sa•na

Provider Manual

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Introduction

Welcome to the Sana Community!

Sana offers innovative health plans and commercial third-party administration. We make things easy for patients and providers by providing amazing support, simple payments, and robust medical coverage.

Whether you're checking a patient's benefits, looking for ways to expand your practice's reach, or just want to know that you'll receive quick, reliable, and fair payments, we got you.

Review this manual to learn all about Sana, our plan design, network, how to submit claims, receive payment, etc. More information is available in Sana's Help Center at **sanabenefits.zendesk.com**.

If you have any additional questions, you can reach us via online chat at **sanabenefits.com/healthcare-providers**, email at **hello@sanabenefits.com**, or phone at **(833) 726-2123** Monday through Friday, 7:00 AM to 7:00 PM Central Standard time.

Brief Summary of Sana Plans

Sana offers a broad selection of PPO Plus and HSA-compatible plan options to our clients. Coverage is largely standardized across plans with the exception of deductible, out-of-pocket max, and coinsurance amounts. Below is a snapshot of our most popular 2021 plan offerings:

sana Medical Plans

Questions? (888) 966-5864 sales@sanabenefits.com

		H70	H50	E60	E35	E15	P45	P25	P05
The Basics		PPO Plus HSA		PPO Plus			PPO Plus		
Deductible	Individual	$7,000	$5,000	$6,000	$3,500	$1,500	$4,500	$2,500	$500
	Family	$14,000	$10,000	$12,000	$7,000	$3,000	$9,000	$5,000	$1,000
Out of Pocket Max	Individual	$7,000	$5,000	$7,500	$7,500	$7,500	$6,000	$5,000	$2,500
	Family	$14,000	$10,000	$15,000	$15,000	$15,000	$12,000	$10,000	$5,000
Coinsurance	After deductible	Plan pays 100%		Plan pays 70%			Plan pays 80%		
Physician Services									
Virtual Services for Primary Care, Pediatric Care, and Mental Health Care		All members on all plans enjoy unlimited complimentary virtual appointments through a Sana Care provider. Sign in to your account to see which Sana Care providers are available in your area							
Office Visits		Plan pays 100% after deductible		Primary office visits: $25 copay			Specialty office visits: $50 copay		
Chiropractic				$25 copay			Up to 30 visits per plan year		
Physical Therapy & Massage Therapy				$25 copay			Up to 30 visits per treatment, with a maximum of 60 total therapy visits per plan year		
Acupuncture				$25 copay			Up to 20 visits per plan year		
Mental Health				Office visits: $50 copay	and		Inpatient residential, intensive outpatient, partial hospitilization programs: Coinsurance applies after deductible		
In-Hospital Visits, Surgery, Imaging, Anesthesiology, Labs, Medical Equipment				When booked through a Sana Care provider: $0 copay	or		When provided by member's choice of facility: Coinsurance applies after deductible		
Preventive & Wellness									
Routine Adult & Child Care, Immunizations, Cancer Screenings, Mammograms, OBGYN Exams		All plans pay 100% of preventive care before deductible							
Emergency Services									
Emergency Room		Plan pays 100% after deductible		$200 copay waived if admitted	and		Additional services: Coinsurance applies after deductible		
Urgent Care				$25 copay	and		Additional services: Coinsurance applies after deductible		
Prescription Drugs									
Check with SmithRx to determine the tier and coverage of your prescription		Plan pays 100% after deductible		Generic / Tier 1 $10 retail copay (30 day) $30 retail copay (90 day) $20 mail order copay (90 day)		Brand Formulary / Tier 2 $30 retail copay (30 day) $90 retail copay (90 day) $60 mail order copay (90 day)	Brand Non-Formulary / Tier 3 $55 retail copay (30 day) $165 retail copay (90 day) $110 mail order copay (90 day)	Specialty / Tier 4 $55 retail copay (30 day) N/A retail copay (90 day) N/A mail order copay (90 day)	

This is a summarized example of coverage. Benefits and coverage are defined by your Summary Plan Description (SPD). In case of a conflict, the SPD supersedes all summaries. 050321

Checking Eligibility, Benefits, and Claim Status

We're proud of our 97% satisfaction rating with providers, and a lot of this has to do with our fast and easy communications tools!

In addition to our chat and phone support, Sana is proud to partner with Change Healthcare to allow providers to instantly verify eligibility, benefits, and claim statuses electronically through an existing EMR or medical record system. Change Healthcare integrates with most EMR and medical record systems.

Providers can verify member eligibility and benefits through the following methods:

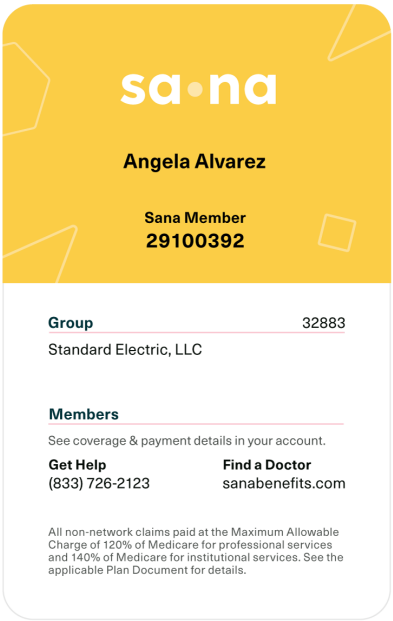
1. Electronically through your EMR or medical record system using our Payer ID: SANA1
2. Via online chat at sanabenefits.com/healthcare-providers
3. Via our support line at (833) 726-2123

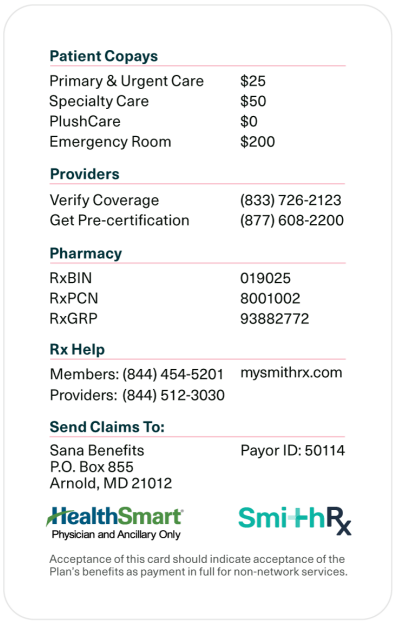
We are available via chat or phone Monday through Friday, 7:00 AM to 7:00 PM Central Standard time.

Please have the following information ready when contacting Sana:

- Patient Name
- Patient Date of Birth
- Member ID Number
- Provider office NPI number

Example of a Sana medical ID card:





Claims and Payment Procedures

Sana accepts claim submissions both electronically and via mail. This section outlines the claims submission process details.

How to Submit a Claim

Electronic Submission (highly recommended): Sana is able to receive electronic claim submissions when a provider submits using Payer ID: **50114**

Paper Claim Submission: Sana is able to receive paper copies of UB-04 or CMS-1500 standard claim forms. These forms should be mailed to:

Sana Benefits
P.O. Box 855
Arnold, MD 21012

Filing a Clean Claim

Providers must submit a clean claim by providing the required data elements on standard claims forms (paper or electronic), along with any attachments and additional elements to support their claim.

Timely Filing of Claims

A provider must submit a clean claim to Sana within 180 days from the last date of service on the claim. If applicable, Providers should refer to their respective contracts to confirm their specific timely filing deadlines.

Timely Processing of Claims

Sana is committed to an exceptional and quick provider payment experience. Sana strives for a quick and streamlined payment process. Upon receipt of a clean claim, the majority of claims are processed and paid by Sana within **5 business days**, although some claims can take up to **30 calendar days** after receipt. Incomplete claims and claims lacking information will result in a denial and extension of the processing time once all relevant information has been received.

Claim Audits

Sana reserves the right to audit all claims submitted, processed, and paid. For these audits, Sana may request additional information, including medical and billing records, to determine whether a claim is eligible for payment. These audits can occur pre-payment or post-payment. Reviews can center around a number of different components including, but not limited to:

- Potential Third-Party Liability
- Potential Fraud, Waste, and Abuse
- Billing and Coding Issues
- Pre-certification

In the event that a review results in the identification of an overpayment, Sana will attempt to make appropriate adjustments and/or recoup the relevant overpayments directly from the provider (see "Claims Overpayments" section below)

Pre-payment Audits

Pre-payment audits are reviews initiated prior to a provider receiving payment from a claim submission. These typically involve a request for more information before a claim can be fully processed. If relevant documentation is not received by Sana, the claim in review will be denied.

Post-payment Audits

Post-audits are reviews that are initiated after a provider has received the payment for a claim. These reviews are typically initiated on a monthly basis via a random sampling of claims for quality assurance review.

Claims Overpayments

When Sana makes a determination that a claim has been overpaid, Sana will submit a written refund request directly to the provider. The written request will include all applicable information, including patient and member information, claim and services, as well as the identified overpayment details and rationale.

When the provider receives the requests, the provider must issue a refund or provide a written explanation of why they disagree with the request **within 30 calendar days**. Requests or written disagreements can be sent to:

Sana Benefits, Inc.
ATTN: TPA Operations
PO Box 660675 #35777
Dallas, TX 75266-0675

Failure to provide a response or refund within 30 calendar days will result in the overpayment amount being referred to an external agency for collection efforts.

Claim Notifications

Sana will notify both the member and the provider of any benefit determination made during the claims adjudication process. Providers are notified of a claim's settlement status, including any denials, via an Explanation of Provider Payment (EPP) which is delivered alongside any payments.

Payments

Providers are reimbursed directly with predictable, fast, and accurate payments. Sana partners with ECHO Health, Inc. to distribute payments, explanation of payments, explanation of benefits, as well as 1099 forms to appropriate parties. Most payments are processed within 5 business days of Sana receiving a clean claim.

Payment Options

Providers have the following options to receive payment. For more information on how to manage these payment options see the following section titled Payment Management.

1. **ACH Direct Deposit:** Requires enrollment and security validation through ECHO.
2. **Virtual Credit Cards (Vcard):** If you'd like to opt-out of Vcards please contact QuicRemit, at (877) 705-4230 Monday through Friday, 7:00 AM to 5:00 PM CST.
3. **Elavon:** Third-party partner leveraged by ECHO to provide electronic payments to providers with Elavon POS machines. Contact Evalon directly with questions.
4. **MedPay:** Paper check replacement giving providers the freedom to decide what they'd like to do for individual payments, including options to print paper checks in the office for rapid processing.
5. **Paper Check:** Traditional paper-based payment sent via USPS mail delivery.

Payment Management

Providers have a number of options to manage the payments they receive:

Card Payment Management

Providers can self-service questions or issues regarding individual VCard payments by visiting www.echovcards.com. An account is not required for this option.

ECHO's Provider Payment Portal

Providers are encouraged to use the www.providerpayments.com website to self-service the retrieving of documents, such as EPPs, EDI file information, and to view the settlement status of a check (cleared date, not cleared, voided).

MedPay (MPX - Medical Payment Exchange)

Providers who receive VCards or Paper Checks can utilize MedPay to enroll in EFT or print Paper Checks to be deposited right away. Providers can also download EPPs from the portal. The Medical Payment Exchange can be accessed at www.echochecks.com.

ECHO Health Direct Contact

Provider's are also able to contact ECHO Health directly to resolve any issues that might arise.

ECHO Health, Inc.
810 Sharon Drive
Westlake, Ohio 44145
Phone: (888) 834-3511
Fax: (440) 835-5656
Email: CS_Requests@echohealthinc.com

Appeals

Sana provides the opportunity for both the member and the provider (on the member's behalf) to submit claim review requests in writing. This section outlines the appeal opportunities and instructions for submission.

Levels of Appeals

Sana provides the opportunity for two (2) internal levels of appeals. Upon determination of the initial appeal, a second level appeal may be available if an adverse benefit determination was upheld.

After the internal appeals have been exhausted, a provider may request an external review process for:

1. Any eligible adverse benefit determination by Sana that involved a medical judgment
2. A rescission of coverage

External Reviews are referred to an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review.

Submitting an Appeal

Appeal Requirements

All appeals submitted to Sana or the appropriate partners in response to an adverse benefit determination should include the following information:

- Name of the member/patient
- Member/patient's social security number or member identification number
- Group name or identification number
- All facts and theories supporting the claim for benefits
- Statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim
- Any material or information that the member/patient has which indicates that they are entitled to benefits

Appeal Filing Deadlines

1. Initial appeals must be filed **within 180 days** following the receipt of an adverse benefit determination
2. Second level appeals must be made **within 60 days** following the receipt of the first level adverse benefit determination
3. External Reviews must be requested **within four months** of the receipt of the second level adverse benefit determination

Pre-service Claims Appeals Submission Process

All pre-service claims must be sent to the Utilization Review Manager. Oral appeals should be submitted in writing as soon as possible after it has been initiated. To file any appeal in writing, the appeal must be addressed as follows:

Valenz
12802 Tampa Oak Boulevard, Suite 330
Tampa, FL 33637
Phone: (877) 608-2200
Fax: (813) 514-0607

Post-service Claims Appeals Submission Process

Post-service claims **must be made in writing**. To file any appeal in writing it must be addressed as follows:

Sana Benefits, Inc.
PO Box 660675 #35777
Dallas, TX 75266-0675
Fax: (833) 694-1505

Pharmacy Appeals Submission Process

Pharmacy appeals must be submitted to SmithRx (see "Prescription Drug Benefits" section).

Appeals Notification

For urgent pre-service and concurrent claims, Valenz (Sana's utilization management partner) will make a determination as soon as possible and within 72 hours after receipt of the appeal. For non-urgent pre-service, concurrent, and post-service claims, Sana and Valenz will review and make a determination within a reasonable time and within 60 calendar days upon receiving a written appeal. Notifications are sent to the mailing address or the fax number on file at the time of determination.

Pre-Certification and Utilization Management

Sana partners with Valenz for all utilization management aspects, including and especially medical reviews for pre-certification. Valenz is an Utilization Review Accreditation Commission (URAC) accredited organization. This section outlines which services require pre-certification as well as how to initiate the pre-certification process.

Services Requiring Pre-Certification

- Inpatient hospitalization.
- Outpatient Surgery performed in a Hospital or Ambulatory Surgery Center
- Outpatient Hospice
- Intensive Outpatient Substance Abuse
- Home Health Care
- Occupational Therapy
- Speech Therapy
- Cardiac Rehab
- Respiratory Therapy
- CT Scan
- MRI
- MRA
- PET Scan
- Bone Scan
- Pain Management Epidural Steroid Injections
- Pain Management Radiofrequency Ablation or Rhizotomy
- Pain Management Trigger Point or Facet Injections
- Arteriograms & Angiograms of other than Heart
- Dialysis
- Infusion Therapy (excluding antibiotic infusion therapy)
- Specialty Injectable Medications
- Durable Medical Equipment, rental greater than two months, or purchase in excess of one thousand dollars ($1,000) billed per date of service
- In-Vitro Fertilization (IVF)
- Mental Health Services that are performed at a Residential Treatment Facility, under Partial Hospitalization, or in an intensive outpatient setting.
- Radiation Therapy
- Participation in an Approved Clinical Trial

Sana will automatically pre-certify a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours for a cesarean delivery. Stays beyond that require pre-certification.

NOTE: Pre-certification approval does not verify eligibility nor does it guarantee benefit payments from Sana.

Pre-Certification Procedures for Hospital Admission

Urgent Care or Emergency Admissions

Sana does not require prior approval for medical services provided in response to an emergency situation or urgent care scenario. If a member must be admitted on an emergency basis, the provider

should follow these instructions carefully and contact the pre-certification department as follows:

1. For emergency admissions after business hours on Friday, on a weekend or over a holiday weekend, a call to the pre-certification department must be made within 72 hours after the admission date, but no later than the first business day following the emergency admission, by or on behalf of the covered patient.
2. For emergency admissions on a weekday, a call to the pre-certification department must be made within 24 hours after the admission date, by or on behalf of the covered patient.

While prior approval is not required, Sana reserves the right to request additional information prior to the adjudication of a submitted claim.

Non-Emergency Admissions

Inpatient hospital stays scheduled in advance require pre-certification as soon as possible and prior to services being rendered. Once a pre-certification request is received, it will be routed to an appropriate review specialist who will create an online patient file. The review specialist will contact the attending physician to obtain information and to discuss the specifics of the admission request. If appropriate, alternative care will be explored with the physician.

If, after assessing procedure necessity, the need for an inpatient confinement is confirmed, the review specialist will determine the intensity of management required and will remain in contact with the physician or hospital during the confinement.

If, at any time during the review process, medical necessity cannot be validated, the review specialist will refer the episode to a board certified physician advisor who will immediately contact the attending physician to negotiate an appropriate treatment plan. At the end of the hospital confinement, the review specialist is also available to assist with discharge planning and will work closely with the attending physician and hospital to ensure medically appropriate arrangements are made.

In any instance, failure to obtain appropriate pre-certification will result in a claim denial or may result in a reduction of payment.

Initiating Pre-Certification

To request pre-certification for an upcoming procedure, please call Valenz at (877) 608-2200.

Additional Valenz contact information can be found below:

Valenz
12802 Tampa Oak Boulevard, Suite 330
Tampa, FL 33637
Phone: (877) 608-2200
Fax: (813) 514-0607
Email: carecustomerservice@valenzhealth.com

Prescription Drug Benefits

Sana partners with SmithRx, a pharmacy benefit manager, to administer drug coverage to all plans. SmithRx is responsible for providing a nationwide network of participating pharmacies as well as a drug formulary. In addition, SmithRx manages the drug formulary and all aspects of the outpatient prescription drug benefit including adjudication, utilization management, and appeals. This section outlines the formulary as well as SmithRx contact information.

Drug Formulary

SmithRx is responsible for building and maintaining the drug formulary. As part of this process the SmithRx pharmacy and therapeutics committee makes decisions on medication coverage and coverage requirements after meeting on a bi-monthly basis to review existing medications and new medications to market.

As such, the formulary is often subject to change. You should always refer to the formulary or contact the SmithRx team prior to prescribing a medication to a patient to ensure current coverage status of a drug.

A copy of the formulary can be accessed **here**.

The presence of a drug on this formulary does not guarantee coverage and the drugs listed on the formulary are subject to change.

Contact Information

SmithRx can be contacted to confirm patient eligibility, pharmacy benefits, and formulary coverage. In addition, they can also be contacted for all items related to the medical management and appeals processes for drug coverage.

SmithRx
PO Box 994
Lehi, UT 84043
Phone: (844) 454-5201
Fax: (866) 642-5620
Website: www.mysmithrx.com

Provider Network Access & Reimbursement Rates

Sana offers all-access PPO Plus and PPO Plus HSA health plans. Sana members are not restricted by a network and can see any provider of their choice without impacting their cost-sharing. We do not require members to designate a specific PCP, require referrals to see a specialist, or penalize members for receiving care from non-contracted providers.

Providers who are contracted with Sana are listed in our provider directory, which is accessible to all Sana members and dependents through our member portal.

Licenses and Credentialing

Contracted Providers

A contracted provider and each of its employees, contractors, and agents have and shall maintain current, valid, and unrestricted professional licenses and certifications, and satisfy Sana's credentialing requirements. Credentialing may be performed by Sana or a delegated vendor. A contracted provider shall notify Sana within 48 hours if the provider or any of the provider's employees, contractors, or agents have a license or certification that becomes suspended, limited or terminated, or excluded under a federal and/or other government program. A provider shall not permit any employee of the provider to provide services to Sana members should such employee fail to obtain or maintain credentials.

Non-Contracted Providers

A non-contracted provider who delivers covered services to Sana members, and each of its employees, contractors, and agents, are expected to have and maintain current, valid and unrestricted professional licenses and certifications.

Provider Reimbursement

At Sana our goal is to create a financial relationship with the providers we work with that is fair and transparent. That is why we strive to reimburse providers using Fair-Value Reimbursement, paying a set percentage over Medicare's reimbursement schedule.

Contracted Providers

Contracted providers are reimbursed based on the terms of the fee schedule attached to their Provider Services Agreement.

Non-Contracted Providers

All reimbursements are based on a percentage over the current CMS Medicare pricing for both professional/ancillary and facility services. This is not in any way affiliated with Medicare or Medicare Advantage, the CMS data is simply used for a pricing benchmark.

- For medical-service codes for which Medicare does not create a payable allowed amount (e.g., wellness codes, pediatric codes and ob/gyn codes), a “Medicare Equivalency Code” derived from RBRVS-RVU tables will be used, multiplied by the agreed upon percentage rate.
- Please refer to the fee schedule in your Provider Services Agreement for complete information on reimbursement rates.

Questions? Contact Us.

We’re so glad to have you in our provider community and we look forward to working with you! If you have questions, we’d love to hear from you!

You can reach us via email at **hello@sanabenefits.com**, online chat at **sanabenefits.com/healthcare-providers**, or phone at **(833) 726-2123** Monday through Friday, 7:00 AM to 7:00 PM Central Standard time.