work history in writing.
- Verification of professional liability claims history for previous five (5) years must be obtained by accessing the National Practitioner Data Bank.
- Written documentation from the applicant explaining circumstances surrounding malpractice claims is requested as part of the application. The documentation is reviewed to determine if additional information may be required.
- Written verification of previous or current sanctions, restrictions, and limitations on scope of practice by accessing the NPDB or the Department of Health's (DOH) on-line license verification system at https://medicalboard.georgia.gov/
- Verification of applicant's Medicare and Medicaid provider status by accessing the NPDB.

Recredentialing

Re-credentialing is conducted every three years in accordance with Sonder Health Plans policies and procedures. Three months prior to the Physician's/Provider's re-credentialing date, a re-credentialing application form will be sent to the Physician/Provider. The Physician/Provider has thirty (30) calendar days from the mailing date to return the completed application and requested documentation.

If a Physician/Provider fails to submit a completed re-credentialing application and documentation before his/her credentialing expiration date, the Provider Engagement Department staff will attempt to secure a completed re-credentialing application and the requested documents for purposes of re- verification. A completed re-credentialing application must be secured for the Physician/Provider to maintain Sonder Health Plans privileges. The Physician/Provider *may not* provide services to Sonder Health Plans members if he/she is not credentialed or re-credentialed by Sonder Health Plans. The Physician's/Provider's application and the results of performance evaluations completed by Sonder Health Plans, in areas of member satisfaction and quality management, are reviewed by the Sonder Health Plans Credentialing Committee.

The Committee will deny, modify, or approve continued credentialing of the physician for another credentialing period of three years or less. Upon re-credentialing the provider is considered to be re- credentialed unless otherwise notified. Sonder Health Plans offers a hearing procedure to Physicians/Providers denied for quality-of-care issues.

Site Inspection Evaluation:

As part of the credentialing process, Sonder Health Plans requires site inspection evaluations be performed by a Provider Engagement Representative or other designated Sonder Health

Plans staff member authorized to conduct a site inspection evaluation for each location in which a PCP, OB/Gyn and/or high-volume specialist as identified by Sonder Health Plans may conduct clinical services to Sonder Health Plans members.

When reviewing the office or facility of a participating provider, Sonder Health Plans will ensure that the review is conducted by a Sonder Health Plans representative who:

- Carries identification that includes the Sonder Health Plans name and logo.
- Schedules reviews at least five (5) business days in advance unless otherwise agreed.
- Relies on a site inspection evaluation review tool that clearly defines the criteria to conduct an onsite review to address at least the following:
  - Patient access, including physical access for the disabled and access to appointments and to medical advice in a timely manner.
  - The office's public health policies and procedures concerning infection control, hazardous materials, and medication; and
  - The office's safety standards concerning policies and procedures for fire safety, emergency procedures, laboratory, and medical equipment maintenance.
- Conduct a review of a random sample of at least one Sonder Health Plans member's medical record to ensure:
  - Organization, completeness, and consistency in format.
  - Evidence of proper documentation.
  - Relevant information concerning patients' history, diagnosis, treatment, and allergies.
- Supplies a summary of the onsite review standards and process to provider.

Sonder Health Plans Credentialing Committee:

The Sonder Health Plans Credentialing Committee is a standing sub-committee of the Sonder Health Plans Quality Management Steering Committee, with operational support from the Sonder Health Plans Credentialing Department. The Sonder Health Plans' Credentialing Committee evaluates new Physicians/Providers entering the Sonder Health Plans network (initial credentialing) and those presently in the network (re-credentialing) against Sonder Health Plans standards, guidelines, policies, and procedures. The functions of the Committee include credentialing, ongoing and periodic performance assessment, re-credentialing, and establishment of credentialing and re-credentialing policies and procedures for Sonder Health Plans. The Credentialing Committee meets no less than six times per year for purposes of initial credentialing and re-credentialing.

Provider Termination:

Either the Physician/Provider, Sonder Health Plans or other Contracted Entity may terminate the Sonder Health Plans Participating Provider Agreement without cause by giving the other party written notification of termination at any time up to 60 days prior to the effective date of termination, unless otherwise specified in current contract with health plans. Sonder Health Plans has to notify its members and arrange for continuation of care and/or transfer of members to another provider whenever a PCP or specialist whom the member is seeing

regularly leaves our network, therefore we ask for your cooperation in giving us as much advance notice as possible if you intend to leave our network.

All other terminations are addressed in the Sonder Health Plans participating provider agreement, unless superseded by applicable federal or state laws, rules, and regulations.

Sonder Health Plans must follow the specific requirements for a Managed Care organization as identified in Medicare Managed Care Manual Chapter 11 Procedures and Contract Requirements.

- Must give the affected physician written notice of the reason for the action, including, if relevant, the standards and profiling date used to evaluate the physician and the number are a mix of physicians needed by the MA organization.
- Must allow the physician to appeal the action, and give the physician written notice of his/her right to a hearing and the process and timing for requesting a hearing.
- Must ensure that the majority of the hearing panel members are peers of the affected physician.

Affected Physicians have the right to appeal by sending a written request for appeal to the address of notice in the Agreement within five (5) business days of the letter of notification. The appeal process includes a right to a hearing panel, the majority of which will be the physician's peers. Such hearing will be conducted within twenty (20) business days following receipt of appeal.

Provider Termination Notice Requirement:

Sonder Health Plans requires a sixty (60) day prior written notification to our Provider Engagement Department or the Sonder Health Plan's Corporate Office for Provider Terminations.

Requests in writing should be submitted on Provider's company letterhead or sent via company email with company signature. Requests must identify the following for processing requests:

- Practice Name (on W-9)
- Tax ID Number
- Terming Provider NPI(s)
- Terming Provider Name(s)
- Terming Provider Specialty Type(s)
- Requested Termination Effective Date
- Reason(s) for Terming

If a Primary Care Physician within a group is requesting to term from a group, the Members within that PCP practice remain with the practice and shall be reassigned to another PCP within the practice. As such, if the request is regarding termination of a PCP from a group, please advise what PCP and location the existing membership should be reassigned to upon the termination of requested PCP.

Example below:

Request Date: 8/1/2021

Group: PCP Today,
LLC (as on W-9)
Tax ID: ##-
#######

RE: Request to Term PCP from Practice

Please term the following Provider from our practice and reassign their membership to the identified PCP below Effective 10/1/2021.

Term Provider NPI: ########## Term Provider Name: John Doe, MD

Requested Date of Termination: 9/30/2021

Reassign Membership to:

Provider NPI: ##########

Provider Name: John Doe, MD Provider Location: 1234 Care Cir, Atlanta, GA ####

Effective: 10/01/202

Provider may identify the requested date of termination, however, based on Member notification requirements and/or continuation of care, Sonder Health Plans reserves the right to determine termination dates and Provider Engagement shall confirm approved termination effective date of Provider upon processing of their request.

Provider Termination Appeals Process

Physicians have termination appeal rights; this does not apply to Ancillary Service Providers, Hospitals and/or other health care practitioners. Physicians have the right to appeal Sonder Health Plans' termination notice by submitting a letter in writing within five (5) business days of receipt of termination notice. Address to:

Sonder Health Plans, Inc. Attention: Providers Terminations
6190 Powers Ferry Road, Suite 320
Atlanta, Georgia 30339
Fax: 1 (888) 216-5210

When a termination appeals letter is received and acknowledged, Sonder Health Plans will schedule a meeting, and the Physician/Provider will be notified in writing of the date/time of the scheduled meeting.

Physician/Provider will be notified in writing of the appeal hearing decision.

Model of Care Attestation Compliance

Purpose:
To ensure that all practices contracted with the Sonder Health Plans Medicare Advantage plan complete the Model of Care (MOC) attestation within 30 days of the contract effective date and annually thereafter.

Scope:
This policy applies to all practices contracted with the Medicare Advantage plan.

Policy Statement:
All contracted practices must complete the Model of Care (MOC) attestation within 30 days of the contract effective date and annually thereafter. This requirement is in accordance with CMS guidelines to ensure compliance with the provisions of the MOC
.

Procedures:

1. **Initial Attestation:**
    a. Upon the effective date of the contract, practices must complete the MOC attestation within 30 days.
    b. The attestation must confirm that the practice understands and agrees to comply with the MOC provisions.
2. **Annual Attestation:**
    a. Practices must complete the MOC attestation annually, within 30 days of the anniversary of the contract effective date.
    b. The annual attestation must reaffirm the practice's commitment to adhering to the MOC provisions.
3. **Documentation and Submission:**
    a. Practices must submit the completed attestation to Sonder Health Plans' compliance department.
    b. The compliance department will maintain records of all attestations for audit and review purposes.
4. **Compliance Monitoring:**
    a. Sonder Health Plans will monitor compliance with the attestation requirements.
    b. Non-compliance may result in corrective actions, including potential termination of the contract.

Responsibilities:

- **Practice Administrator:** Ensure timely completion and submission of the MOC attestation.
- **Compliance Department:** Monitor and maintain records of attestations, and enforce compliance.

Review and Revision: This policy will be reviewed annually and revised as necessary to ensure ongoing compliance with CMS Model of Care provisions.

SECTION 7: CLAIMS

General Claims Information

A major goal of Sonder Health Plans is to provide prompt and accurate processing of claims.

The information that follows contains Sonder Health Plans instructions for filing a clean claim. Providers must follow these instructions to have their claims considered "clean" by Sonder Health Plans. Claims not meeting the definition of a clean claim may either be rejected or denied. Resubmission of rejected claims is subject to timely filing requirements.

NOTE: Please be advised that Sonder Health Plans may have delegated arrangements with certain provider groups, for which there may be a different process, form, or steps to take other than outlined here for Sonder Health Plans in cases of prior authorization requests or claims submissions.

Clean Claim Definition:

A clean claim is one that has no defect, impropriety, lack of any required substantiating documentation, or circumstance requiring special treatment that prevents timely payment. Clean claims must be processed within 30 days of receipt.

To meet the Sonder Health Plans definition of a "clean claim", a provider must:

- Complete all required fields with accurate and valid information on a CMS1500 or UB-04, or as required for electronic submission in accordance with the Medicare Claims Processing Manual.
  - Medicare Claims Processing Manual, Chapter 25, Completing and Processing the Form CMS-1450 (UB-04) Data Set https://www.cms.gov/Regulations-andGuidance/Guidance/Manuals/Downloads/clm104c25.pdf
  - Medicare Claims Processing Manual, Chapter 26 – Completing and Processing Form CMS-1500 Data Set https://www.cms.gov/Regulations-andGuidance/Guidance/Manuals/Downloads/clm104c26pdf.pdf
- Include any additional data elements (i.e., copy of the Referral Form, Pre-certification Form, medical documentation) required by Sonder Health Plans as specified in this manual or other official notices from Sonder Health Plans issued from time to time for claims.
- Include any primary payer's Explanation of Payment (EOP) or payment voucher showing the amount paid by the third party if the member is covered by another insurance or HMO carrier other than Sonder Health Plans.
- Indicate services which are provided consistent with any referrals or authorizations necessary as directed by Sonder Health Plans.
- File the claim in a timely fashion in accordance with the provider contract.
- Maintain a valid written assignment of benefits from the member on file. This will serve as evidence that the provider is entitled to payment for service. Sonder Health Plans reserves the right to review the original signed assignment document at any time.
- Itemize charges accordingly.
- Validate the scope of services provided and billed through medical records documentation.

Claims not meeting all required criteria are not considered clean claims. Depending upon the type of information missing or invalid, claims are either rejected and will require resubmission or are denied and will require a Participating Provider Claim Dispute outlined in Section 5.

Other/Unclean Claim Definition

An other/unclean claim is defined as an incomplete claim, a claim that is missing any of the above information, or a claim that has been suspended in order to get more information from the provider in order to make an organization determination. An other/unclean claim must be processed within 60 days of receipt.

If a claim is submitted as incomplete or with inaccurate information, we may reject the claim, delay processing, or make a payment determination (i.e. denial, reduced payment) that may be adjusted later when complete information is obtained.

Provider acknowledges and agrees that no reimbursement is due for a covered service unless performance of that covered service is fully and accurately documented in the member's medical record prior to the initial submission of any claim. Furthermore, provider acknowledges and agrees that at no time shall members be responsible for any payments to provider except for applicable copayments, coinsurance, deductibles, and non-covered services provided to such members. Notification that a service is not a covered benefit must be provided to the Member prior to the service and be consistent with Sonder Health Plans policy, in order for the Member to be held financially responsible. Sonder Health Plans policy requires that the notification include the date and description of the service, name and signature of the Member, name and signature of the Provider, and be in at least 12-point font. Documentation of that pre-service notification shall be provided to Sonder Health Plans or its designee upon request to substantiate Member appeals. In addition, consistent with current Medicare policy for non-covered services, Sonder Health Plans will not issue payment for a particular surgical or other invasive procedure to treat a particular medical condition when the practitioner erroneously performs:

a) A different procedure altogether
b) The correct procedure but on the wrong body part
c) The correct procedure but on the wrong patient.

Sonder Health Plans will also not cover hospitalizations and other services related to these non-covered procedures.

Claims must be submitted to the correct address. For information on where to send your claims, please refer to the "Provider Quick Reference & Plan Contact Information" at the beginning of this manual. The member's Sonder Health Plans ID card will also list the claims address. Submitting claims to the incorrect address will result in delay of processing. All claims for payment, whether electronic or non-electronic must be submitted within the timeframe stipulated in the Sonder Health Plans agreement.

Claim status may be obtained by contacting the Provider Services Line at 1-888-525-1730, Monday through Friday between 8:00 am and 5:00 pm, or logging into the Provider Portal. See the "Sonder Health Plans Provider Quick Reference & Plan Contact" section of this manual for portal registration instructions.

Providers are encouraged to submit claims and/or encounters electronically. If you are not currently submitting electronically, contact your Provider Engagement Representative or the Provider Help Line at 1-888-525-1730.

Provider Billing and Required Information:

The following data must be valid and included on every claim:

- Member Name
- Member Date of Birth
- Member Sex
- Member ID Number
- Other Insurance Information
- Name of Referring Physician
- Diagnosis(es) Codes
- Authorization Number or copy of Referral (when necessary)
- Date of Service
- Place of Service Codes
- CPT or HCPCS Procedure Code with appropriate modifier when applicable
- When billing for supplies or services with no CPT or HCPCS code, include a copy of the supplier's invoice
- Billed Charges
- Number of days or units for each service line
- Submitted Provider Tax ID or Social Security Number
- Provider Name
- Provider Billing Name and Address
- Individual Provider NPI number, not Group NPI number

Sonder Health Plans requires all professional claims to be submitted electronically or on a CMS 1500 form and hospital claims to be submitted on a UB-04 form in either paper or electronic format.

Provider Identification (PIN) Number Requirements

The NPI number and Tax ID number will be required on all claims submitted to Sonder Health Plans.

- Electronic CMS-1500 Claims: Include the provider number in Field FA0-23 of the NSF format or NM109, element 67 in ANSI.
- Electronic UB-04 (CMS 1450) Claims: Include the provider number in Field FAO-23 of the NSF format or NM109, element 67, in ANSI.

The physician/provider submitting the claim to Sonder Health Plans is responsible for ensuring the accuracy of the provider identification numbers specified on each claim.

Electronic Claims Submission

Advantages to Electronic Claim Filing:

Sonder Health Plans encourages filing claims electronically. Benefits of filing via electronic media include:

- Decrease in turnaround time for payment.
- Streamlines the billing process.
- Reduction in Costs for Filing (i.e., postage costs, forms cost, printing costs, labor).
- Confirmation of Receipt.
- Prompt Identification of omitted/incorrect information.
- Ability for Provider to quickly track number of rejected versus accepted claims.

Claims Clearinghouse:

Sonder Health Plans receives claims electronically. Sonder Health Plan payer ID is A0339 (Availity).

Submission Process:

- Contact Availity (Payor ID # A0339) at technical support: 1 (800) 282-4548 for any technical problems or provider questions.
- Request your clearinghouse to send your claims to Sonder Health Plans.
- Your clearinghouse reformats the claims and sends it to us as an electronic file, which goes directly to our claims payable computer system.
- The claim is evaluated for compliance standards.
- Electronic acknowledgements are sent to the clearinghouse.
- The claim is sent through all the data edits.
- Once the claim passes all edits it will be sent for adjudication.
- Any rejected claims are the responsibility of the provider and will not be worked until resubmitted with the specific corrections outlined in the rejection.

Transmission Frequency:

Electronic claims can be transmitted daily; however, claims transmitted on Saturday, Sunday and legal holidays are not downloaded into Sonder Health Plans claims processing system until the following business day.

The unique Sonder Health Plans Provider ID number is the provider NPI number and is required on electronically (and paper) submitted claims.

Paper Claims Submission

Sonder Health Plans will not accept super-bills or similar submissions as valid claims.
Claims must be computer generated or typed (not handwritten).

Claim Signature Requirements:

When filing a paper claim, the physician or provider's handwritten signature (or signature stamp) must be in the appropriate block of the claim form (box 31).

Providers delegating signature authority to a member of the office staff or to a billing service remain responsible for the accuracy of all information on a claim submitted for payment.

Initials are only acceptable for first and middle names. The last name must be spelled out.

Claims prepared by computer billing services or office-based computers may have "Signature on File" in the signature block along with the printed name of the provider. For claims prepared by a billing service, the billing service must retain a letter on file from the provider authorizing the service.

Where to Submit Paper Claims:

For paper claims from physicians and ancillary providers, mail to:

Sonder Health Plans, Inc. C/O Mirra TPA,
PO Box 3325
Spring Hill, FL 34611

Coding

Sonder Health Plans requires use of standard CPT, ICD-10, and HCPCS coding, unless otherwise directed by Sonder Health Plans as outlined in this manual or participating provider contract.

Diagnosis codes should be billed with the highest degree of specificity. Use fourth and fifth digits whenever applicable. If a diagnosis code requires a fourth or fifth digit, and is not coded as such, the claim will be denied.

New and Deleted Codes:

Providers must bill for services using current CPT, ICD-10 and HCPCS codes and modifiers that are appropriate for the service provided. Annually, as CPT and HCPCS codes are added and deleted from the American Medical Association (AMA) and CMS listings of valid codes, Sonder Health Plans policy will be as follows:

- New codes are accepted by Sonder Health Plans beginning the date on which they become effective.
- Deleted codes are not accepted. Services coded with deleted codes will be denied.
- Sonder Health Plans will only accept HIPAA approved code sets.

Unlisted Codes:

Sonder Health Plans will accept a provider's use of an unlisted code only when there is no valid CPT or HCPCS code available, or an authorization has been obtained for use of an unlisted code or when the physician/provider's contract with Sonder Health Plans specifically requires use of the unlisted code. Except as noted above, any claim submitted for a service that is CPT coded as an "unlisted" procedure or service must be filed with a detailed description of the procedure or service being billed. Failure to provide a description will result in the claim being denied. Additional documentation may be requested if the description provided is not sufficient.

For unlisted supplies (e.g., HCPCS code El399), the claim should include a detailed description of the supply. The description can be typed in detail on the claim form or provided as an attachment (i.e., a copy of the supply invoice).

If billing for an unlisted drug, physician/provider must include a detailed description, the dosage given and the NDC number for the drug.

If a claim is filed using an unlisted code and a valid code is available, unless specifically allowed by physician/provider contract, Sonder Health Plans will deny the service or supply and the claim for that service or supply will need to be re-filed by the physician or provider.

Claims Filing Deadlines

Initial Claim Filing:

Unless otherwise stated, the Sonder Health Plans contract/agreement requires that claims must be submitted within ninety (90) calendar days following the date on which the Covered Health Services were rendered, or for continuous Covered Health Services, for which one charge will be made, the date on which the Covered Health Services are completed by the provider, but no later than one hundred eighty (180) calendar days. Claims not received by Sonder Health Plans within one hundred eighty (180) calendar days will be denied and are to be considered waived by the physician. These services are not to be billed to the member for payment.

Hospitals should provide current insurance information to hospital-based physicians when available to allow those physicians to file claims to Sonder Health Plans in a timely manner.

Exceptions to the Filing Deadline

Providers who fail to meet the filing deadline may request reconsideration of their claim through the Claims Dispute process. Sonder Health Plans recognizes there are instances where extenuating circumstances may result in missing the filing deadline (e.g., theft or destruction of Physician's records, disability or death of Physician, complete system failure). In these instances, providers must submit a written dispute to the Sonder Health Plans Audit and Recovery Department/Claims Disputes. Sonder Health Plans may waive the filing deadlines at its sole discretion. Provider will need to evidence that the claim was filed within the allowable time.

NOTE: If an exception to the filing deadline is granted by Sonder Health Plans and multiple claims are involved, the physician/provider should submit all claims as a batch to the Audit and Recovery Department/Claims Disputes, at that time an adjustment will be done to the original submission. All requests for adjustments or appeals on contracts are to be submitted within 90 days from the date of receipt of denial and or underpayment.

Initial Claim Filing When There is Another Insurance:

If the member has other insurance and that insurance is the primary payer, the claim must meet the following criteria:

It must be filed with Sonder Health Plans within ninety (90) calendar days of the date on the primary payer's Explanation of Benefits (EOB) or Remittance Advice (RA).

A copy of the primary payer's EOB or the primary payer's paid amount, showing the amount paid by that carrier, must be submitted with any claim filed with Sonder Health Plans. Sonder Health Plans requires the provider to adhere to the primary payer's criteria (e.g., filing deadlines).

NOTE: Sonder Health Plans payment as a secondary payer will not exceed the amount specified according to contract, less the primary payer's payment amount.

Balance Billing:

Sonder Health Plans participating providers are not permitted to balance bill our members. Providers who continually bill members will be issued a written warning by the Plan. Please refer to the organization determination process if you require a denial to be issued on items/services that are not covered under the members plan to protect your rights with billing for those services.

Coordination of Benefits and Subrogation:

As a participating provider with Sonder Health Plans we require that you notify the Plan of any third-party information you may have received and that you assist the Plan in complying with the Medicare Secondary Payer rules. In addition, if you are notified of a Medicare Set Aside Plan please notify the Plan immediately. You can contact the Plan's Provider Services Department at 1 (888) 525-1730.

Sonder Health Plans is subject to the rules and regulations as defined by the Social Security Act and the CMS Medicare Secondary Payment (MSP) provision. Medicare Advantage Organizations are allowed four (4) provisions in which Medicare is considered a secondary payer.

1. Employer Group Health Plans (EGHP) and Large Group Health Plans (LGHP)
2. Liability Insurance Plans
3. No-fault Insurance Plans
4. Workers' Compensation Plans (WC)

Employer Group Health Plans (EGHP):

Policy: Coverage under a health plan offered by an employer in which a Medicare beneficiary is covered as:

1. An employee (age 65+) or
2. As a dependent under another subscriber (of any change) covered under such plan

NOTE: Medicare is the secondary payer for beneficiaries assigned to Medicare under the ESRD benefit for up to 30 months beginning when the individual becomes eligible for Medicare if the beneficiary was not otherwise eligible due to age or disability

Liability Insurance and No-Fault Insurance

Policy: Types of liability include, but are not limited to automobile liability, malpractice, homeowner's liability, product liability, and general casualty insurance. Medicare is considered the secondary payer to all liability and no-fault insurance providers.

Workers' Compensation (WC)

Policy: Medicare does not coordinate benefits with Workers Compensation payers. Workers' Compensation assumes full liability for the payment of items and services related to a claim meeting their coverage requirements.

When a Member has coverage, other than with Sonder Health Plans , which requires or permits coordination of benefits from a third-party payer in addition to Sonder Health Plans , Sonder Health Plans will coordinate its benefits with such other payer(s). In all cases, Sonder Health Plans will coordinate benefits payments in accordance with applicable laws and regulations and in accordance with the terms of its health benefits contracts. When permitted to do so by such laws and regulations and by its health benefits contracts, Sonder Health Plans will pay the lesser of:

(i) the amount due under the prevailing agreement;
(ii) the amount due under the prevailing agreement less the amount payable or to be paid by the other payer(s); or
(iii) the difference between allowed billed charges and the amount paid by the other payer(s). In no event, however, will Sonder Health Plans , when its plan is a secondary payer, pay an amount, which, when combined with payments from the other payer(s), exceeds the rates set out in the prevailing agreement; provided, however, if Medicare is the primary payer, Sonder Health Plans will, to the extent required by applicable law, regulation or Center for Medicare/Medicaid Services (CMS) Office of Inspector General (OIG) guidance, pay the Provider an amount up to the amount Sonder Health Plans would have paid, if it had been primary, toward any applicable unpaid Medicare deductible or coinsurance.

Recovery: Provider and Sonder Health Plans agree to use reasonable efforts to determine the availability of other benefits, including other party liability, and to obtain any information or documentation required by Sonder Health Plans and Provider to facilitate coordination of such other benefits. Upon request by Sonder Health Plans Provider will provide Sonder Health Plans with a copy of any standard Provider forms used to obtain the necessary coordination of benefits information.

Members Enrolled in Hospice

When a Member enrolled in hospice receives care from your practice or facility, it is important that all the care be coordinated with their hospice physician. Sonder Health Plans enrolls Hospice members into a new group effective the 1st of the month, following election of hospice, and removes them from the group at the end of the month, if the Member terminates or revokes the hospice benefit. The Plan will continue to assist in coordination of the Member's care to the best of its ability, however, the payment process to provider's changes.

For Hospice diagnosis related care, providers need to bill the Medicare-approved hospice organization with which the patient is enrolled. For care not related to the hospice related diagnosis, that is a Medicare covered benefit, providers need to bill the Fiscal Intermediary or CMS directly. If a Member's hospice is revoked during a month, you must continue to bill the hospice organization or the Fiscal Intermediary for CMS through the end of that month. Sonder Health Plans is only responsible for additional benefits not covered by Medicare, (i.e. transportation, dental, etc.). Any claims received by Sonder Health Plans for Medicare-covered services that are not additional plan benefits, will be denied by the Plan.

When hospice services are requested by a Member, confirmed with the Centers for Medicare & Medicaid Services (CMS) and updated in the Plan's system, the Member is sent a new enrollment card reflecting a new group number beginning with RH*. This process may take time, depending on when the Hospice Form is received by CMS and when their system is updated.

Interim Bills

Interim bills will not be accepted for DRG or APC Claims. In order to properly adjudicate a claim paid on a Medicare Allowable basis, the patient must be discharged.

Itemized Statements

Sonder Health Plans may require itemized statements as deemed necessary and appropriate.

Service Location Codes

Sonder Health Plans accepts valid CMS place of service codes. Consultations and professional services rendered in a hospital setting will be processed according to the level of care authorized and in accordance to Medicare Guidelines. Improper coding, including procedure and location coding may result in denial of the claim.

Reimbursement will also be made based on the applicable locality where service was rendered in accordance to Medicare Guidelines (i.e. Atlanta 01, Rural 99)

Preventable Adverse Events ("PAEs"):

Notwithstanding any provision in the Provider's Agreement or provisions herein to the contrary, when any CMS-adopted Never Event or CMS-defined Hospital-Acquired Condition (collectively referred to as a Preventable Adverse Event or "PAE") that was not present on admission, occurs with respect to a Covered Individual, the Facility shall neither bill, nor seek to collect from, nor accept any payment from Plan or Covered Individual for the Charges and/or days which are the result of the PAE. If Facility receives any payment from Plan or Covered Individual for such events, it shall refund such payment to the entity making the payment within ten (10) business days of becoming aware of such receipt. Further, Facility shall cooperate with Plan, to the extent reasonable, in any Plan initiative designed to help analyze or reduce such PAEs. Facility must populate the Present on Admission (POA) indicator on all inpatient acute care Claims which are billed to Plan.

Audit and Recovery

Claims Dispute

If you believe, the Plan has not paid your services according to the terms of your provider agreement, or has denied payment for services already rendered, please submit a request to review. A copy of the Dispute Form is available on the Sonder Health Plan's website:

https://sonderhealthplans.com/wp-content/uploads/2025/03/Claim-Dispute-Form.v2.pdf

There are two types of submissions that are handled within the dispute process;

Participating Provider Claim Dispute: The claim has been finalized but you disagree with the amount that you were paid.

Provider Administrative Plea: The claim has been finalized, but you disagree with the administrative denial that has been applied. An administrative denial is applied within the claims process when it is determined that the Provider failed to follow the terms and conditions of their contract. Examples of administrative denials are as follows; denials such as no Prior authorization or late notification.

A resolution will be rendered and communicated to the provider within 60 calendar days of your dispute receipt date. To submit a Dispute, please send the request via mail, e-mail or fax to the Audit and Recovery Department:

Audit and Recovery Department

Sonder Health Plans
Attn: Audit and Recovery Department, Dispute Unit
6190 Powers Ferry Road, Suite 320
Atlanta, Georgia 30339
Email: providerdisputes@sonderhealthplans.com
Fax: 1-678-813-5594

Overpayments

Sonder Health Plans Health Plans reserves the right to audit all claims, itemized bills, and applicable medical records documentation for billing appropriateness and accuracy. If the audit identifies an overpayment, the Plan has the right to request a refund from the provider.

Overpayments include, but are not limited to, situations in which a Provider has been overpaid by Sonder Health Plans due to incorrect claims processing such as billing errors, ineligible members, or Coordination of Benefits. In the event of an overpayment, Sonder Health Plans will notify the Provider of the refund amount due in writing via mail. The Provider is responsible for immediately refunding to Sonder Health Plans the overpayment amount according to the instructions stated in the written notification. All providers have the right to dispute Sonder Health Plans refund request in writing within 45 days of receipt of Sonder Health Plans refund letter. If a refund or dispute has not been received within timeframe, Sonder may recoup the outstanding amount due from any future payments. To submit an Overpayment Request Dispute, please send the request via mail, e-mail or fax to the Audit and Recovery Department:

Audit and Recovery Department

Sonder Health Plans
Attn: Audit and Recovery Department, Overpayment Unit
6190 Powers Ferry Road, Suite 320
Atlanta, Georgia 30339
Email: recovery@sonderhealthplans.com
Fax: 1-678-813-5594

Medicare Risk Adjustment and Coding

Purpose of the Sonder Health Plans Risk Adjustment Coding Team

Sonder Health Plans has established a dedicated team of Risk Adjustment (RA) analysts and certified coders to support accurate and complete documentation of member health conditions. The primary goal of this team is to assist providers in documenting each condition to the highest level of specificity, ensuring that the patient's true health status is accurately captured at the time of the encounter.

Risk Adjustment and Data Submission

Risk adjustment is the process used by CMS to adjust the payments made to Medicare Advantage Organizations (MAOs) based on the collective health status of the MAO's members. Risk adjustment was implemented to pay MAOs more accurately for the predicted health cost expenditures of members by adjusting payments based on demographics (age and gender) as well as health status. Diagnosis data collected from encounter and claims data is required to be submitted by the MAO to CMS for purposes of risk adjustment. Because CMS requires that MAOs submit "all ICD-10 codes for each beneficiary", Sonder also collects diagnosis data from the members' medical records created and maintained by the provider.

Under the CMS risk adjustment model, the MAO is permitted to submit diagnosis data from face-to-face encounters (in-person or via telehealth, using a real-time interactive audio and video system) only. These encounters must meet all other criteria for risk adjustment eligibility which include, but are not limited to, being from an allowable inpatient, outpatient, or professional service rendered by an acceptable physician specialty/provider type.

Risk Adjustment Data Validation (RADV) Audits

As part of the risk adjustment process, CMS will perform RADV audits in order to validate the MA members' diagnosis data that was previously submitted by the MAO. These audits are typically performed once a year. If the MAO is selected by CMS to participate in a RADV audit, the MAO and the providers that treated the MA members included in the audit will be required to submit medical records to validate the diagnosis data previously submitted.

Other Risk Adjustment Documentation Reviews and Audits

Providers may be required to submit medical records to Sonder for purposes of provider documentation and coding reviews and/or audits. Sonder Health Plans may also engage with providers regarding education and/or remediation to support submission of diagnosis code data that is truthful, accurate, and complete based on best knowledge, information, and belief. Based on the outcome of such documentation and coding reviews and/or audits, providers will be asked and are expected to participate in education and/or remediation.

ICD-10-CM Codes

CMS requires that providers currently use the ICD-10-CM Codes (ICD-10 Codes) and coding practices for Medicare Advantage business. In all cases, the medical record documentation must support the ICD-10 Codes selected and substantiate that proper coding guidelines were followed by the provider. For example, in accordance with the guidelines, it is important for providers to code all conditions that coexist at the time of an encounter and that require or affect patient care or treatment. In addition, coding guidelines require that the provider code to the highest level of specificity which includes fully documenting the patient's diagnosis.

Medical Record Documentation Requirements (Risk Adjustment)

Medical records significantly impact risk adjustment because:

- They are a valuable source of diagnosis data;
- They dictate what ICD-10 Code is assigned;
- They are used to validate diagnosis data that was previously provided to CMS by the MAO.

Because of this, the provider plays an extremely important role in ensuring that the best documentation practices are established.

CMS record documentation requirements include:

- Patient's name and date of birth should appear on all pages of record.

• The date of service should be clearly documented for each encounter.
• Patient's condition(s) should be clearly documented in record.
• The documentation must show that the condition was monitored, evaluated, assessed/addressed, or treated (MEAT).
• The documentation describing the condition and MEAT must be legible.
• The documentation must be clear, concise, complete and specific.
• When using abbreviations, only standard and appropriate abbreviations should be used. Because some abbreviations have multiple meanings, the abbreviation that is appropriate for the context in which it is being used should be applied.
• Provider's signature, credentials and date must appear on the record and must be legible.

Best Practices for Documentation and Coding

- Document all active and chronic conditions at least once per calendar year
- Link diagnosis to assessment or treatment plans
- Avoid vague or unspecified diagnoses when more detail is available
- Ensure problem lists are up to date and accurately reflect current conditions
- Capture MEAT: Monitor, Evaluate, Assess/Address, or Treat each condition

Telehealth and Encounter Types

CMS allows diagnosis data from telehealth visits that:

- Use real-time, interactive audio and video
- Are provided by acceptable provider types
- Meet all other risk adjustment criteria

Note: Telephone-only visits are not eligible for risk adjustment data submission.

Medicare Risk Adjustment (MRA): Training and Education

Training and education is an essential part of every compliance program; and this is true of Sonder's MRA compliance program. To help Sonder, Sonder's Compliance team requires that all Providers, practitioners, and facilities complete appropriate Compliance and Medicare Risk Adjustment training to help ensure all Providers, practitioners, and facilities are prepared to perform the work functions assigned to them in a manner that complies with MRA rules and CMS regulations.

Regular and required training:

• Make available onboarding training and regular retraining for Providers, Coders and staff, as applicable.
• Conduct training at least annually and following audits for Providers, Coders and staff, as applicable.
• Review education and training materials at least annually and update as needed.
• Engage certified Sonder coding educators.

Certifications:

• Providers should hire certified coders to perform coding activities.
• Coders should participate in continuing education (for staff who perform MRA coding, auditing and/or training).
• Coders must complete minimum amount of continuing education units to maintain certification.

Risk Score Integrity and Financial Impact

Accurate documentation and coding are essential not only for compliance, but also to:

- Ensure proper reimbursement from CMS
- Maintain financial integrity for the health plan
- Enable accurate forecasting of healthcare utilization and patient needs
- Support care coordination, quality improvement, and value-based programs

For access to training tools and resources, visit the Education Resources section at [Sonder Health Plans](https://sonderhealthplans.com) Education Resources - Sonder Health Plans

SECTION 8: QUALITY MANAGEMENT

Sonder Health Plans promote quality care and service excellence for its beneficiaries. The organization's Quality Management (QM) Program provides the framework and structure within which the health plan pursues this commitment framework in which the health plan consults with network physicians in selecting and prioritizing quality improvement projects, developing indicators, analyzing performance, identifying, and proposing solutions to problems and aiding in communication of program activities with other providers.

The Program promotes objective and systematic measurement, monitoring, and evaluation of services and implements quality improvement activities based upon findings. It is established at the direction of and approved by the Board of Directors, the governing body for Sonder Health Plans. The Chief Executive Officer has designated the authority and responsibility for the overall operation of the Program to the Chief Medical Officer (CMO). The CMO, the Quality Management Manager, is responsible for all clinical aspects of the Program and works closely with the Senior Vice President of Health Services to carry out those responsibilities. All senior and department leadership are responsible for implementing the Program throughout the organization. The Plan committee structure has an important role in implementing the Program; the Medical Management, the Credentialing, and Peer Review Committees include network providers in their membership. See Section Three for more information on committees.

The Program is designed to comply with regulatory and AAAHC accreditation guidelines. It is evaluated and updated on an annual basis.

The overall goal of the Quality Management Program is to achieve quality care and services for members through the development, implementation, and ongoing improvement of organizational systems.

Consistent with its emphasis on quality, Sonder Health Plans maintains the Quality Management Program with goals to:

- Promote physical and mental health for Sonder Health Plans members.
- Promote evidence-based medicine.
- Promote healthy lifestyles, risk identification, and early intervention.
- Promote active involvement by the member in health care planning and decision-making.
- Promote and coordinate efficient and effective resource utilization.
- Facilitate timely access and availability to care and services.
- Facilitate communication regarding performance improvement initiatives.
- Promote consumer safety.

Scope

A comprehensive Program, it addresses the needs of members, providers, and other external consumers as well as internal departments and operational efficiencies. It integrates industry performance standards and data from within the organization. The Program addresses components of health care management including the anticipation, identification, measurement, monitoring, evaluation of health care needs and system performance, and the design and implementation of effective improvement strategies.

Components of the Sonder Health Plans Quality Management Program include but are not limited to:

- Access and availability
- Case management
- Clinical quality improvement initiates, including quality improvement projects
- Credentialing and re-credentialing
- Delegation oversight
- Disease management
- Grievances and appeals
- Health education
- Health literacy
- Member rights and responsibilities, including advance directives
- Member and provider communication
- Member satisfaction
- Medical record documentation practices
- Peer review
- Preventive health
- Provider satisfaction
- Risk management
- Health Services

Physicians and other providers play an integral role in the implementation of the quality program and are expected to understand and acknowledge the Sonder Health Plans Quality Management Program, policies, and procedures. A copy of the Sonder Health Plans Quality Management Program and associated policies and procedures is made available to providers upon request.

Medical Records Recording and Maintenance Criteria

Sonder Health Plans requires providers to maintain complete and accurate medical records for all Sonder Health Plans members that:

- Document the chronology of member care.
- Serve as a basis for planning member care and for continuity in the evaluation of member's condition and treatment.
- Document evidence of the course of a member's medical evaluation, treatment, and change in condition.

- Document communication between the responsible provider and other health professionals that contribute to the member's care.

Periodic reviews of the medical records maintained by participating providers are conducted to assess compliance with documentation standards and procedures regarding medical records management and privacy/confidentiality of member's medical information.

Providers are expected to comply with the following medical record documentation standards:

- Personal/biographical data including member name, identification number, gender, date of birth, phone number, address, and legal guardianship, when indicated, are recorded in the record.
- Each and every page in the record contains the member's identification; name and/or ID number.
- Documented assessment of communication needs, need for language translation, e.g., hearing impaired.
- Documentation of primary language.
- All entries are dated.
- All entries are signed; author identification by profession is included e.g., MD, DO, RN, MA, etc.
- The record is legible to individuals other than the individual making the entry.
- Medication allergies and adverse reactions are prominently and uniformly noted in the record. If the member has no known allergies or history of adverse reactions, this is noted in the record e.g., no known allergies - NKA.
- The medical history, to include current medications, is documented.
- Documentation of tobacco, alcohol, and drug use and/or abuse.
- A problem list to include significant medical and surgical history is maintained.
- Current immunization record or age-appropriate immunization status is documented.
- Patient's chief complaint and objective findings are documented.
- Diagnoses or clinical impressions consistent with findings are documented.
- A plan of care, to include prescribed medications, is documented.
- Unresolved problems from previous visits are addressed.
- Member education regarding risk factors and the plan of care is documented.
- Documented evidence that ordered consultations and diagnostic testing were accomplished and results reviewed.
- Information regarding emergency department visits and hospitalizations is documented.
- Evidence of age-appropriate preventive health screening and education.
- The record contains documentation of whether or not the individual has received written information or executed an advance directive.

Additional medical record requirements include:

- All entries are neat, legible, complete, clear, and concise, written in blue or black ink (no other colored ink).

- Entries are dated and recorded in a timely manner.
- Records are not altered, falsified, or destroyed.
- Addendum notes are dated and timed to accurately reflect the time the entry is made.
- Incorrect entries are corrected by:
  - Drawing a single line through the error.
  - Do not obscure initial entry.
  - Dating and initialing each correction.
  - Making no additions or corrections to a medical record entry if a medical chart has been provided to outside parties for possible litigation.
- All triage calls and telephone messages are documented.
- Medical records are secured in a safe place to promote confidentiality of member information.
- Medical records and information are maintained in a confidential manner. Minor members' consultations, examinations, and treatment for sexually transmittable diseases are maintained confidentially.

Advance Directives

Sonder Health Plans provides written information to all members at the time of enrollment concerning their rights under Georgia law to make decisions concerning the right to accept or refuse medical or surgical treatment and the right to formulate, at the member's option, advance directives. Providers are asked to also provide members with information regarding advance directives. The member's medical record must indicate whether or not the individual has executed an advance directive, and a copy of such advance directive must be retained as part of the medical record of the member. Member education regarding advance directives should likewise be documented in the medical record.

Access Standards

Sonder Health Plans maintains and monitors a provider network sufficient to provide adequate access to and availability of covered services. Access and availability standards have been established and are monitored within the organization. There are standards related to provider practices and to which providers are required to comply. Compliance is monitored with results reported through the committee structure. Failure to comply with below standards could result in provider termination from the network.

Standards Regarding Appointment Access and Availability:

1. Access to physician services 24 hours per day/7 days per week.
2. Urgent Care and emergent appointments available within 24 hours.
3. Non-urgent care appointments available within 7 calendar days.
4. Routine and preventive care PCP appointments available within 30 calendar days.
5. Regular specialty referral appointments within thirty (30) calendar days.
6. Practice capacity shall not exceed: One (1) physician FTE to 2500 Medicare members.
7. An allied health care professional (PA or ARNP) counts as 0.5 physician FTE for Medicare members.
8. Members with scheduled appointments shall be seen within thirty minutes of the scheduled appointment time.

9. Members shall be informed of unavoidable delays and provided with alternatives.

Member Health Education

Providers are expected to provide health education to Plan members on topics that are reflective of the demographics, local culture and health status of the population served. Members with specific health education needs should be provided education specific to those needs and access to health education resources, programs, or services appropriate for their needs.

Member health literacy relates effective provider-member communication and health education. Sonder Health Plans encourages all providers to assess communication barriers and use appropriate language and reading level materials to facilitate quality health education.

Sonder Health Plans encourages providers to participate in initiatives to educate Sonder Health Plans members by submitting articles for publication in member newsletters. If you have a topic to suggest or an article to submit, contact the Health Services Department or your Provider Engagement representative.

Preventive Health Services/Evidence-Based Guidelines

Sonder Health Plans promotes preventive health education and screening to support member health and quality of life independent of age. Sonder Health Plans follows CMS recommendations for preventive health. Evidenced-based, clinical guidelines are adopted by the health plan through selection and approval by the Medical Management Committee. Information regarding clinical guidelines is available to providers and members on the Sonder Health Plans website. Sources for preventive health guidelines include, but are not limited to, the U.S. Preventive Services Task Force (USPSTF), Center for Disease Control (CDC) Recommendations for Adult Immunizations, HEDIS Effectiveness of Care Measures, and the American Diabetes Association, Standard of Medical Care in Diabetes.

Member screening rates and plan performance are monitored through HEDIS access and effectiveness of care measures, quality improvement projects, and periodic review of medical record documentation.

Targeted Disease Management Programs

Sonder Health Plans is committed to continually provide quality health care and services to members through the development of Disease Management Programs that have the potential of facilitating dramatic improvement in the health, productivity, satisfaction, and quality of life of members with chronic diseases. The goals of Sonder Health Plans Disease Management Programs are to:

- Reduce unnecessary disparities in the delivery of health care services to members with chronic or acute diseases through the adaptation and implementation of evidenced-based clinical treatment and practice guidelines.
- Improve the health and quality of life of Sonder Health Plans members with acute or chronic conditions through intervention programs that identify, inform, and educate members, providers, and other partners in health care.
- Measure and track the improvements yielded by the intervention programs through clinical and outcome studies based on reliable tested information and methodology.

The Disease Management Programs consist of integrated systems of measurements and interventions that seek to identify, assess, and address issues that compromise the efficient and effective delivery of health care services. Each Disease Management Program involves

active participation from the member, the member's family (if available), and health care providers (physicians and case managers) to further maximize the effectiveness of the interventions. The goal is to empower individual members with chronic conditions to work collaboratively, in a partnership relationship, with primary care physicians, specialists, case managers, and their family members to modify lifestyle behaviors and take control of their condition and exhibit compliance with recommended treatment regimens.

Sonder Health Plans offers targeted disease management for the following conditions:

- Diabetes
- Cardiovascular Disease
- Dementia
- Chronic obstructive pulmonary disease (COPD)
- Renal Disease

Each of the targeted Disease Management Programs share the following common components and corresponding component specific objectives:

1. Comprehensive Assessment and Risk Stratification designed to:
    - Fully profile the health, mental health, and functional status of the member.
    - Identify lifestyle risk factors associated with the member's condition.
    - Ensure that members, based on determined risk factors and co-morbid conditions, are administered appropriate treatment regimens.
2. Member Information/Education intended to:
    - Increase member's level of understanding of their chronic condition and the potential consequences of lifestyle behaviors on the staging of the condition and the development of other serious co-morbid chronic conditions.
    - Empower members with the skills and motivations to alter negative lifestyle behaviors.
    - Enlist the member as a partner in the care and management process.
3. Provider Education designed to:
    - Ensure that providers are aware of and utilize current practice guidelines for the treatment and management of targeted conditions.
    - Ensure that providers keep pace with new and effective treatment protocols.
    - Enlist PCPs and Specialists as partners in the overall treatment and disease management process, to ensure modifications in the member's lifestyle behaviors.
4. Member Case Management and Planning directed at:
    - nursing coordination of appropriate and effective care and treatment.
    - Developing individualized care plans that correspond to the unique needs of the member.
    - Reinforcing and motivating members toward positive lifestyle behaviors.
    - Serving as a liaison for the member in the treatment and management process.
    - Influencing appropriate treatment and medication compliance.
5. Medication/Treatment Compliance Surveillance designed to:

- Monitor and enhance medication treatment compliance among members.
- Monitor and evaluate medication treatment patterns among providers.
- Identify potential negative effects of medication treatment, to include drug-to-drug interactions, contraindications, and medication side effects.

6. Outcome Evaluation designed to determine the effectiveness of the targeted Disease Management Program relative to the following outcome measures:
    1. Lifestyle health behaviors
    2. Self-care management
    3. Provider/member interactions
    4. Medication and treatment compliance
    5. Member quality of life
    6. Use of evidence-based practice guidelines
    7. Disease complications and co-morbid conditions
    8. Emergency room visits
    9. Hospital admissions and re-admissions

Potential member candidates for the Sonder Health Plans Disease Management Programs are identified by the PCP, family member, or the Health Services and Medical Care Management Areas. Once identified, the member is assigned a case manager to guide the member through their health care process.

The disease case manager, member, PCP, and family members (if available), establish a care plan. The case manager communicates with the member and the PCP to identify progress toward the management of the condition, problems regarding treatment compliance and adherence, and provide support and reassurance.

Sonder Health Plans encourages PCP participation in the Case/Disease Management Program at SHP. PCP's as well as members will be invited to all Interdisciplinary Team Meetings (ICT).

Quality Improvement Initiatives

Improvement initiatives are both clinical and non-clinical and may involve quality improvement projects, focus studies, monitoring operational indicators, and consumer input.

Clinical improvement initiatives focus on the improvement of different aspects of clinical care and services. Quality improvement projects (QIPs) are designed and conducted in accordance with regulatory requirements and AAAHC accreditation standards. Quality projects measure and analyze health plan performance using objective, clearly defined indicators; they are evidence-based, and capable of measuring outcomes or valid proxies of outcomes such as health or functional status, member satisfaction, and/or use of preventive services demonstrated to improve health outcomes. Valid techniques are used to measure baseline data, conduct periodic re-measurement, and assess performance and effectiveness of specific interventions. Performance improvement is measured against pre-established, quantifiable goals.

HEDIS data measures performance on different dimensions of care and services and allows for comparisons with other Medicare Advantage plans within the State and nationally. Audited,

reliable data, is used for many initiatives within the organization. Much of the data collected for HEDIS reporting, as well as other quality initiatives, is obtained through administrative data such as claims, encounter and pharmacy data, and some measures require administrative data and medical record review. During the process of medical record review and abstraction, Sonder Health Plans relies on the cooperation of network providers for timely access to the records.

Sonder Health Plans have clinical QIPs in place at all times focusing on the prevention of acute or chronic health conditions and consumer safety.

Operational improvement initiatives involve monitoring key operational indicators and focus on improving organizational processes and operational efficiencies.

Member Satisfaction

Member satisfaction is continuously monitored to enhance processes and outcomes. Information sources include grievances, appeals, and the CAHPS (Consumer Assessment of Healthcare Providers and Systems) satisfaction survey. Data is analyzed to identify outstanding performance and areas for improvement. Initiatives are implemented to address adverse trends, refine processes, and maintain high levels of member satisfaction.

Provider Satisfaction

Provider satisfaction is important to Sonder Health Plans' and is monitored with the intent of continuously improving the processes and outcomes that affect providers. In addition to the routine interaction between Sonder Health Plans' many departments and network providers, sources of satisfaction information include disputes and an internal Provider Satisfaction Survey. Data is evaluated for outstanding performance and improvement opportunities. Improvement initiatives are implemented to reverse adverse trends, improve processes, and achieve and sustain high levels of provider satisfaction.

Sonder Health Plans encourages providers to participate in the survey process. Surveys are administered each calendar year and are distributed through a variety of ways.

Peer Review Process

Sonder Health Plans has a mechanism in place to investigate and take action to resolve quality of care issues and concerns, to include the monitoring and trend analysis. The peer review process is evidence-based and involves participating network providers. All peer review activity is treated confidentially.

The Peer Review Committee, with a membership that includes network providers, plays a key role in the process (*see Section Three*). Providers have the right to participate in the Peer Review Committee process; they may participate through the submission of written materials, and/or by participating in Committee meetings via teleconference or in-person. Providers who wish to participate in the peer review process should contact their provider services representative. All providers who participate in the Peer Review Process or sit on the Peer Review Committee must be approved by the Chief Medical Officer.

Providers have the right to dispute actions taken as a result of a quality-of-care investigation or professional competency or conduct. Providers are notified of decisions in writing to include dispute rights and instructions. Disputes must be file in writing within fifteen (15) business days of receipt of the notification.

The dispute process offers two-levels of dispute. The first-level review panel is convened within twenty (20) business of receipt of the dispute request and written notification of the decision is mailed within three (3) business days. Notification of a decision in favor of the provider will include an explanation of actions being taken to effectuate the decision. If the decision of the first-level review is not in favor of the provider, the provider is notified of the effective date, the right to consideration by a second-level panel, and the procedures and timeframes to request the additional review. A second-level review panel includes providers not involved in previous reviews and is convened within twenty (20) business days of the request. Notification of second-level reviews, mailed within three
(3) days, include the decision, an explanation of actions being taken to effectuate the decision, and the effective date.

The exception to the procedures above is in the event of an emergency suspension of a providers participation status in the network; in this case, the provider is notified immediately by phone, with written notification to follow and the convening of the Peer Review Committee for the first-level review is within five (5) business days of the suspension action.

SECTION 9: HEALTH SERVICES/CARE/CASE MANAGEMENT

Accreditation Organization standards (AAAHC) Program is designed to meet contractual requirements and standards as defined by Federal regulations and AAAHC accreditation standards while providing members access to high quality, cost-effective, medically necessary care in the most appropriate setting and ensuring prompt and accurate payment to our providers.

The Health Services program focuses on:

- Providing access to culturally sensitive services that are medically necessary, appropriate, and are consistent with the member's diagnosis and level of care required.
- Monitoring, tracking, and trending care provided to members to ascertain that quality healthcare is being provided.
- Reducing overall healthcare expenditures by developing and implementing programs that encourage preventive health care behaviors and member partnership to foster improved care and wellness.
- Facilitating communication and partnerships among members, families, providers, delegated entities, and the Plan in an effort to enhance cooperation and appropriate utilization of health care services.
- Identifying members with special needs, potential or high-risk disease states, high resource usage, or high-cost diagnosis, and intervening to maximize appropriate utilization and delivery of appropriate healthcare through the efficient use of resources.
- Reviewing, revising, and developing medical coverage policies to ensure members have appropriate access to new and emerging technology; and
- Enhancing the coordination and minimizing barriers in the delivery of behavioral health and medical health care services.

Medically necessary services are defined as services that include medical or allied care or services furnished or ordered to:

- Be necessary to protect life, to prevent significant illness or significant disability or to

alleviate severed pain.

- Be individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the member's needs.
- Be consistent with the generally accepted professional medical standards in light of conditions at the time of treatment and not be experimental or investigational:
- Be reflective of the level of service that can be furnished safely and for which not equally effective and more conservative or less costly treatment is available; and
- Be furnished in a manner not primarily intended for the convenience of the member, the member's caretaker, or the provider.

The fact that a provider has prescribed, recommended, or approved medical or allied services does not, in itself, make such services medically necessary or a covered service/benefit.

Health Services Decision Making

Sonder Health Plans uses review criteria that is nationally recognized and based on sound scientific, medical evidence and current clinical principles and best practices. The appropriate use of criteria is incorporated in all phases of the utilization decision-making process by licensed staff and the Medical Director(s). They are to be used as a reference resource, screening criteria, and guideline in making decisions regarding medically necessary services and not as a substitute for professional judgment.

The following criteria are utilized by the UM department along with State and Federal Regulation, but not limited to:

- MCG
- National Coverage Determinations (NCD)
- Local Coverage Determinations (LCD)
- Coverage Issues Manual (CIM), CMS online: http://cms.hhs.gov/
- Member's Benefit Coverage as described in the Evidence of Coverage
- Regulatory and/or governmental bodies, e.g., FDA, NIH, PubMed
- Federal and State mandates

The Medical Director evaluates all cases that do not meet medical necessity and will make the appropriate utilization decision based on review of the clinical information provided and if necessary, in conjunction with discussion with the ordering or attending physician.

The Medical Director is available to discuss their decision in the event that a practitioner/provider questions the medical necessity/appropriateness of a modified or denial determination made by the Medical Director. The utilization criteria used in the decision process is available to the requesting physician upon request.

Sonder Health Plans does not reward practitioners, staff, or other individuals for denying coverage or services. Sonder Health Plans does not provide financial incentives to employees, including Health Services staff, for decisions that establish barriers to care or decisions that support under-utilization.

Health Services (UM) Process:

The UM process is comprehensive and includes the following review processes:

- Referrals

- Prior Authorizations
- Notifications
- Concurrent Review
- Under certain circumstances, Retrospective Review

A copy of the Prior Authorization Request Form is located under Section 14 Appendices of this manual and under the Provider Section of Sonder Health Plans' website

(www.sonderhealthplans.com) along with Sonder Health Plans Quick Reference Guide.

Referrals

Sonder Health Plans believes in the concept that the PCP is the "Medical Home" for its members. A ***referral*** is a request by a PCP for a member to be evaluated and/or treated by a Sonder Health Plan participating specialty physician. Except as noted in the exceptions that follow, Sonder Health Plans requires members to obtain a PCP to Specialist Referral from their PCP in order to visit or obtain treatment from a participating specialty physician. An authorization request form must be submitted to see or get treatment from a non-participating physician. Please see section: Out of Network referrals. Sonder Health Plans **does** not require a referral as a condition of payment for evaluation and management (E & M) codes. All diagnostic tests and procedures do need a referral from the PCP unless an authorization for that test or procedure is required. *Please refer to Referral/Pre-Authorization guidelines.* The specialist should document the receipt of the request and the reason for the consultation in the medical record and send his/her consultation notes to the referring PCP within five days of the visit or as soon as the consultation notes are complete.

The specialist physician must notify the PCP of any planned procedure that requires prior authorization. If a specialist feels it is necessary for the member to return for follow-up beyond the scope of the original referral, the PCP should be contacted (by the specialist or the member).
The specialist does not need to send a copy of the referral to the Plan. The specialist should include the name of the referring provider on the claim form. If the specialist feels it is necessary to refer the member to another specialist, the PCP should be contacted (by the specialist or the member) .

***Specialists to Specialist referrals are not permitted**. Exceptions to the referral requirement:

- OB/GYN Routine women's health care, which includes breast exams, mammograms, PAP tests and pelvic exams
- Flu shots and pneumonia vaccinations
- Emergency/urgently needed care
- Most preventive services
- Dialysis when the member is temporarily outside the Plan's service area

Admission Notifications Requirements

Notifications are communications to Sonder Health Plans within one (1) business day of admission for claims to be adjudicated. Acute Care Facilities must notify Sonder Health Plans of:

- Members admitted for an observation stay within one (1) business day, as well as

complete appropriate discharge planning.

- Members admitted for an inpatient stay (unplanned or ER admit) within one (1) business day, as well as provide concurrent discharge planning. Note, if an observation stays rolls into an inpatient stay, notification should be submitted on the day the member converts to inpatient status.
- Members admitted for an inpatient stay that are pre- scheduled/planned in advance require prior authorization. Please follow the Prior Authorization – Request for Organization Determination process.

Concurrent Notifications/Discharge Planning

Concurrent notification activities involve notification to the Utilization Review (UR) Nurses from the attending physician, hospital UM staff, Case Management staff or hospital clinical staff involved in the member's care within 24 hours of the admission or the next business day (whichever is sooner). Notification of continued stay and discharge planning is required to ensure appropriate post-acute care services and discharge planning occurs. Discharge planning is a collaborative and cooperative effort among the attending physician, hospital discharge planner, Sonder Health Plans UR Nurse, Sonder Health Plans Case Manager, member, ancillary providers, and community resources in the coordination of care and services.

Discharge planning begins on admission and is designed for early identification of medical/psycho- social issues that will need post-hospital intervention. The goal of discharge planning is to initiate cost-effective quality-driven treatment intervention for post-hospital care at the earliest point in the admission in support of appropriate utilization.

All facilities are required to perform medication reconciliation with all member discharges, fully document such reviews within the medical record and provide notification to the members PCP and Plan Utilization Management Department.

Please note that a determination on payment for services rendered will be evaluated upon claims submission. Sonder Health Plans will review to ensure all notification requirements have been met prior to reviewing for payment. Please note that all inpatient stays require providers to justify the billing being submitted to the plan. Payment determinations are not made during the current notification process however failure to provide notifications are taken into consideration when claims are processed. As a participating provider with Sonder Health Plans, you have agreed that all Sonder Health Plans' Medicare Advantage Members shall be held harmless from and shall not be liable for payment for failure to abide by or comply with all Sonder Health Plan notification and discharge planning requirements.

MCG Retrospective Review for Hospital Admissions

Retrospective reviews for services that have already been completed are not conducted within the Utilization Management Department but require review through the Participating Provider Payment Reconsideration Process once a claim has been submitted and processed accordingly. Additionally, Sonder Health Plans reserves the right to review claims on a post-payment basis.

Prior Authorization – Request for Organization Determination

Prior authorization allows for efficient use of covered healthcare services and ensures that members receive the most appropriate level of care in the appropriate setting.

Authorizations may be required for but not limited to:

- Medical necessity review
- Non-Participating providers
- Appropriate setting (all IP hospital admits require prior authorization)
- Case or Disease Management considerations

Prior authorization is required in advance of rendering a service that may or may not require a benefit or medical review consideration. Elective admissions, SNF, LTAC, or inpatient rehabilitation admissions and other outpatient services or course of treatment in a hospital or other facility as designated by Sonder Health Plans require prior authorization. The Sonder Health Plans Referral and Authorization forms are located in Section 14 of this manual or on the website. Sonder Health Plans will make determinations based on the clinical information obtained at the time of the review. Sonder Health Plans may request additional documentation or medical records to assist in the determination process.

The proper form should be filled out completely and legibly to be processed in a timely manner. A current, operating fax number or secure e-mail must be included on the form. Once Sonder Health Plans agrees that the treatment is necessary and is a covered benefit, an authorization number, which is necessary for payment, will be provided electronically or via fax. Prior authorization requests should include:

- Member demographic information
- Physician/Provider demographic information, including requesting and referred to providers
- Requested service/procedure, including specific CPT/HCPCS codes
- Member diagnosis (ICD code and description)
- Location of where the service will be performed
- Clinical indication necessitating service or request
- Pertinent clinical and laboratory information supporting the medical necessity of the request

Once the PCP has been notified and agrees with the need for the member to have a procedure or hospitalization, the PCP is responsible for obtaining the prior authorization for the elective/non-urgent procedure or admission. Providers may request an "Expedited" authorization for services that are emergent/urgent in nature by indicating this on the pre-cert request and stating the reason for the "Expedited" request. Sonder Health Plans *will make a determination within 72 hours for expedited requests as long as all pertinent information is provided.* Please have the member's name, ID number, diagnosis, and requested service available when calling and the requests will be handled expeditiously.

Expedited is defined as, "a service, if delayed, which would detrimentally affect a member's health or functional capabilities if not performed immediately." This does not include requests that the office failed to submit in a timely fashion.

To ensure the request is completed in a timely manner, providers must submit relevant clinical information along with the request for authorization. All Providers are to provide the necessary information to Sonder Health Plan in order to render a decision in a timely manner. Failure to provide that information limits our ability to render decisions in a timely manner.

As a participating provider with Sonder Health Plans, you have agreed that all Sonder Health Plans' Medicare Advantage Members shall be held harmless from and shall not be liable for

payment for failure to abide by or comply with all Sonder Health Plan referral and prior authorization requirements.

NOTE: Please be advised that Sonder Health Plans may have delegated arrangements with certain provider groups, for which there may be a different process, form, or steps to take other than outlined here for Sonder Health Plans in cases of prior authorization requests or claims submissions.

Organization Determinations

Requests submitted for prior authorization determinations should be requested fourteen days prior to the date of service, when possible. If you require the item/service within 14 days, please advise of the date of service on your request. If required for the requested service, fax pertinent medical records to support the need for the service and/or procedure requested along with a completed Prior Authorization Request Form. This will allow your request to be processed in the most efficient manner. Sonder Health Plans will work collaboratively with the provider and expects the provider to supply any and all information necessary or requested by the request date to properly review and issue a timely decision on all organization determinations. In no event will an organization determination be made for a service that has already been completely administered/rendered. Retrospective reviews are not conducted within the Utilization Management Department but require review through the Participating Provider Payment Reconsideration Process once a claim has been submitted and processed accordingly. If the service is in process, such as a SNF, therapy or HHC course of treatment, an organization determination will only be processed from the date of notification to the plan. Any service dates prior to that notification will have to be reviewed through the Participating Provider Payment Reconsideration Process once a claim has been submitted and processed accordingly. As a participating provider with Sonder Health Plans, you have agreed that all Sonder Health Plans' Medicare Advantage Members shall be held harmless from and shall not be liable for payment for failure to abide by or comply with all Sonder Health Plan referral and prior authorization requirements.

Standard Organization Determination

Sonder Health Plans is committed to a 72-hour turnaround-time on requests for a prior authorization once all the required information is obtained, however will not exceed or mandated turnaround time. Authorization responses will be sent via fax to the providers' fax number(s) that are included on the Prior Authorization Form. However, by contract, Sonder Health Plans has up to fourteen (14) calendar days from receipt of request to determine whether a member's request for non-urgent services is a medically appropriate and covered service. An extension may be granted for an additional fourteen (14) calendar days if the member or the provider requests an extension or if Sonder Health Plans justifies a need for additional information and the extension is in the member's best interest.

If you are aware of a member request or plan on providing a service that is not covered under the Medicare program, please use this process to provide advance notification to the member. Providers may not charge a member for a non-covered service where the member has not been properly notified in advance with the mandated OMB-approved standardized language. Sonder Health Plans will assist in protecting our participating providers by providing the necessary notifications with required CMS language, however can only do that if notified.

Any adverse decision will include a notification of liability that will include any appeal or reconsideration rights that are available.

- Any pre-service adverse member liability decision will issue CMS approved Notice of

Denial of Medical Coverage or Payment (Form CMS-10003-NDMCP), also known as the Integrated Denial Notice (IDN) that includes the OMB-approved standardized appeal language. All appeals associated will follow the Member Appeals process, please refer to that section of this manual.

- Any SNF/HHA/CORT termination decisions will follow the Medicare QIO Review Process of SNF/HHA/CORF Terminations.
- Any adverse provider liability decision will issue the Sonder Health Plans Participating Provider Notice and follow the applicable Participating Provider Resolution Process. Members are not liable and cannot be billed when a Sonder Health Plans Participating Provider Notice is issued. Disputes related to these decisions are between Sonder Health Plans and the Participating Provider and billing of the member is prohibited.

Expedited Organization Determination

If the provider indicates on the Prior Authorization Request Form, that following the standard timeframe could place the member's life, health, or ability to regain maximum functionality in serious jeopardy, Sonder Health Plans will make an expedited authorization determination and provide notice within 72 hours. Sonder Health Plans may extend the 72-hour time period up to fourteen (14) calendar days if the member or the provider requests an extension, or if Sonder Health Plans justifies to CMS a need for additional information. Providers and/or members may request an expedited organization determination by telephone or fax.

Expedited Organization Determinations should follow the CMS guidelines. Expedited requests should be clearly marked as such and should indicate that applying the standard timeframe could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. Sonder Health Plans will not take any punitive action against a physician who acts on behalf or in support of a request for expedited determination.

Medicare QIO Review Process of SNF/HHA/CORF Terminations

All Sonder Health Plans Providers are responsible for following the CMS requirements for the delivery and documentation of written notification at least two days in advance of services ending for Skilled Nursing Facilities (SNF), Home Health Agencies (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) terminations. Sonder Health Plan will provide you with a member specific CMS approved notice with the appropriate discharge dates and appeal language to deliver.

All members receiving covered services in these settings must receive a Notice of Medicare Non-Coverage (NOMNC), delivered by the facility or provider at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily. The provider must ensure that the member or authorized representative receives a paper copy of the notice, as well as signs and dates the NOMNC to demonstrate that the member or representative received the notice and understands that the termination decision can be disputed. Notification confirmation needs to be documented in the medical record with a copy of the signed NOMNC.

Should the member or authorized representative be able to sign however refuses to do so, advise them of the non-coverage date and read the notice to them, leaving a copy oof the notice with the member or authorized representative. Confirm notification by documenting on a copy of the NOMNC, the date and time notice was provided as well as the fact that the member refused to sign. Place a copy in the medical record and ensure a copy is provided to the member.

Providers are required to develop procedures to use when the member is incapable or

incompetent and the provider cannot obtain the signature of the members authorized representative through direct personal contact. If the provider is personally unable to deliver a NOMNC to an authorized representative then the provider should telephone the authorized representative to advise them of the non-coverage date and read the notice to them. Confirm notification by documenting on the NOMNC the date, time and representatives name and contact information used to deliver the notification as well as the mailing address and documentation that a copy has been mailed to the representative. Place a copy in the medical record and mail a copy directly to the representative.

When direct phone contact cannot be made, notify Sonder Health Plans immediately. Also provide Sonder Health Plan UM Dept with a copy of the signed notice.

The member has the right to request an immediate review by the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) when a SNF, HHA, or CORF decides to terminate previously approved coverage. In the event that a member appeals the termination of services, Sonder Health Plans will work collaboratively with the provider and expects the provider to supply any and all information necessary or requested by the BFCC-QIO to review these cases within the allotted time frame. Sonder Health Plans works collaboratively with the QIO for any information required during the QIO review.

Failure to follow the CMS delivery and documentation requirements shall result in the provider's responsibility and financial liability for such services until such time as the member (or authorized representative) has been properly notified. Sonder Health Plan will abide by the decision of the BFCC-QIO. However, any decision that results in technical overturn for the providers failure to properly deliver, or document delivery or supply requested information with the appeal shall result in the provider's responsibility and financial liability for such services until such time as the member (or authorized representative) has been properly notified of the termination again.

Services not requiring authorization by Sonder Health Plans:

Sonder Health Plans has determined that many routine procedures and diagnostic tests may be performed without medical review to facilitate timely and effective treatment of members. Certain diagnostic tests and procedures are considered, by Sonder Health Plans, to be a routine part of an office visit, such as cystoscopy, EKG, and plain film x-rays. [See Section 14 Appendices for a copy of the Prior Authorization Form, Referral Form and the Referral and Authorization Guide.] Please note that this does not apply when non-emergent services are rendered by an out of network provider for our HMO Plans. Please see section: Out of Network referrals as services rendered outside of the plans participating provider network is not a covered benefit for our HMO products unless the services are considered urgent/emergent or prior approval from the plan has been obtained.

Emergency Services

Sonder Health Plans covers, without an authorization, emergency services necessary to screen and stabilize members. Sonder Health Plans provides coverage for emergency services furnished by a qualified provider that are needed to evaluate or stabilize an emergency medical condition that is found to exist using the "prudent layperson" standard-A Standard for determining an emergency as a condition a prudent layperson who possesses an average knowledge of health and medicine experts. Sonder Health Plans does not impose restrictions on coverage of emergency medical services that are more restrictive than those permitted by the "prudent layperson" standard. Sonder Health Plans does not deny payment based on a member's failure to notify Sonder Health Plans in advance of seeking treatment or within a

certain period of time after the care was provided.

Sonder Health Plans provides for emergency services, when necessary, care is not available within the provider network or is needed outside of the service area, the "prudent layperson" standard applies.

Authorization is not required for emergency services based on the "prudent layperson" standard.

Services provided by physicians in the ER to treat or stabilize the member are not subject to utilization review.

Prior authorization is not required for transportation to the ER.

Second Medical Opinion

All Sonder Health Plans members have the right to request a second opinion from their PCP or Specialist. Sonder Health Plans Member Care Services Professionals can provide assistance to the member in obtaining the consultation service, if necessary.

A member may request and is entitled to a second opinion when he/she:

- Feels that he/she is not responding to the current treatment plan in a satisfactory manner after a reasonable lapse of time for the condition being treated.
- Disagrees with the opinion of the physician regarding the reasonableness or necessity of a surgical procedure or the treatment of a serious injury or illness.

Out of Network Referrals

All out of network referrals for our HMO Plans require prior authorization and must be faxed to Sonder Health Plans on the Prior Authorization Request Form. Out of network referrals are made only on an exception basis after Sonder Health Plans has performed the following:

- Verified the non-availability of a participating specialist.
- Informed the PCP of arrangements made with a non-participating provider.

In the event that a non-participating provider treats a Sonder Health Plans member for non-emergent services and has failed to obtain the proper plan approval, could result in a not a covered benefit denial and financial responsibility to the member. Please notify Sonder Health Plans if you need to refer a member out of the Sonder Health Plans network in advance for all non-emergent services through the Organization Determination process. Sonder Health Plans monitors member complaints to determine any failure on our participating providers with this requirement.

While referrals are not required for any Sonder Health PPO Plans, any request to cover an out of network provider at the in-network cost-sharing rate will require approval in advance. If you are referring to an out of network provider for a PPO member and are unable to locate a participating provider, please initiate an organization determination if requesting in-network coverage/cost-sharing for the member.

Care Transition/Coordination of Care

The PCP is the member's "medical home" and is responsible for the coordination of care and services for the member. All members are encouraged to see their selected PCP to assist in the management and direction of care.

Sonder Health Plans, in collaboration with the PCP, makes a special effort to manage Transitions for its members and to coordinate care for members who move from one Care Setting to another. Plan member benefits are examined, and members are assisted in obtaining these benefits so that members feel as if they are seamlessly transitioned from one setting to another.

Sonder Health Plans facilitates safe transitions for its members by:

- Identifying planned transitions
- Communicating with the member or responsible party about the transition process
- Communicating with the member or responsible party about changes to the member's health status and care plan
- Assigning a case manager to support the member through all transitions of care
- Communicating with the member's usual practitioner.
- Conducting analysis of the Sonder Health Plans performance on the above measures at least annually.
- Coordinating services for members at high risk of having a transition
- Educating members or responsible parties about transitions and how to prevent unplanned transitions.
- Analyzing rates of all member admissions to facilities and emergency room visits at least annually to identify areas for improvement.

Continuation of Care After Termination of Agreement

When a contract between Sonder Health Plans and a treating provider is terminated for any reason other than for cause, each party shall allow the member for whom treatment was active to continue coverage and care when medically necessary, through completion of treatment for a condition for which the member was receiving care at the time of termination, until the subscriber selects another treating provider, or during the next open enrollment period offered by Sonder Health Plans, whichever is longer, but not longer than 6 months after termination of the contract. If applicable, each party to the terminated contract shall allow a subscriber who has initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue care and coverage until the completion of postpartum care.

Case Management

While the provision of health care services and the exercise of professional medical judgment is the purview of treating physicians and other health care providers, Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an individual's health needs, using communication and available resources to promote quality, cost-effective outcomes. It is one component used to control, direct, and approve access to the services available to members in their benefit packages. Case Management emphasizes continuity of care for the members through the coordination of care among physicians and other providers. Case Management is not an episode but occurs across a continuum of care, addressing ongoing individual needs rather than being restricted to a single practice setting. Case Management helps members with multiple and/or complex conditions or who have experienced a critical event or diagnosis and need extensive resources, navigate through the system, and access care.

- PCPs serve as the principal care manager and coordinator of care. Sonder Health

Plans Case Management Team serves as support capacity to the PCP and assists in coordinating care actively linking the member to providers, medical services, residential, social, and other support services where needed.

- All members that meet criteria for case management are enrolled in the program, however, the program is strictly optional, and members may choose to enroll or dis-enroll at any time.
- Providers may request enrollment for their members who have complex or ongoing healthcare needs into the case management program by calling Health Services or by contacting the Case/Disease Management Department at Sonder Health Plans.
- The Case Management team is comprised of specially qualified nurses who assess the Member's risk factors and develop an individualized treatment plan in collaboration with the PCP, specialists, member/caregiver, and members of the healthcare team. The care plan is based on a health needs assessment and identifies immediate, short-term, and long-term goals, monitors outcomes and evaluates whether the goals remain appropriate and realistic, and what actions may be implemented to enhance positive outcomes.
- Sonder Health Plans has incorporated Case Management programs that manage members who have complex or ongoing healthcare needs, preventive health and lifestyle issues or coordination of care/care transition needs. Members may also be referred to our programs that are designed to educate the member on self-management of their chronic condition utilizing evidence-based guidelines.

Sonder Health Plans has adopted clinical practice guidelines that are based on valid and reliable clinical evidence from agencies such as the American Diabetes Association (ADA) for diabetic management.

Delegation

Sonder Health Plans delegates some Health Services activities to external entities and provides oversight and accountability of those entities.

In order to receive a delegation status for Health Services activities, the delegated entity must demonstrate that ongoing, functioning systems are in place and meet the required Health Services standards. There must be a mutually agreed upon written delegation agreement describing the responsibilities of Sonder Health Plans and the delegated entities.

Delegation of select functions may occur only after an initial audit of the Health Services activities has been completed and there is evidence that Sonder Health Plans delegation requirements are met. These requirements include a written description of the specific Health Services delegated activities, at least quarterly reporting requirements, evaluation mechanisms, and remedies available to Sonder Health Plans if the delegated entity does not fulfill its obligations. On an annual or more frequent basis, audits of the delegated entity are performed to ensure compliance with Sonder Health Plans delegation requirements.

Transplant Management

Sonder Health Plans offers transplant management with an assigned Case Manager to ensure that information is available to providers and to facilitate all aspects of the transplant process. The Case Manager is available to interpret transplant benefits and to assist the member in choosing a facility from the Sonder Health Plans transplant network. Each transplant facility is chosen based upon its level of expertise and standards of care using an established set of criteria. Transplant coverage includes pre-transplant, transplant, and post-discharge services and treatments of complications after transplantation. Plan members' benefits are examined,

and members are assisted in obtaining these benefits.

SECTION 10: PROVIDER SERVICES

The primary purpose of Sonder Health Plans Provider Services Department is to respond to inquiries and resolve any issues from Physicians/Providers. Sonder's Provider Services Representatives are available Monday through Friday (April – September) from 8:00 a.m. until 5:00 p.m. and during open enrollment (October – March) Monday through Sunday from 8:00 am – 5:00 p.m. (Eastern Standard Time) and they can be reached at 1 (888) 525-1730. Translation services are available as needed.

Speech and hearing-impaired members may call TTY (711) and ask to be connected to Sonder's Provider Services at 1 (888) 525-1730.

Identifying a Sonder Health Plans Member

When a member seeks medical attention from a Physician/Provider's office, eligibility should always be determined **BEFORE** services are rendered.

There are four (4) ways to verify eligibility:

1. Membership Card: All Sonder Health Plans Plan members are issued an identification card that displays the following (see Appendices for a copy):
    - Member Identification Number
    - Member Name
    - Primary Care Physician
    - Office visit and prescription co-payment amounts

2. Provider Services:
    - Call toll free number 1 (888) 216-5210
    - Email at providerservices@sonderhealthplans.com

3. Monthly Eligibility List: Sonder Health Plans Primary Care Physicians may receive a list of Members assigned to his/her panel on or before the 10th day of the month upon request. Please call the Provider Engagement Department at 1 (470) 563-1855 to receive your copy.
4. Sonder Online Access: Participating Providers may access eligibility and claims status information through our secure website. Pre-registration is required. Call your local Provider Engagement Representative for more details.

Member Care Services Assistance

Members should call the Member Care Services Department at 1 (888) 428-4440 for assistance with any Sonder Health Plan related item or healthcare need, including but not limited to the following reasons:

Part C

- Benefit summary inquiry
- Claims inquiry *(dental, hearing, medical and /or vision)*
- Co-payment inquiry
- General requests *(i.e., new member ID card, due to name change, address change, or request documents etc.)*
- Inquiry on the supplemental benefits

- Verify eligibility and coverage
- To request documents/forms
- PCP Look-up/assistance (*to ensure PCP is in network*) Part D
- Over the Counter (catalog) information/assistance completing the form
- Pharmacy Information *(pharmacy location or they are not appearing in the system)*
- LIS (Low Income Subsidy) Information - Extra Help Needed for Part D
- Formulary Information *(drug coverage inquiry)*

Case Management Information

- Prior Authorization *(submission or status inquiry)*
- Referral request *(submission or status inquiry)*

Compliance

- Appeals and Grievance

Member Selection of a Primary Care Physician (PCP)

At the time a Medicare Beneficiary completes an Enrollment Form for participation in Sonder Health Plans, (s)he selects a Primary Care Physician (PCP) from the Sonder Health Plans Provider Directory. If the Physician/Provider selected is not accepting new members or has terminated his/her Relationship with Sonder Health Plans, or if a beneficiary does not select a PCP, Sonder Health Plans assigns the Member a PCP. The member can change his/her PCP on a monthly basis.

PCPs are encouraged to send a Welcome Letter to new Members. If a Welcome Letter is mailed, we suggest that the office specify hours of operation and provide the Member with information on how to access care 24 hours a day / 7 days a week.

Each Member is mailed a member ID card. Some Members may be effective prior to receiving their member ID cards. For Medicare members, a copy of their Enrollment Form or a temporary ID card is proof of eligibility. It is customary practice for the Physician/Provider to ask to see the member ID card before services are rendered. If the Member has not received an ID card, or the card is lost, please contact Sonder Health Plans' Member Services to verify eligibility.

Member Transfers

The following guidelines apply to the transfer of a Sonder Health Plans member, upon his/her request, from one PCP to another:

- The Member's decision to transfer should be strictly voluntary.
- The Member must not have been directly recruited by phone or in person by anyone involved with the PCP.
- The Member must not have been influenced to transfer due to improper/incorrect information or for medical reasons.
- Upon receipt of a Member's Medical Release Form, the PCP office is required to send the member's medical records to the new PCP.

Whenever these guidelines are not followed, Sonder Health Plans will review the transfer. A transfer will not be approved if any of the preceding guidelines are violated.

- If the change is requested before the 5th of the month, then the change will be retro-active to the first of the month in which the member called to request the change. Exception: If the member already saw their PCP in the first 5 days of the month, the change will be effective the first day of the following month.

- If the change is requested after the 5th of the month, then the change will be effective the first of the following month.

Disenrollment

Voluntary Disenrollment of Members:

Sonder Health Plans members may voluntarily dis-enroll from Sonder Health Plans by:

- Contacting Medicare directly at 1-800-Medicare or,
- By calling the Sonder Health Plans Member Services Department at 1 (888) 428-4440 or,
- By submitting a written request directly to the Sonder Health Plans Enrollment Services Department at the following address

Enrollment Services Department
Sonder Health Plans, Inc. 6190 Powers Ferry Road Suite 320
Atlanta, Georgia 30339

Involuntary Disenrollment of Members:

CMS allows Sonder Health Plans to involuntarily dis-enroll members from the health plan due to:

- Fraud
- Behavior that is unruly, abusive, or uncooperative to the extent that continued membership seriously impairs the plan's ability to furnish services to the member or other members.

The plan must notify CMS and ask for permission to involuntary dis-enroll members for these reasons. In the case of disruptive behavior, the plan must provide supporting documentation. The plan must also provide the member with several notices and an opportunity to change his/her behavior. Each step in the process requires CMS permission. CMS must be satisfied that the member's behavior is not due to the member's use of, or lack of use of, medical services, member's choice of or refusal of treatment and that plan has made reasonable accommodations for problems due to member's mental health/cognitive conditions.

Please report suspected fraud (e.g., misuse of ID card, theft of prescription drug pads, drug-seeking behavior) or disruptive behavior to Sonder Health Plans. Please note that disruptive behavior must meet the CMS definition. We will need documentation of the behavior as well as efforts made to accommodate the member.

Procedure for Requesting Member Discharge from your practice

A Provider requesting to "discharge" a Sonder Health Plans Member from their panel must submit a written request to the Provider Engagement Department for review and approval.

ACCEPTABLE REASONS FOR MEMBER DISCHARGE

- Missed Appointments and/or repeated "no-shows" for scheduled appointments.
    - Missed appointment may be defined as an intended appointment that was not canceled or rescheduled at least 2 hours before the designated time.

- No-Show is defined as four (4) or more visits missed in a twelve (12) month period.
- Dates of no-shows must be documented in Member's record.

- Threatening behavior displayed toward practice staff.
  - Behavior and practice response must be documented in Member's record.
- Members previously discharged from the practice, prior to coverage with Sonder Health Plans.
  - Provider should submit evidence of previous discharge with request.
- Persistent non-compliance with a documented care plan.
  - Non-compliance and steps to educate the member must be documented in Member's record.
- Evidence of Member doctor-shopping to obtain prescriptions, as per O.C.G.A. §16-13-43.(a)(6).
  - Details of this activity, including DOS and Member contact should be documented in the Member's record.
- Fraudulent behavior identified.
  - Details should be well documented in the Member's record. PROVIDER

DOCUMENTATION AND REQUIRED ACTIONS

- Document all acceptable reason(s) for requesting discharge within Member's record.
- Document all resolution attempts and activities made within the Member's record.
- Notify the Member in writing that they have been discharged from your practice.
  - PCPs should provide Members with at least a thirty (30) day prior notice to targeted discharge effective date.
  - Providers must offer 30 days of urgent/emergent care to the Member following the practice discharge date: and,
  - Providers are expected to participate in any Member transfer and coordination of care activities required as a result of the change
- Request Member Discharge by sending your SHP Provider Engagement Representative a PCP Request for Member Transfer Form.
  - Attach copies of your documentation from the member's record indicating reason(s) for request and resolution attempts.
  - Include copy of the Provider's notification to the Member regarding dismissal from practice.

Provider Engagement Representative will review Provider requests promptly and shall notify Provider of approval or denial for each request, confirming effective date(s) of discharge, as appropriate to ensure compliance with applicable CMS Program and regulatory requirements.

Approved Primary Care Provider (PCP) assignment changes will be effective the 1st of the month, following the thirty (30) day prior notice to the Member but may differ in some instances based on the case.

Example:
7/28/2022 PCP sends Member notification of dismissal from practice, advising them that they are discharged from their practice effective 9/1/2022.

Sonder Health Plans will review the information and appropriateness of discharge requests.

For example, Providers should not request discharge due to the Member's utilization of services or in retaliation against a grievance filed regarding the provider or their practice. Providers must demonstrate efforts to work with Members who are non-compliant with treatment plan and the barriers and interventions taken to-date for the non-compliance.

Upon approval of a PCP's request to discharge a Member, Provider Engagement Representative shall identify if Member has already conducted outreach to Member Services to select a new PCP for the 1st of the following month in response to PCP's discharge notice. If Member has not requested new PCP, Provider Engagement Representative shall submit request to Member Services to conduct Member outreach and help the Member select a new PCP. If transition of care is required, Case Management will also assist with the transition process.

Please contact Provider Engagement for any questions or concerns you may have. You may also contact the Provider Services Department to receive an electronic or faxed copy of the PCP Request for Member Transfer form.

SECTION 11: MEMBER RIGHTS AND RESPONSIBILITIES

Sonder Health Plans strongly endorses the rights of Plan members as supported by State and Federal laws. As well, Sonder Health Plans expects members to be responsible for certain aspects of care. In joining the SONDER plan, members become a partner with the Sonder Health Plans family of health care professionals. The establishment of this partnership is an important element in satisfying the mission of Sonder Health Plans.

All member rights and responsibilities are to be acknowledged and honored by Sonder Health Plans staff and all participating Physicians/Providers. Sonder Health Plans urges Providers to post the Sonder Health Plans Member Rights and Responsibilities in their office(s). Additionally, all Providers are expected to abide by the Georgia Patient's Bill of Rights and Responsibilities. Copies of these Rights and Responsibilities are located at the Appendices of this Provider Manual.

Member Rights

All members of the Sonder Health Plans have the right to:

- Be treated in a manner that respects their dignity and right to privacy.
- Complete confidentiality involving medical diagnosis, treatment and care received from Sonder Health Plans providers with assurance that any information regarding their treatment and/or diagnosis cannot be released without their written consent unless required by law.
- Refuse the release of identifiable personal information, except when such release is required by law.
- Have their medical situation explained to their satisfaction and complete understanding, and to participate with the Sonder Health Plans case management team in making decisions regarding their health care.
- Be given information on all alternative treatments available to them and the potential values and risks of those treatments.
- A discussion of appropriate or medically necessary treatment options regardless of cost or benefit coverage.
- Receive prompt, courteous, and appropriate treatment, care, and assistance.
- Be provided with information regarding their benefits, exclusions, limitations, and any responsible charges (i.e., copayments, deductibles, etc.)
- Be provided with a directory of participating providers, to select a Primary Care

Physician of their choice, and to change their Primary Care Physician for any reason.

- Voice a complaint or file a grievance or appeal regarding a Sonder Health Plans provider, or the care they have received from them, and receive a response in a timely manner. If they are not satisfied with the decision regarding the complaint, they may initiate a formal grievance or appeal process.
- Receive information about Sonder Health Plans, its services, its practitioners and providers, and member rights and responsibilities.

Member Responsibilities

All Sonder Health Plans members are responsible for:

- Selecting a Primary Care Physician.
- Keeping their appointments with the providers at the scheduled date and time.
- Presenting their Sonder Health Plans ID card prior to receiving services.
- Conducting themselves in an appropriate manner when seeking medical assistance.
- Following the care and treatment recommended by the providers of Sonder Health Plans.
- Timely payment of all co-payments and fees.
- Following instructions and guidelines given by those providing health care services.
- Providing any applicable information that Sonder Health Plans or its Physicians/Providers may need in order to render proper treatment.
- Understanding the benefits, exclusions, and limitations of the Sonder Health Plans.

SECTION 12: Medicare Member Grievances and Appeals Process

All Sonder Health Plans Members have a right to file an Appeal and/or a Grievance.

Sonder Health Plans Member Appeals and Grievance Process, including instructions on where and how to file Member Grievances and Appeals, is described in our Members Evidence of Coverage, and is available on the Sonder Health Plans website. The process for filing a Member Appeal is also included in the organization determination notice issued.

All Sonder Health Plans Participating Providers are educated on, and expected to acknowledge, understand, and comply with Sonder Health Plans Appeals and Grievance policies and procedures. As such, Providers are responsible for instructing and assisting Sonder Health Plans Members on how to file a Grievance with the Plan when they voice a complaint .

Additionally, Contract provider disputes involving notices of a Participating Provider who fails to follow plan rules/requirements, lack of authorization, failure to provide medical records and, plan payment issues are governed by the Participating Provider Claim Dispute process, found in Section 5 of this Provider Manual.

Medicare Member Grievance: A "Grievance," also known as a complaint, is an expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken.

NOTE: Member Grievance procedures are separate and distinct from initial determination and Member appeal procedures. Decisions made under the grievance process are not subject to appeal.

Grievance examples, include, but are not limited to:

- Matters involving a health plan provider, including complaints about the quality of services the member received.
- Delivery of care, including issues involving waiting time, physician behavior, adequacy of facilities, or other similar Member concerns.
- Plan enrollment/disenrollment issues.
- Any problems involving the delivery of a Sonder Health Plans benefits package/materials.

The Member can request an expedited Grievance in certain cases when an expedited coverage request or Appeal is diverted to the standard process or the Plan takes an extension in deciding on a coverage request or Appeal.

Sonder Health Plans Members may file a complaint with the Plan by calling the Member Care Services Department. If the Member contacts the Member Care Service Professional to file a complaint, they will promptly assist to resolve issues communicated. In the event the Member Care Service Professional cannot resolve the matter promptly, the information is routed to the Appeals & Grievance Department for timely resolution.

Members and/or their representatives may also file a Grievance with Sonder Health Plans by completing the Grievance Submittal Form (available on our website) and submitting it to us, along with any supporting documents (such as medical records, medical bills, a copy of their Explanation of Benefits, or other applicable information).

Completed Grievance Submittal Forms can submitted to the Plan by mail or fax at the below:

Mail to:
Sonder Health Plans
ATTN: Member Grievances
6190 Powers Ferry Road, Suite 320
Atlanta, GA 30339

Fax to:
(941) 866-2319
ATTN: Grievance & Appeals Department

If you have any questions or need assistance with educating the Member or their representative on how to file a Grievance, please contact us immediately.

Sonder Health Plans will take prompt, appropriate action, including a full investigation of the Grievance, as expeditiously as the member's case requires, based on the member's health status, in accordance with CMS guidelines. Sonder Health Plans will work collaboratively with the provider and expects the provider to supply any and all information necessary or requested by the request date to properly review and issue a timely decision on all Grievances.

Quality of Care Grievances are Grievances related to whether the quality of covered services provided by a Participating Provider meets professionally recognized standards of care, including whether healthcare services were provided or were provided in an appropriate setting. Quality of Care Grievances are reviewed with the Plan's Chief Medical Officer and by the Plan's Quality Department. Members are also informed of their right to submit Quality of Care Grievances to the Beneficiary and Family Centered Quality Improvement Organization (BFCC-QIO). The BFCC-QIO is an organization contracted with CMS. The BFCC-QIO for Georgia is Acentra Health (formerly KEPRO). Sonder Health Plans cooperates with all inquiries from the BFCC-QIO related to Quality of Care Grievances filed with the BFCC-QIO.

The Member Appeals Process:

Sonder Health Plans is committed to fair and accurate adjudication of Member Appeals. Sonder Health Plans Members and/or their authorized or appointed Representatives may file a request for reconsideration (Appeal) with Sonder Health Plans within sixty-five (65) calendar days from the date of receiving an adverse organization determination notice from Sonder Health Plans, unless good cause is presented to the Plan to excuse a submission past the sixty-five (65) days timely filing requirement.

An adverse organization determination may be a denial of a claim payment request, a denial of a request foran for prior authorization for an item, service, or drug, or a decision about a cost-sharing amount. If a party shows good cause, Sonder Health Plans may extend the time frame for filing a request for reconsideration. Sonder Health Plans will designate someone other than the person involved in the initial denial to review the appeal request. If the initial denial was based on a lack of medical necessity, the appeal decision will be made by a physician with sufficient knowledge and other expertise appropriate to the services under review.

Sonder Health Plans will work collaboratively with the provider and expects the provider to supply any and all information necessary and/or requested by the request date to properly review and issue a timely decision.

Sonder Health Plans processes all Member Appeals within timeframes set by Medicare prevailing guidelines. Please refer to CMS approved adverse determination notice issued to the member for specific appeals rights and information. The process and submission information is different for Part C and Part D Appeals.

For appeal requests received Sonder Health Plans will make a decision and/or authorize or provide the service or benefit as expeditiously as the Member's health condition requires, but no later than the timeframes mandated by CMS based on the type of appeal and service in dispute. In certain situations, Sonder Health Plans may be allowed to extend processing time frames by up to fourteen (14) calendar days if the Member requests, or if Sonder Health Plans needs additional information and the delay is in the member's interest. When the Plan extends the timeframe, we will notify the Member in writing of the reasons for the delay and to inform the Member of their right to file an Expedited Grievance if they disagree with the Plan's decision to grant an extension.

Member Appeal Submittal Form

Completed forms and supporting documentation may be submitted to Sonder Health Plans Appeals Department by mail or fax at the below:

Medical Item/Service or Part B Drug	Part D Prescription Drug Benefit

Sonder Health Plans ATTN: Member Appeals 6190 Powers Ferry Road, Suite 320 Atlanta, GA 30339 Fax: 1 (941) 866-2319 *(please include denial letter with request)* CALL**:** 888-428-2110 *(press 1 for Appeals)*	Verbal requests should be transferred to the Plan Pharmacy Benefits Manager: CALL**:** Contact MedImpact at 833-674-6200 (Choose Option 3). Written Requests: Should you receive, or the appellant wants to file in writing with clinical information to support their case they can: • FAX**:** 877-503-7231 • MAIL**:** Elixir c/o Sonder Health Plans Freedom Avenue NW North Canton, OH 44720

Medicare Member Appeal: An "Appeal" is a request for the review of an adverse initial determination made by the Plan on health care services or benefits under Part C or Part D the Member believes they are entitled to receive, including a delay in providing, arranging for, or approving the health care service or drug coverage (when a delay would adversely affect the Member) or an any amounts the Member must pay for a service or drug. Participating Providers do not have Appeal rights under the Medicare Program; however, may submit a pre-service Appeal on behalf of the Member.

Note, Participating Providers do not have appeal rights under the Member Appeal process. Contracted provider disputes involving failure to follow plan rules/requirements, lack of authorization, failure to provide medical records, and Plan payment issues are governed by the Participating Provider Claim Dispute process, found in Section 5 of this Provider Manual.

Providers should refer to the original organization determination notice that outlines the appropriate process that should be followed. The Medicare Administrative Appeals Process as outlined in the Medicare Managed Care Manual and set forth at 42 CFR Part 422 Subpart M is followed for all adverse organization determinations rendered with Member liability, including providing the appropriate parties with the prescribed CMS adverse determination notice describing the Appeal process.

Providers can request pre-service Appeals on behalf of Members; however, if the Appeal is not requested by the Member's treating physician (or the treating physician's staff acting on their behalf), an Appointment of Representative (AOR) Form may be required. The AOR Form can be found online and downloaded at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.

Reminder of Expedited Appeal Requirements

An "Expedited Appeal" may be requested when taking the standard timeframe to make a determination could seriously jeopardize the Member's life, health, or ability to regain maximum function. Treating physicians (or a prescriber in the case of a Part D Appeal) may request that an Appeal be expedited when this standard is met.

SECTION 13: PRESCRIPTION DRUG FORMULARY

Sonder Health Plans pharmacy benefit manager, Elixir Solutions administers the pharmacy

network, Pharmacy and Therapeutics Committee, complete pharmacy claims administration, Medication Therapy Management Program, and the Prescription Drug Formulary.

Sonder Health Plans has 4 Benefit Plans with a 5-tier or 6-tier Formulary, depending on the Benefit Plan:

- Tier 1 – Preferred Generic Drugs
- Tier 2 – Non-Preferred Generic Drugs
- Tier 3 – Preferred Brand Name Drugs
- Tier 4 – Non-Preferred Brand Name Drugs
- Tier 5 – Injectables and Specialty Drugs
- Tier 6 – Select Care Drugs (only applicable to Plans 003/004)

Member co-pays vary by tier, see above cost-share grid by Plan(s) and tier(s). Generally, Tier 1 and/or Tier 2 Generics are covered in full or with nominal co-pay, then co-pays increase with each tier, and Tier 5 drugs always require a % coinsurance from the member.

Some Sonder Health Plans benefit plans cover all Tier 1 generics through the coverage gap. Some Sonder Health Plans benefit plans do not cover drugs during the coverage gap. To help members maximize the prescription drug coverage and help them pay for their prescriptions through the coverage gap, we encourage members and their providers to review the Formulary for generic alternatives.

The Comprehensive Formulary is available on our website, and it is also mailed to all our members. Our website also includes a Formulary Search link that shows the drug tier for a particular drug and dosage.

Prior Authorization, Step Therapy and Quantity Limit Requirements:

Some drugs on the Formulary require Prior Authorization and some drugs have Step Therapy and/or Quantity Limit requirements. These requirements are also posted on our website, under the Prescription Drugs/Formulary tab.

Sonder Health Plans' members or their physicians can request an Exception to these requirements. They can also request a Formulary exception. These requests require supporting medical documentation. The exception request form is posted on the Sonder Health Plans website. Elixir Solutions will evaluate and decide all exceptions requests within 72 hours. (24 hours for expedited requests). If an exception request is denied, the member will be notified of the denial and appeal rights.

E-Dispense Vaccine Manager:

We encourage our participating providers to use electronic prescription systems, Elixir Solutions Vaccine Manager, to submit their vaccine claims electronically. For vaccines covered under Medicare Part D (e.g., Zostavax), Sonder Health Plans pays for the vaccine administration only, not the vaccine.

Vaccine Manager Features:

- Easy online access to patient-specific coverage
- Ability to received reimbursement for vaccines covered under Part D
- Real-time out-of-pocket (copay) cost and reimbursement information

- Electronic claims submission for vaccines covered under Part D
- Excellent support and administrative tools

Elixir Solutions connects to the Centers for Medicare and Medicaid Services (CMS) database in real- time to first determine if your patient is enrolled in a Medicare Part D plan. If enrolled, Elixir Solutions provides you with the patient out-of-pocket cost and your reimbursement amount.

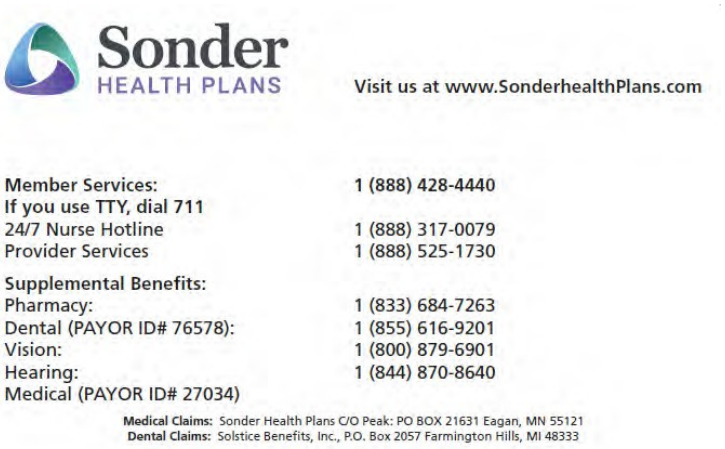
For additional information, please contact Elixir Solutions at 1 (833) 684-7258 or www.elixirsolutions.com

SECTION 14: APPENDICES

APPENDIX A: Sample Member ID card

Front Image of Member ID Card:

Back Image of Member ID Card:



Self-Determination Information
and Forms Information Regarding
Healthcare Advance Directives

POLICY:

Sonder Health Plans must provide all members with information concerning Advance Directives at the time of enrollment.

PROCEDURES:

All Sonder Health Plans members are to be provided information on Advance Directives in their Evidence of Coverage or Member Handbook at the time of enrollment. Documentation must be placed in the member's medical record for all Sonder Health Plans members who elect to establish an Advance Directive. This information should include, at a minimum, the following:

What is an Advance Directive?
Advanced Directives are legal documents in which members express their wishes about the kind of health care they want to receive should they become unable to make their own treatment decisions. There are two types of Advanced Directives: The Living Will and the Durable Power of Attorney for Health Care.

What is a Living Will?
A Living Will is a legal document in which members are able to state in advance their desire to receive or their desire to withhold life support procedures when they are permanently unconscious or terminally ill and unable to make informed decisions.

When does a Living Will apply?
The Living Will applies only when two physicians determine that a member is either in an irreversible coma or is suffering from a terminal illness. The Living Will only applies when the member is unable to make decisions for him/herself. As long as a member is able to make health care decisions, the Living Will cannot be used.

What treatments are covered?
The Living Will permits the withholding or withdrawal of any treatment that might be considered life-prolonging or that artificially extends the dying process.

Who can complete a Living Will?
Anyone over the age of 18 years who is of sound mind can complete a Living Will. It must be witnessed by two adults or can be notarized.

Can a Living Will be revoked?
A Living Will can be revoked at any time and in any manner, e.g., by the member simply tearing the Living Will document, expressing orally the desire to revoke the document, or in writing by the member. Sonder Health Plans providers who witness such revocations should document them in the member's medical record.

What is a Durable Power of Attorney for Health Care?

The Durable Power of Attorney for Health Care is a document that allows a member to specify in advance who should make health care decisions for them should they become unable to make their own health care decisions. The individual named is the "agent" or "attorney-in-fact" for the patient.

When does a Durable Power of Attorney for Health Care take effect?
The Durable Power of Attorney for Health Care takes effect anytime the member loses the ability to make his/her own health care decisions. Unlike the Living Will, the member does not need to be terminally ill or suffering from an irreversible coma.

What treatments are covered?
The Durable Power of Attorney for Health Care document allows a member to name an "agent" or "attorney-in-fact" with broad or specific powers to provide consent or refusal for any type of health care. Durable Powers of Attorney for Health Care are thus very flexible documents allowing both the naming of an agent to make decisions for the member when the member is unable to do so and the specification of the treatments that the member wants or does not want to receive.

Who can be named as an agent?
Anyone over the age of 18 years can be named as the agent except for the physician (and those in the employ of the physician) who is providing care to the member. The agent named has no legal obligation to serve and the agent is not responsible for the financial costs associated with treatment.

Who can complete a Durable Power of Attorney for Health Care?
Any adult of sound mind may complete a Durable Power of Attorney for Health Care. Living Wills and Durable Powers of Attorney for Health Care are frequently prepared without the assistance of lawyers by using standard forms. Sonder Health Plans Providers and the Sonder Health Plans Member Services Department provide members with the standard forms upon request.

Can more than one agent be named?
Only one agent can serve at a time, but other individuals can be named as successor agents if the first individual named as the agent is not able or is unwilling to serve.

Can a Durable Power of Attorney for Health Care be revoked?
A Durable Power of Attorney for Health Care can be revoked at any time and in any manner, e.g., by the member simply tearing up the Durable Power of Attorney for Health Care document, expressing orally the desire to revoke the document, or in writing by the member. Sonder Health Plans providers who witness such revocations should document them in the member's medical record.

How is the Living Will and Durable Power of Attorney for Health Care implemented?
Both documents require that two physicians determine the member in question has lost the capacity to make health care decisions. A Living Will has the additional requirement that the patient must be suffering from a terminal condition or is in an irreversible coma.

***What are some other differences between the Durable Power of Attorney for Health* Care and the Living Will?**
The Living Will simply requires the withholding or withdrawal of life-prolonging treatment whereas the Durable Power of Attorney for Health Care names a specific an agent who is authorized to make decisions for the member. Specific instructions may be given to the agent in the Durable Power of Attorney for Health Care, but they are not required.

Will my provider inform me about Advance Directives?
Sonder Health Plans requires all participating providers to ask members or family upon their first visit about the existence of Advanced Directives. If a member has a copy of an Advanced Directives providers are instructed to place the Directive in the medical record. Also, Sonder Health Plans providers are instructed to document the content of discussions about end-of-life desires or any expression of treatment preferences.

Do Not Resuscitate (DNR) Orders
Advanced Directives are not DNR orders. DNR orders are written by physicians to indicate that a member should not be resuscitated. The order may be written to reflect a member's or surrogate's expressed wishes about resuscitation or because the member will not benefit from resuscitation. For example, for someone with a Living Will or Durable Power of Attorney for Health Care, CPR may be appropriate if they are suffering from an acute life-threatening condition. Members with Advanced Directives may want aggressive treatment for potentially reversible conditions.

Sonder Health Plans supports the position that Advanced Directives only take effect when the member loses decisional ability. Before that time, the member's current expressed wishes should be followed.

Advanced Directives do not replace active communication with members and their families. Sonder Health Plans strongly endorses that members and families should be provided appropriate and sufficient information to make informed health care decisions. Member's expressed preferences about health care treatments should be documented as they evolve in the course of treatment.

Sonder Health Plans supports the use of Advance Directives by patients but does not require that any member complete an Advance Directive as a condition for treatment.
If you would like to read more about organ and tissue donation to persons in need you can view it on our website (Click on "Site Index," then scroll down to "Organ Donors") or the federal government site www.organdonor.gov. If you have further questions you may want to talk with your health care provider.

Various organizations also make Advanced Directive forms available. One such document is "Five Wishes" that includes a living will and a health care surrogate designation. "Five Wishes" gives you the opportunity to specify if you want tube feeding, assistance with breathing, pain medication, and other details that might bring you comfort, such as what kind of music you might like to hear, among other things. You can find out more at:

Aging with Dignity www.agingwithdignity.org (888) 594-7437
Other resources include:
American Association of Retired Persons (AARP)
www.aarp.org (Type "Advanced directives" in the website's search engine)

Partnership for Caring www.partnershipforcaring.org

Your local hospital, nursing home, hospice, home health agency, and your attorney or health care provider may be able to assist you with forms or further information.

APPENDIX C: Statutory Form Georgia Advance Directive for Health Care

This statutory form of the Georgia Advance Directive for Health Care is provided as an example only. An Advance Directive for Health Care need not be in this exact form and may contain different or additional provisions. Always read the document provided to determine its scope and applicability.

By: [Printed Name]_____
Date of Birth:_____

This advance directive for health care has four parts:

PART ONE	**HEALTH CARE AGENT**. *This part allows you to choose someone to make health care decisions for you when you cannot (or do not want to) make health care decisions for yourself. The person you choose is called a health care agent. You may also have your health care agent make decisions for you after your death with respect to an autopsy, organ donation, body donation, and final disposition of your body. You should talk to your health care agent about this important role.*
PART TWO	**TREATMENT PREFERENCES**. *This part allows you to state your treatment preferences if you have a terminal condition or if you are in a state of permanent unconsciousness. PART TWO will become effective only if you are unable to communicate your treatment preferences. Reasonable and appropriate efforts will be made to communicate with you about your treatment preferences before PART TWO becomes effective. You should talk to your family and others close to you about your treatment preferences.*
PART THREE	**GUARDIANSHIP**. *This part allows you to nominate a person to be your guardian should one ever be needed.*
PART FOUR	**EFFECTIVENESS AND SIGNATURES**. *This part requires your signature and the signatures of two witnesses. You must complete PART FOUR if you have filled out any other part of this form.*

You may fill out any or all of the first three parts listed above. You must fill out PART FOUR of this form in order for this form to be effective.

You should give a copy of this completed form to people who might need it, such as your health care agent, your family, and your physician. Keep a copy of this completed form at home in a place where it can easily be found if it is needed. Review this completed form periodically to make sure it still reflects your preferences. If your preferences change, complete a new advance directive for health care.

You may revoke this completed form at any time. This completed form will replace any advance directive for health care, durable power of attorney for health care, health care proxy, or living will that you have completed before completing this form.

PART ONE: HEALTH CARE AGENT

[*PART ONE will be effective even if PART TWO is not completed. A physician or health care*

provider who is directly involved in your health care may not serve as your health care agent. If you are married, a future divorce or annulment or your marriage will revoke the selection of your current spouse as your health care agent. If you are not married, a future marriage will revoke the selection of your health care agent unless the person you selected as your health care agent is your new spouse.]

(1)HEALTH CARE AGENT

I select the following person as my health care agent to make health care decisions for me:

Name:_____

Address:_____

Telephone Numbers:_____
(Home, work, mobile)

(2)BACK-UP HEALTH CARE AGENT

[*This section is optional. PART ONE will be effective even if this section is left blank.*]

If my health care agent cannot be contacted in a reasonable time period and cannot be located with reasonable efforts or for any reason my health care agent is unavailable or unable or unwilling to act as my health care agent, then I select the following, each to act successively in the order named, as my back-up health care agent(s):

Name:_____

Address:_____

Telephone Numbers:_____
(Home, work, mobile)

Name:_____

Address:_____

Telephone Numbers:_____
(Home, work, mobile)

(3)GENERAL POWRS OF HEALTH CARE AGENT

My health care agent will make health care decisions for me when I am unable to communicate my health care decisions or I choose to have my health care agent communicate my health care decisions.

My health care agent will have the same authority to make any health care decision that I could make. My health care agent's authority includes, for example, the power to:

- Admit me or discharge me from any hospital, skilled nursing facility, hospice, or other health care facility or service;
- Request, consent to, withhold, or withdraw any type of health care; and
- Contract for any health care facility or service for me, and to obligate me to pay for these services (and my health care agent will not be financially liable for any services or care contracted for me or on my behalf).

My health care agent will be my personal representative for all purposes of federal or state law related to privacy of medical records (including the Health Insurance Portability and Accountability Act of 1996) and will have the same access to any medical records that I have and can disclose the contents of my medical records to others for my ongoing health care.

My health care agent may accompany me in an ambulance or air ambulance if in the opinion of the ambulance personnel protocol permits a passenger, and my health care agent may visit or consult with me in person while I am in a hospital, skilled nursing facility, hospice, or other health care facility or service if its protocol permits visitation.

My health care agent may present a copy of this advance directive for health care in lieu of the original and the copy will have the same meaning and effect as the original.

I understand that under Georgia law:

- My health care agent may refuse to act as my health care agent;
- A court can take away the powers of my health care agent if it finds that my health care agent is not acting properly;
- My health care agent does not have the power to make health care decisions for me regarding sterilization, involuntary hospitalization, or involuntary treatment for mental or emotional illness, developmental disability, or addictive disease; and
- My health care agent does not have the power to make health care decisions that are otherwise covered under a psychiatric advance directive that I have executed pursuant to Chapter 11 of Title 37 of the Official Code of Georgia Annotated, including decisions related to treatment or hospitalization for mental or emotional illness, developmental disability, or addictive disease.

(4)GUIDANCE FOR HEALTH CARE AGENT

When making health care decisions for me, my health care agent should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in PART TWO (if I have filled out PART TWO), my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health care agent should make decisions for me that my health care agent believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

(5)POWERS OF HEALTH CARE AGENT AFTER DEATH

(A) Autopsy

My health care agent will have the power to authorize an autopsy of my body unless I have limited my health care agent's power by initialing below.

_____ (Initials) My health care agent will not have the power to authorize an autopsy of my body (unless an autopsy is required by law).

(B) Organ Donation and Donation of Body

My health care agent will have the power to make a disposition of any part or all of my body for medical purposes pursuant to the Georgia Revised Uniform Anatomical Gifts Act, unless I have limited my health care agent's power by initialing below.

[*Initial each statement that you want to apply.*]

_____ (Initials) My health care agent will not have the power to make a disposition of my body for use in a medical study program.

_____ (Initials) My health care agent will not have the power to donate any of my organs.

(C) Final Disposition of Body

My health care agent will have the power to make decisions about the final disposition of my body unless I have initialed below.
_____ (Initials) I want the following person to make decisions about the final disposition of my body:

Name:_____

Address:_____

Telephone Numbers:_____
(Home, work, mobile)

I wish for my body to be:
_____ (Initials) Buried
OR
_____ (Initials) Cremated

PART TWO: TREATMENT PREFERENCES

[*PART TWO will be effective only if you are unable to communicate your treatment preferences after reasonable and appropriate efforts have been made to communicate with you about your treatment preferences. PART TWO will be effective even if PART ONE is not completed. If you have not selected a health care agent in PART ONE, or if your health care agent is not available, then PART TWO will provide your physician and other health care providers with your treatment preferences. If you have selected a health care agent in PART ONE, then your health care agent will have the authority to make all health care decisions for you regarding matters covered by PART TWO. Your health care agent will be guided by your treatment preferences and other factors described in Section (4) of PART ONE.*]

(6)CONDITIONS

PART TWO will be effective if I am in any of the following conditions:

[*Initial each condition in which you want PART TWO to be effective.*]

_____ (Initials) A terminal condition, which means I have an incurable or irreversible condition that will result in my death in a relatively short period of time.

_____ (Initials) A state or permanent unconsciousness, which means I am in an incurable or irreversible condition in which I am not aware of myself or my environment and I show no behavioral response to my environment.

My condition will be certified in writing after personal examination by my attending physician and a second physician in accordance with currently accepted medical standards.

(7)TREATMENT PREFERENCES

[*State your treatment preference by initialing (A), (B), or (C). If you choose (C), state your additional treatment preferences by initialing one or more of the statements following (C).*

You may provide additional instructions about your treatment preferences in the next section. You will be provided with comfort care, including pain relief, but you may also want to state your specific preferences regarding pain relief in the next section.]

If I am in any condition that I initialed in Section (6) above and I can no longer communicate my treatment preferences after reasonable and appropriate efforts have been made to communicate with me about my treatment preferences, then:

(A) _____ (Initials) Try to extend my life as long as possible, using all medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive. If I am unable to take nutrition or fluids by mouth, then I want to receive nutrition or fluids by tube or other medical means.

OR

(B) _____ (Initials) Allow my natural death to occur. I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me. I do not want to receive nutrition or fluids by tube or other medical means except as needed to provide pain medication.

OR

(C) I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me, except as follows:
[*Initial each statement that you want to apply to option (C).*]

_____ (Initials) If I am unable to take nutrition by mouth, I want to receive nutrition by tube or other medical means.

_____ (Initials) If I am unable to take fluids by mouth, I want to receive fluids by tube or other medical means.

_____ (Initials) If I need assistance to breathe, I want to have a ventilator used.

_____ (Initials) If my heart or pulse has stopped, I want to have cardiopulmonary resuscitation (CPR) used.

(8)ADDITIONAL STATEMENTS

[*This section is optional. PART TWO will be effective even if this section is left blank. This section allows you to state additional treatment preferences, to provide additional guidance to your health care agent (if you have selected a health care agent in PART ONE), or to provide information about your personal and religious values about your medical treatment. For example, you may want to state our treatment preferences regarding medications to fight infection, surgery, amputation, blood transfusion, or kidney dialysis. Understanding that you cannot foresee everything that could happen to you after you can no longer communicate your treatment preferences, you may want to provide guidance to your health care agent (if you have selected a health care agent in PART ONE) about following your treatment preferences. You may want to state your specific preferences regarding pain relief.*]

_____

_____

(9)IN CASE OF PREGNANCY

[*PART TWO will be effective even if this section is left blank.*]

I understand that under Georgia law, PART TWO generally will have no force and effect if I am pregnant unless the fetus is not viable and I indicate by initialing below that I want PART TWO to be carried out.

_____ (Initials) I want PART TWO to be carried out if my fetus is not viable.

PART THREE: GUARDIANSHIP

[*PART THREE is optional. This advance directive for health care will be effective even if PART THREE is left blank. If you wish to nominate a person to be your guardian in the event a court decides that a guardian should be appointed, complete PART THREE. A court will appoint a guardian for you if the court finds that you are not able to make significant responsible decisions for yourself regarding your personal support, safety, or welfare. A court will appoint the person nominated by you if the court finds that the appointment will serve your best interest and welfare. If you have selected a health care agent in PART ONE, you may (but are not required to) nominate the same person to be your guardian. If your health care agent and guardian are not the same person, your health care agent will have priority over your guardian in making your health care decisions, unless a court determines otherwise.*]

[*State your preference by initialing (A) or (B). Choose (A) only if you have also completed PART ONE.*]

(A) _____ (Initials) I nominate the person as my health care agent under PART ONE to serve as my guardian.

OR

(B) _____ (Initials) I nominate the following person to serve as my guardian:

Name:_____

Address:_____

Telephone Numbers:_____
(Home, work, mobile)

PART FOUR: EFFECTIVENESS AND SIGNATURES

This advance directive for health care will become effective only if I am unable or choose not to make or communicate my own health care decisions.

This form revokes any advance directive for health care, durable power of attorney for health care, health care proxy, or living will that I have completed before this date.

Unless I have initialed below and have provided alternative future dates or events, this advance directive will become effective at the time I sign it and will remain effective until my death (and after my death to the extent authorized in Section (5) of PART ONE).

_____ (Initials) This advance directive for health care will become effective on or upon

_____ and will terminate upon _____.

[*You must sign and date or acknowledge signing and dating this form in the presence of two witnesses.*

Both witnesses must be of sound mind and must be at least 18 years of age, but the witnesses do not have to be together or present with you when you sign this form.

A witness:

- *Cannot be a person who was selected to be your health care agent or back-up health care agent in PART ONE;*
- *Cannot be a person who will knowingly inherit anything from you or otherwise knowingly gain a financial benefit from your death; or*
- *Cannot be a person who is directly involved in your health care.*

Only one of the witnesses may be an employee, agent, or medical staff member of the hospital, skilled nursing facility, hospice, or other health care facility in which you are receiving health care (but this witness cannot be directly involved in your health care).]

By signing below, I state that I am emotionally and mentally capable of making this advance directive for health care and that I understand its purpose and effect.

_____

(Signature of Declarant) (Date)

The declarant signed this form in my presence or acknowledge signing this form for me. Based upon my personal observation, the declarant appeared to be emotionally and mentally capable of making this advance directive for health care and signed this form willingly and voluntarily.

_____

(Signature of First Witness) (Date)

Print Name:_____

Address:_____

_____

(Signature of Second Witness) (Date)

Print Name:_____

Address:_____

[*This form does not need to be notarized*.]

APPENDIX E: Uniform Donor Form

Uniform Donor Form

The undersigned hereby makes this anatomical gift, if medically acceptable, to take effect on death. The words and marks below indicate my desires:

I give:

(a) ___Any needed organs or parts

(b) ___Only the following organs or parts for the purpose of transplantation, therapy, medical research, or education:

_____

_____

_____

(c) ___My body for anatomical study, if needed. Limitations or special wishes, if any:

_____

_____

_____

Signed by the donor and the following witnesses in the presence of each other: Donor's

Name: _____

Signed: _____

Donor’s Date of Birth: _____

Date: _____

Street Address: _____

City, State, Zip: _____

Witness: 1. _____

Witness: 2. _____

APPENDIX F: Documentation of Advanced Directives

Documentation of Advance Directives

The form below may be used as a convenient method to inform others of your health care Advanced Directives. Complete the form and cut it out. Place in your wallet or purse. You can also make copies and place another one on your refrigerator, in your car glove compartment, or other easy to find place.

I, _____ have created the following Advanced Directives:

___Living Will

___Health Care Surrogate Designation

___Anatomical Donation

___Other (specify) _____

---------- FOLD----------

Contact:

Name_____

Address_____

Phone_____

Signature_____

Date_____

POLICY:

Documentation of Advance Directives must be established in the medical records of Sonder Health Plans' members.

PROCEDURE:

1. Documentation must be placed in the member's medical record for all Sonder Health Plans members who elect to establish an Advance Directive.
2. Documentation must include a copy of the Advance Directive properly signed and dated.
3. All providers are expected to adhere to the Advance Directive established by a Sonder Health Plans' member, unless otherwise indicated by law.

APPENDIX G: Pre-Certification Form

APPENDIX H: Referral Form

APPENDIX I: Provider Information Change

GEORGIA NOTICE OF PATIENTS' RIGHTS

The patient has the right to file a grievance with the Georgia Composite Medical Board concerning the physician, staff, office, and treatment received. The patient should either call the board with such a complaint or send a written complaint to the board. The patient should be able to provide the physician or practice name, the address, and the specific nature of the complaint. You may report complaints to the Board at the following address or telephone number:

Georgia Composite Medical Board Attn. Complaints Unit
No. 2 Peachtree Street, NW 36th Floor Atlanta, GA 30303
(404) 656-3913
www.medicalboard.georgia.gov

APPENDIX L: Sonder Health Plans' Summary of Member Rights & Responsibilities

APPENDIX N: FDR Compliance Attestation

APPENDIX P: Sonder Health Plans' Provider Training

APPENDIX Q: Participating Provider Reconsideration Request Form

Sonder Health
A Medicare Advantage Company

Participating SHP Provider Reconsideration Form

Participating Provider Reconsiderations are requests to resolve the following notifications made by Sonder Health Plans Claims and Utilization Review Departments regarding a notification of:

☐ Failure to provide adequate medical records to review a concurrent inpatient stay in order for the Plan to determine the appropriateness of the services being rendered in accordance with clinical guidelines.

This form is *not* to be used when appealing a member liability denial, Non-Participating Provider or Claims Payment Dispute - Refer to the original notification for information on those processes.

*To submit a request for a Contracted Provider Reconsiderations to Sonder Health Plans, this entire form must be completed in its entirety along with any required supporting documents via:

Fax to: (941) 866-2319 OR Email: ParProviderRecon@SonderHealthPlans.com

Questions or need assistance with this form, please call your Provider Engagement Representative or the Plans Provider Service Team.

*** Requestor Information – you must be or are representing a Participating Provider with SHP**

❑ I am a **Contracted/Participating Provider with SHP** *(skip to next section)*

❑ I am a Representative of a **Contracted/Participating Provider with SHP**

*Relationship to Contracted Provider with SHP (office staff, billing, etc):*_____

Submitter Name (Print first/last clearly): _____

Submitter Direct Phone #: _____ Submitter Fax #: _____

Submitter Email (if submitting via Email: _____

*** Participating Provider Information (must match claim information)**

Participating Provider Name: _____

Provider Tax ID: _____ NPI: _____

Provider Site / Address: _____

City: _____ Zip: _____ Phone: _____ Fax: _____

Participating Provider Reconsideration Information

* **REQUIRED** Claim #: _____

PA # (if applicable): _____

Please Note:

- FAILURE TO COMPLETE ALL * FIELDS OR SEND TO CORRECT AREA WILL RESULT IN YOUR REQUEST NOT BEING PROCESSED
- Provide all required documentation to substantiate your request, additional information or records will not be requested
- Any approvals will be communicated via effectuation of the reconsidered claim
- Refer to the Provider Manual for more information on the Participating Provider Reconsideration Process and other disputes

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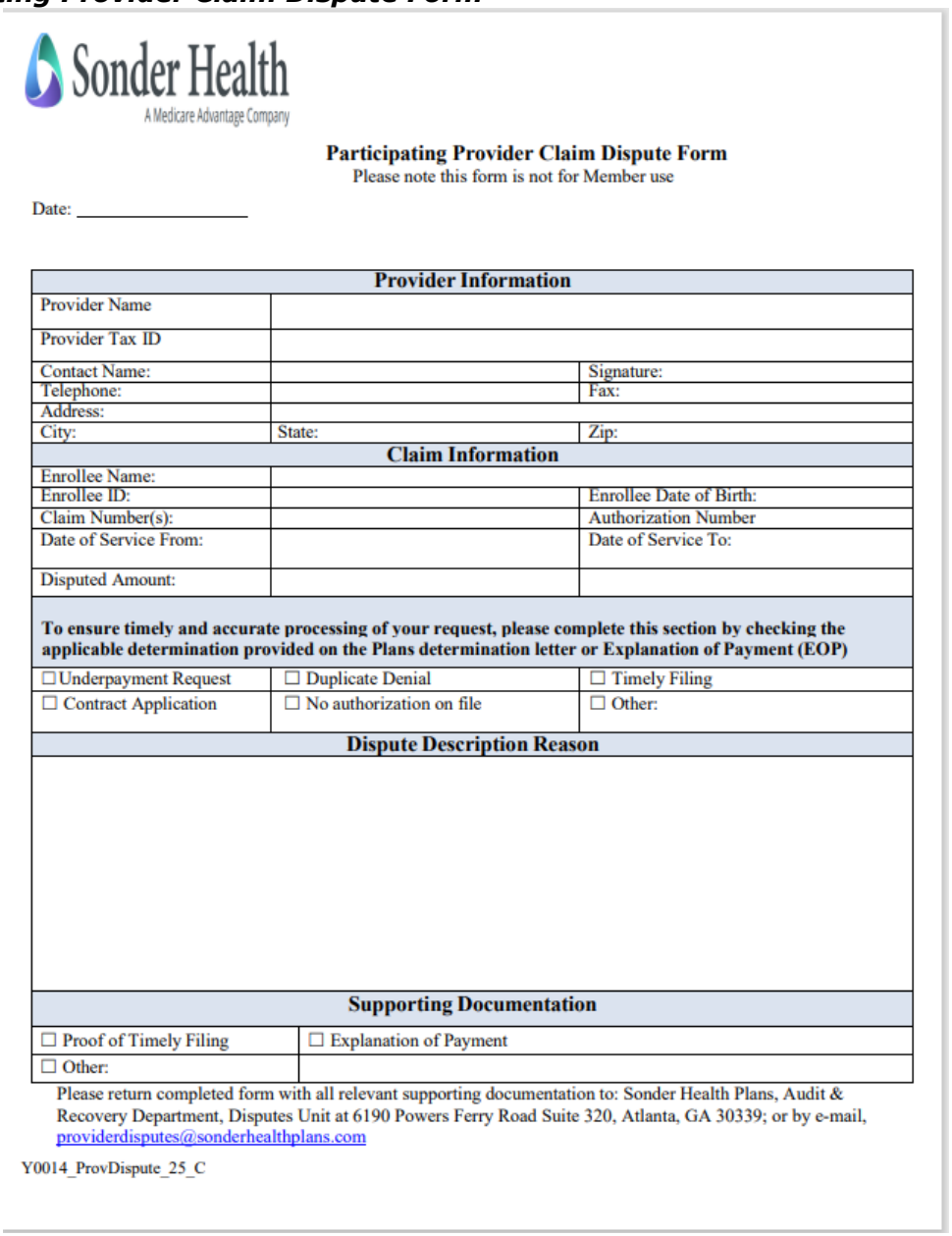
Participating Provider Claim Dispute Form



Sonder Health
A Medicare Advantage Company

Participating Provider Claim Dispute Form
Please note this form is not for Member use

Date: _____

Provider Information		
Provider Name		
Provider Tax ID		
Contact Name:		Signature:
Telephone:		Fax:
Address:		
City:	State:	Zip:
Claim Information		
Enrollee Name:		
Enrollee ID:		Enrollee Date of Birth:
Claim Number(s):		Authorization Number
Date of Service From:		Date of Service To:
Disputed Amount:		
To ensure timely and accurate processing of your request, please complete this section by checking the applicable determination provided on the Plans determination letter or Explanation of Payment (EOP)		
☐ Underpayment Request	☐ Duplicate Denial	☐ Timely Filing
☐ Contract Application	☐ No authorization on file	☐ Other:
Dispute Description Reason		
Supporting Documentation		
☐ Proof of Timely Filing	☐ Explanation of Payment	
☐ Other:		

Please return completed form with all relevant supporting documentation to: Sonder Health Plans, Audit & Recovery Department, Disputes Unit at 6190 Powers Ferry Road Suite 320, Atlanta, GA 30339; or by e-mail, providerdisputes@sonderhealthplans.com

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