Alliance Select

Provider
Administrative
Manual

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Introduction

This Provider Manual describes the important provisions of the Alliance Select health care benefit plan (the "Plan") provided to the associates of the Health Alliance of Greater Cincinnati (the "Health Alliance") and their eligible dependents. The Alliance Select Plan provides partial or full coverage for specific health care services as detailed in the Plan Benefits section. The Plan does not promise to cover every service that is health-related. The Plan Benefits section indicates what the Plan will cover and provides a partial list of some of the services not covered by the Plan. Services not listed explicitly as Covered Services are not covered by the Plan and are the responsibility of the individual. The Health Alliance and Alliance Partners reserve the right to change policies, procedures, and benefit coverage stated in this Manual. This document will reflect those changes and may be viewed on our website at www.Alliance-Partners.net.

Telephone Directory: Alliance Partners (Plan Administrator)

Key Personnel

James J Peters, CEO, Alliance Partners	513-585-7918
Roy Jacobson, M.D., Medical Director, Alliance Partners	513-585-8676

Network Services / Provider Relations

David Hammons, Network Services Representative	513-585-7115
Pat Van Over, Network Services Representative	513-585-7910
Kelly Spaulding, Adm. Provider Contracting	513-585-7913

Claims and Customer Service

Customer Service Line **513-585-6699**

Rod Taylor, Supervisor Claims Administration	513-585-7893
Angela Pavlovski, Manager Customer Service	513-585-7887

Credentialing

General Inquiry Line **513-585-7999**

Cindy Scheets, CPMSM, CPCS, Manager of Credentialing Services	513-585-7896

Medical Management

Pre-Certification/Pre-Authorization Line **513-585-7900**

Karen Braun, R.N., Manager of Medical Management	513-585-7925
Tracy Atkins, Health Service Coordinator	513-585-7885

Understanding the Alliance Select Network

The Plan has contracted with a Network of health care Providers to provide services to Alliance Select Members. The benefits provided by the Plan depend on whether services are provided by contracted Network Providers or not, and whether services were ordered by a Network physician or not. Please refer to the "Summary Table of Benefits" section for details.

There are no Network restrictions for Medically Necessary Emergency Care. Members are encouraged to use Health Alliance hospitals for Emergency Care whenever possible.

A Provider Directory of the Alliance Select Network can be obtained from the Alliance Partners Internet website at *www.Alliance-Partners.net*.

Please note that it is the member's responsibility to determine whether a Provider is in the Plan's Network or not before using that Provider's services. A referral or scheduling of services by a Network physician does not constitute approval by the Plan for Out-of-Network services.

There are three reasons why the Plan limits coverage of services to a Network of Providers (except for Medically Necessary Emergency Care). First, the Plan establishes the credentials of Network Providers thereby helping to ensure that Members receive high-quality services. Second, the Plan *contracts* with Network Providers thereby ensuring that those Providers will comply with the Plan's policies and procedures. Many of these policies protect Members. For example, Network Providers are prohibited from billing Members for Covered Services other than the Co-insurance, Co-payments or Deductibles allowed under the Plan. Third, contracted Providers often have agreed to offer services to the Plan at a *discount*. This reduces the overall cost of services thereby making the Plan more affordable for associates.

The Alliance Select Network includes many of the region's best physicians and hospitals. The Plan offers tiered benefit levels that encourage members to choose an Alliance Hospital facility for medical services that it can provide. The tiers are outlined on the following page. The Network also includes a nationally recognized academic health center (the University of Cincinnati College of Medicine and its affiliated institutions). Occasionally, a Member may need services that are not available in the Plan's Network. Coverage of Out-of-Network services at In-Network benefit levels may be provided at the Plan's option but only if such services meet the criteria for coverage of Out-of-Network Services and are approved by the Plan in advance.

GENERAL INFORMATION

Alliance Select Hospital Panel

Tier 1 Benefits – Plan pays at 100%

- University Hospital
- Jewish Hospital
- Ft. Hamilton Hospital
- Drake Center
- West Chester Medical Center

Tier 2 Benefits – Plan pays at 90%

- University Pointe Ambulatory Surgical Hospital
- Cincinnati Children's Hospital Medical Center
- Children's Hospital of Dayton
- St. Elizabeth – OB/GYN and Pediatric services **ONLY**
- St. Luke Hospitals – OB/GYN and Pediatric services **ONLY**
- Good Samaritan – OB/GYN services **ONLY**
- Bethesda North – OB/GYN services **ONLY**

Tier 3 Benefits – Plan pays at 80%

- St. Luke Hospitals – all other services not listed in Tier 2
- St. Elizabeth Hospital – all other services not listed in Tier 2

Tier 4 Out-Of-Network Benefits – Plan pays at 60% of contracted or network rate AFTER Deductible

- The Christ Hospital
- Mercy Health Partners
- TriHealth Hospitals – All other services not listed in Tier 2

Professional reimbursement for network providers is not impacted by hospital tiers. Please refer to the provider directory for a listing of network providers available at www.alliance-partners.net. .

Criteria for Coverage of Out-of-Network Services

Criteria used by the Plan when evaluating requests for Coverage of Out-of-Network care at In-Network benefit levels are as follow:

Criteria for Coverage of Out-of-Network Services
1.The care or service needed is a Covered Service.
2.The care or services needed are not available within the Network.
3.The Out-of-Network physician or hospital to which the Member has been referred has the special expertise, not available in the Network, to perform the needed care or services.
4.A recommendation documenting the first two criteria is received from a Network specialist in the field most relevant to the Member's condition.
5.The Plan has an opportunity *in advance* to determine what its costs will be and to negotiate appropriate payment terms with the Out-of-Network Provider(s). The Plan reserves the right to select the most cost effective method of providing Out-of-Network care.

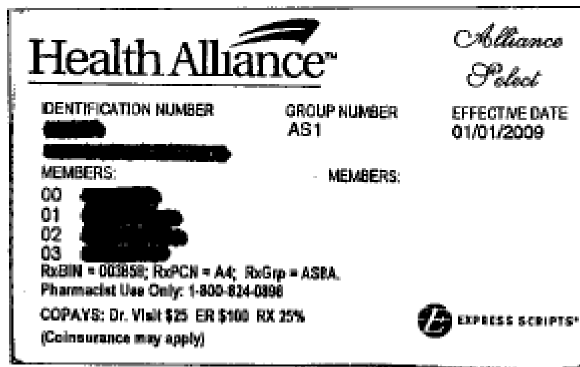
Please note that a referral by a Network physician for Out-of-Network services does not constitute approval for coverage of Out-of-Network care at In-Network benefit levels by the Plan. To receive benefits for Out-of-Network care at the In-Network benefit levels, Pre-authorization for Out-of-Network care other than Medically Necessary Emergency Care must be sought from and approved by the Plan in advance.

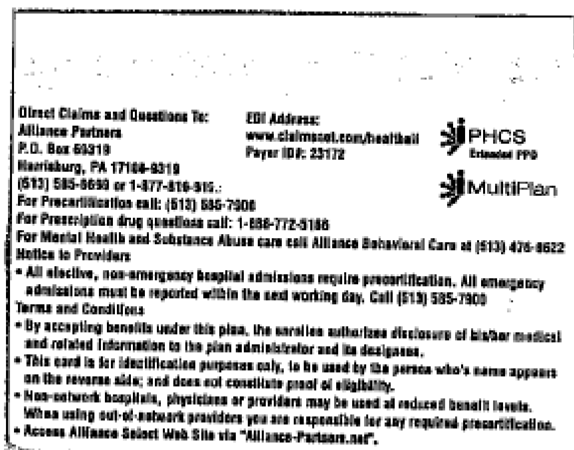
Primary Care Physicians (PCP)

Members enrolled in the Alliance Select Plan should select a Primary Care Physician (PCP) who is a part of the Alliance Select Network. A PCP is a family practitioner, general internist, or general pediatrician designated as a PCP by the Plan. The member should notify the Plan Administrator if they want to change their PCP. Changes will become effective immediately upon notification to the Plan**.** Members are encouraged to contact their PCP whenever they have a medical problem or need medical services so that he/she may provide general care as well as act as an advisor when members are in need of Emergency Care, Urgent Care, or in need of care from a Network specialist. Referrals from the PCP are not required to obtain care from a Network specialist, however the PCP can provide guidance and recommendations on a treatment plan that best suits the member's needs.

Member Identification Card

Members will receive an identification card that indicates they are enrolled in the Health Alliance medical plan. Members will present their identification card whenever they use services covered by the Plan, especially after receiving a new or updated card and when they see a provider for the first time. It is recommended that you keep a copy of the member's card on file. A "sample" of the Alliance Select card is provided below:





Administrators

The Administrators keep the records for the Plan and are responsible for the administration of the Plan. The Administrators will also answer any questions you may have about their specific areas of the Plan or offer any additional information you may need.

Employer, Plan Administrator and Plan Sponsor Information:
The Health Alliance of Greater Cincinnati
3200 Burnet Avenue
Cincinnati, OH 45229
31-1435820

Medical Plan Information and Customer Service:
Alliance Partners
3120 Burnet Avenue, Ste. 203
Cincinnati, OH 45229
513-585-6699 or 1-877-819-9199

Medical Claims Administrator:
Alliance Partners (in care of Amisys Synertech Inc.)
P. O. Box 69319
Harrisburg, PA 17106-9319
513-585-6699 or 1-877-819-9199

Medical Management Administrator:
Alliance Partners
Medical Management
(Noted as Pre-certification or Pre-authorization on the medical ID card)
3120 Burnet Avenue, Ste. 203
Cincinnati, OH 45229
513-585-7900

Pharmacy Claims Administrator Information:
Express Scripts, Inc.
P.O. Box 390873
Bloomington, MN 55439-0873
1-800-451-6245 or TDD 1-800-899-2114
Customer Service Number 1-888-772-5166
MD & Pharmacist Use Only 1-800-824-0898

CuraScript Specialty Pharmacy
1-866-848-9870

COBRA Claims Administrator:
Benefit Concepts, Inc.
20 Risho Avenue
E. Providence, RI 02914
1-800-929-2009 or 1-401-438-7100

Alliance Partners™
www.alliance-partners.net

Alliance Select Quick Reference Guide
January 2009

Provider Relations:
Pat Van Over: 513-585-7910
David Hammons: 513-585-7115

Claims:
Claims Inquiry: www.alliance-partners.net
and 513-585-6699 or 1-877-819-9199

Timely Filing: 180 days

EDI Vendor: ClaimsNet
Payer ID = 23172

Paper claims should be mailed to
PO Box 69319
Harrisburg, PA 17106-9319

Medical Management:
For Precertification or Prior Authorization
Call 513-585-7900

Mail Provider or Member appeals to
Alliance Partners
Member Appeal Coordinator
P.O. Box 19100
Cincinnati, OH 45219

For Urgent Appeals, fax to 513-585-7629

Eligibility Verification:
www.alliance-partners.net
and 513-585-6699 or 1-877-819-9199

Services That Require Pre-Authorization
Health Services
Ambulance transportation (non-emergency)
Blepharoplasty (eye lid surgery)
Breast implant removal or revision
Dental-related anesthesia and hospital services
Dental care related to accidents/medical conditions
EECP Therapy
Experimental or Investigational tests/treatments
Genetic Testing
Home infusion/injection services
Hyperbaric oxygen therapy
IDET Therapy
Keloid removal/Scar revision surgery
Neuropsychological testing
Oral and oro-maxilofacial surgical procedures
Out-of-Network services with Coverage at In-Network benefit levels
Pain control programs and services
PET scans
Penile prosthesis surgery
Plantar fasciotomy/fasciectomy/heel spur surgery
RAST testing (allergies)
Retisert™ (fluocinolone acetonide intravitreal implant)
Septoplasty surgery
TMJ procedures (devices are not covered)
Transplants, solid organ and bone marrow
Varicose vein surgery and procedures
Voice therapy
Weight loss surgical procedures
Wound therapy programs and clinics
Supplies and Equipment
Bone growth stimulators
Durable medical equipment purchases > $500
Durable medical equipment rentals
Neuromuscular stimulator devices
Oxygen
Prosthetic device purchases greater than $500
Prescription Drugs and Injectables
Botox
Enteral and parenteral feeding solutions
Growth hormone
Interferons
Certain specific prescription medications as determined by the Plan
Palivizumab (Synagis) and RSV immune globulin
Retin A for Members over age 25
Facility Notifications
Home Health Care Services
Hospice Care (Inpatient and Outpatient)
Inpatient Admissions (including OB)
Rehabilitation Admissions
Skilled Nursing Facility Admissions

Plan Funding and Administration

The Alliance Select Plan is self-insured by the Health Alliance. In other words, the Health Alliance pays all medical expenses covered by the Plan. Plan expenses are paid in part from Health Alliance's operating revenues and in part by required associate contributions.

As a self-insured Plan, the Health Alliance has responsibility for the policies of the Plan in accordance with federal regulations. The Health Alliance has delegated authority for day-to-day management of the Plan to a Plan Administrator. The Plan Administrator is responsible for processing medical claims for payment as well as providing medical management and customer services to Members. If Members disagree with payment or coverage determinations made by the Plan, they may appeal those determinations using the process described in this section.

Member Eligibility and Benefits

When a member enters your office, it is important for you to know if the member is currently eligible for coverage, if the member's benefits package will cover the services provided or prescribed, if the member is responsible for paying a co-payment at the time of service and if the member has other coverage and, if so, which carrier is primary and which is secondary. While it is not necessary for you to be familiar with the specifics of the benefit plan, knowing these four items of information can save you time and inconvenience, since a member's eligibility and benefits package affects reimbursement for services the member receives.

To inquire about a member's eligibility and benefits, you can call the customer service department at the number listed on the member's ID card or refer to the Plan Administration Telephone Directory. When calling, tell the customer service representative the reason for your call, the member's full name, member's identification number, and the services or procedure the member will receive.

Alliance Partners Website

Member eligibility, as well as claims status, can also be verified via the Alliance Partners website at www.alliance-partners.net. To utilize the website, please contact your provider network representative in order to register and receive your password. One password is assigned to each provider group.

Co-payments and Co-Insurance

Alliance Select members are required to pay an office visit co-pay, with the amount due indicated on the member's identification card. Office visit co-payments are only collected when a physician bills for an office visit. A co-payment should not be collected for services performed in the offices that do not include a physician visit (i.e. allergy injections or immunization).

A co-insurance of 10% (the Plan pays 90%, the member pays 10%) applies to non-office visit physicians' fees, imaging services, physical or other therapies, etc. A co-insurance of 20% (the

Plan pays 80%, the member pays 20%) applies for durable medical equipment and prosthetics. The coinsurance amount for inpatient and outpatient hospital charges varies according to the benefit level tier of the specific hospital as outlined on page 7.

Medical Claim Submission

When you provide Covered Services, a claim must be filed to obtain payment. A claim form must be submitted to the Plan's Claims Administrator at the address that is indicated on the back of the member's insurance card. Claims may also be submitted electronically. Claims must be submitted within 180 days of the date Covered Services are rendered and must include sufficient data to determine what benefits are covered by the Plan. Claims first submitted more than 180 days after the date of the Covered Service may be denied for lack of timely filing.

Electronic Claims Submission

Alliance Partners accepts electronic claims submission from medical providers. We accept these claims via ClaimsNet. Our payer ID # for the Alliance Select Plan is 23172.

Provider Remittance Advice

A sample copy of the Alliance Select provider remittance is included within this Manual (**Attachment A**). This remittance is standard in that it provides claims processing detail to you sorted by specific provider and then member. An overview of the columns and fields on the remit is as follows:
Status: The claim status will indicate Paid, Denied or Reversed. Denied and Reversed claims should contain messages that indicate the reason for the denial or reversal.

Patient #: Represents the provider patient account number submitted on original claim.

Amt Billed: Amount billed on each claim line, and on the total claim.

Not Allowed (Ineligible): Amount not covered on the claim billing.

Contract Paid (Contract Amount): The contractual allowable fee for each line and claim

Patient Portion (Deductions): Patient payment responsibility (Co-payment, Co-insurance, Deductible, Non-covered, etc.).

Benefit Amt: Amount payable under the plan benefit (Contract Paid less Patient Portion).
Other Disc- When COB is applied this field contains the amount paid by the primary payor

Refund Amount: Generally reflects an internal system adjustment to facilitate a claim to be reversed when performing an adjustment to a prior claim. The "refund" amount generally cancels out the reversal to ensure that the Amount Paid is correct.

Amount Paid: The amount paid on each line or claim.

Disbursement of Funds by Check Number: Summary Recap of items on the claims detail of the RA. Summary descriptions different from the claim detail field descriptions are provided in parenthesis above as a cross-reference to the claims detail field description.

COB applied: Indicates the benefit amount determined as secondary payor when COB is applied

Amount Advanced: Reflects a credit due back to the plan from an over payment on a previous claim. This amount offsets claims paid on current RA.

Billing, Coding & Reimbursement Guidelines

Alliance Partners utilizes industry standard guidelines when constructing its reimbursement levels for our providers. Examples of this reimbursement structure are:

Anesthesia Unit Calculation:

Anesthesia is calculated based on the standard "base and time" unit calculation. Each unit equals 15 minutes of Anesthesia time, however when partial units are billed (time units of less than 15 minutes) we use a different method of reimbursement. Any unit of time between 1 and 7 minutes billed on an Anesthesia claim will be reimbursed at 50% of the current per unit Anesthesia rate. Time from 8 minutes up to 15 minutes is reimbursed at 100% of the current per unit Anesthesia rate. Anesthesia codes are based on the American Society of Anesthesiology coding guidelines. Base units are assigned based on the current standards of this organization when calculating allowable fees.

New CPT Codes:

Each year Medicare releases new CPT codes. Alliance Select will allow reimbursement for these codes effective January 1st of the year in which the new code is effective per CMS.

CPT and HCPCS Reimbursement:

Allowable reimbursement fees for these codes are generally built utilizing a percentage of the Medicare allowable fees for the State of Ohio. Medicare and CMS standards are also used for global surgery periods and other related guidelines as well.

Drug/J-Code Reimbursement:

Injections and other drug related procedures billed to the medical insurance are priced utilizing a percentage of the State of Ohio's Medicare Allowable Fee or a percentage of the Average Wholesale Price based on current year guidelines from First Data Bank.

Other reimbursement methodologies may be created based on specific contracting needs and definitions.

Claims Information

Claims Edits:
Alliance Partners utilizes industry standards in claims adjudication during its claims payment process. Edits are used to identify cases of fragmented billing, code unbundling, and other types of billing issues. When a claim is edited and services are denied or paid at a level other than the "standard" method, a Denial Code will be evident on the Provider Remittance Advice as such.

Any denial to the provider for "re-bundling" type issues are not billable to the member and are seen as inclusive in the services that Alliance Partners is reimbursing on the same claim.

Other Reimbursement Guidelines:
Multiple Procedure Billing – When a claim is submitted and procedures are submitted with a "multiple procedure" modifier (51) the primary procedure will be paid at 100% of the allowable fee. Each additional procedure will be paid at 50% of the allowable fee.

Maternity Global Services – During the course of a normal pregnancy case the physician will have all of their services beyond the initial visit denied as part of the Global Pregnancy Period. The entire global fee for the pregnancy will be paid to the provider after the delivery. These denied services for a global period are not billable to the member.

Assistant Surgeon – If services are billed with an Assistant Surgeon modifier (80) they will be paid at 20% of the standard allowable rate for that service.

Pathology/Specimen Handling - Specimen handling charges are payable only when a claim does not include charges for a pap smear. If Pap smear services are charged then the specimen handling charges will be denied and cannot be billed to the member.

Miscellaneous charges – Other costs associated with rendering medical services to members are typically not covered as additional expenses. These would be charges such as supplies used, surgical tray charges, casting material, etc. These services generally are considered part of the larger service being performed and therefore are being reimbursed when paid for that service.

Provider Responsibility on Non-Covered Services:
Messages are generally provided on the RA that describe reasons for non-coverage and if the remaining balance is a Provider responsibility that cannot be billed to the member.

Payment Determinations on Initial Claims

The Plan endeavors to provide quick processing of all health insurance Claims. There are two types of Claims that may be filed under the Plan: Pre-service Claims and Post-service Claims. A Pre-service Claim is a request for benefits prior to receipt of treatment or a Pre-authorization request as required under the Plan (see the Pre-authorization section of the Plan for benefits requiring Pre-authorization). A Post-service Claim is a Claim for benefits after the treatment has already been rendered. As illustrated below, Pre-service Claims and Post-service Claims are treated differently by the Plan. Moreover, the Plan will treat Pre-service Claims differently based upon whether the Claim is an Urgent Care Claim. For purposes of this manual, an Urgent Care Pre-service Claim is any Claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim.

Determinations of Urgent Care Pre-service Claims will be made by the Plan/Claims Administrator as soon as possible, taking into account the medical necessity, and notification of such determination shall be given to the Member not later than 72 hours from the time the Urgent Care Pre-service Claim is received unless the Member failed to provide sufficient information in order for the Claims Administrator to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Plan/Claims Administrator shall notify the claimant as soon as possible, but not later than 24 hours after receipt of the Claim, of the specific information necessary to complete the Claim. The claimant will be given 48 hours after receipt of the notice to provide the requested information. Within 48 hours of its receipt of the requested information, the Plan/Claims Administrator shall notify the claimant of its determination. If the claimant fails to timely provide the requested information, the Plan/Claims Administrator will notify the claimant of its determination within 48 hours after the expiration of the time to provide the information.

If a claimant files an Urgent Care Pre-service Claim improperly, the Plan/Claims Administrator will notify the claimant of the improper filing and how to correct it as soon as possible (but not later than 24 hours) after the failure is discovered. This notice may be oral, unless the claimant requests written notification.

Non-urgent care Pre-service Claims will be determined by the Plan/Claims Administrator within a reasonable period of time appropriate to the medical circumstances, and notification of such determination shall be given to the Member not later than 15 days from the time the non-urgent care Pre-service Claim is received. This 15-day period may be extended if the Plan/Claims Administrator determines that the extension is necessary due to matters beyond the control of the Plan and properly notifies the Member of such extension prior to the expiration of the initial 15-day period. The extension notice shall include the circumstances requiring the extension and the expected date of the determination. If the extension is requested because of the need for additional information, the Plan/Claims Administrator will notify the claimant of the needed information within the initial 15-day period and pend the Claim until the information is received. The claimant will be given 45 days after receipt of the notice to provide the requested

information. Within 15 days of its receipt of the requested information, the Plan/Claims Administrator shall notify the claimant of its determination. If the claimant fails to timely provide the requested information, the Plan/Claims Administrator will notify the claimant of its determination within 15 days after the expiration of the time to provide the information.

If the claimant files a non-urgent care Pre-service Claim improperly, the Plan/Claims Administrator will notify the claimant of the improper filing and how to correct it as soon as possible (but not later than 5 days) after the failure is discovered. This notice may be oral, unless the claimant requests written notification.

If a Member has already received approval for a course of treatment to be provided over a specified number of treatments or a specified period of time, any cutback in that course of treatment is considered under these rules as an adverse benefit determination entitling the Member to utilize the Plan's appeals procedures outlined below. Any such denial will be done sufficiently in advance of the cutback to allow the Member to appeal and obtain a determination on review before the benefit is reduced.

If a Member has already received approval for a course of treatment and the Member desires to extend the treatment beyond the treatment already approved, such extension will be treated as a new Claim, but the Plan shall notify the Member of its determination regarding Urgent Care benefits as soon as possible, taking into account the medical necessity, not later than 24 hours after receipt of the request. However, if a request for extended treatment involving Urgent Care is not made at least 24 hours prior to the end of the already approved treatment, the request will instead be treated as an Urgent Care Claim, as discussed above.

Post-service Claims will be determined by the Plan/Claims Administrator within a reasonable period of time, and notification of such determination shall be given to the Member not later than 30 days after receipt of the Claim. The Plan may extend this 30-day period by 15 days if the Plan/Claims Administrator determines that the extension is necessary due to matters beyond the control of the Plan and properly notifies the Member of the extension prior to the expiration of the initial 30-day period. The extension notice shall include the circumstances requiring the extension and the expected date of the determination. If the extension is requested because of the need for additional information, the Plan/Claims Administrator will notify the claimant of the needed information within the initial 30-day period and pend the Claim until the information is received. The claimant will be given 45 days after receipt of the notice to provide the requested information. Within 15 days of its receipt of the requested information, the Plan/Claims Administrator shall notify the claimant of its determination. If the claimant fails to timely provide the requested information, the Plan/Claims Administrator will notify the claimant of its determination within 15 days after the expiration of the time to provide the information.

If your Claim is denied by the Plan/Claims Administrator, the denial notice will provide:

- the specific reason(s) for the denial, and, if applicable, either the specific internal rule, guideline, protocol or other similar criterion (if any) relied upon in making the denial, or a statement that the rule, guideline, protocol or other similar criterion that was relied upon in making the denial and that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge upon request;
- references to the part of the Plan on which the denial is based;

- a description of any additional material or information necessary for you to perfect your Claim and an explanation why such material or information is necessary;
- appropriate information as to the steps to be taken if you desire to appeal the denial, including notice of applicable time limits, and a statement regarding your right to bring suit under Section 502(a) of ERISA following an adverse benefit determination on review;
- if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for such denial that applies the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and a description of the expedited review process for Urgent Care Pre-service Claims.

The Plan/Claims Administrator may orally provide you the above information if your Urgent Care Pre-service Claim is denied if written notification is subsequently furnished to you not later than 3 days after the oral notification.

Appeals of Plan Determinations, including Time Limits

If you have a question about benefits, you may contact the Alliance Customer Service Center at the number listed on the back of your insurance card. Most issues can be resolved by the Alliance Customer Service Center and do not require a formal appeal.

If you (or, a Provider) disagree with a benefit determination made by the Plan about coverage, payment or a Pre-authorization request for services, you may request a formal Plan Review ("Plan Review") within 180 days after you receive notification of an adverse benefit determination. Requests received after 180 days will not be considered. All requests should be made in writing to the Plan Administrator; provided, however, that requests regarding Urgent Care Claims may be made orally to the Plan Administrator. Plan Reviews of Pre-service Claims are decided by the Plan's Appeals Committee. Plan Reviews of Post-service Claims are decided by the Medical Director (or, his designee).

If a Plan Review is requested, the claimant shall have the following rights:

- to submit written comments, documents, records and other information relating to the Claim for benefits and for the Plan Review to take into account all submitted materials regardless of whether such materials have already been submitted or considered during the initial benefit determination;
- upon request and free of charge, access to and copies of all documents, records and other information relevant to the Claim for benefits;
- for a Plan Review that does not take into account the initial adverse benefit determination, and that is conducted by an appropriate named fiduciary who is neither the individual who made the initial benefit determination nor the subordinate of such individual;
- if the Claim is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, a health care professional who has the appropriate training and experience in the field of

medicine will be consulted (and that the consulted health care professional will not be an individual who was consulted during the initial benefit determination nor a subordinate of such individual); and

- to obtain the identification of the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

The determination regarding the appeal of a non-urgent care Pre-service Claim or a Post-service Claim shall be communicated to the claimant (and/or relevant Providers, if applicable) within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after the appeal was received. The determination regarding the appeal of an Urgent Care Pre-service Claim shall be communicated to the claimant (and/or relevant Providers, if applicable) as soon as possible, taking into account the medical necessity, but not later than 72 hours after the appeal was received.

In regard to Post-service Claims only, if a claimant disagrees with the Plan Review determination made by the Medical Director (or, his designee) he may appeal that decision to the Plan's Appeals Committee within 180 days after receipt of the denial. Requests received after 180 days will not be considered. All requests should be in writing to the Claims Administrator, who will deliver the claimant's request to the Plan's Appeals Committee. While a Claim is on appeal to the Plan's Appeals Committee, a claimant is entitled to the same rights as during the first appeal. This includes the right to have a person who was not the person who reviewed (or who was a subordinate of the person who reviewed) the initial Claim or the first appeal make a determination on the claimant's latest appeal, and to a review by the Plan's Appeals Committee that provides no deference to any earlier determinations. Additionally, if a claimant's request involves a medical judgment, health care professionals who were not previously consulted and who are not the subordinates of any previously consulted health care professional will be consulted by the Plan's Appeals Committee. The Plan's Appeals Committee's determination shall be communicated to the claimant within a reasonable period of time not to exceed 30 days after the appeal was received.

If your Claim is denied, the denial notice will provide:

- the specific reason(s) for the denial, and, if applicable, either the specific internal rule, guideline, protocol or other similar criterion (if any) relied upon in making the denial, or a statement that the rule, guideline, protocol or other similar criterion that was relied upon in making the denial and that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge upon request;
- references to the part of the Plan on which the denial is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your Claim for benefits;
- a statement of your right to bring an action under Section 502(a) of ERISA after the exhaustion of the Plan's appeal procedures;
- if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for such

denial that applies the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

- for the initial appeal of Post-service Claims only, appropriate information as to the steps to be taken if you desire to appeal the Plan Review's determination to the Plan's Appeals Committee, including notice of applicable time limits.

The Plan Administrator, the Medical Director, the Plan's Appeals Committee, and/or their respective delegates shall have absolute discretion in determining Claims for benefits under the Plan.

Payment of Benefits

Payment will be made directly to a Provider. However, for Out-of-Network claims, payment will be made as assigned on the claim form.

Limitation of Action

No legal action may be taken to recover benefits under the Plan until all appeal procedures contained herein are exhausted or deemed to be exhausted. No such action may be taken later than 3 years after the time limit for filing claims for the covered service.

How Payment is Determined for Health Care Coverage

Payments for Covered Services will be based on the Network Fee Schedule. Members are not responsible for any balance not paid by the Plan as a result of charges in excess of the Network Fee Schedule as long as a contracted Network Provider is used to obtain services.

All payments will be subject to any applicable Deductible, Co-insurance, Co-payments, Maximum Benefits and other provisions and limitations stated in this manual.

Member's Rights to an Itemized Bill

All members have the right to receive a copy of an itemized bill. This bill would identify the services and supplies rendered to them. To receive a copy of the bill, members should send a written request to the Provider from which they have received care.

Coordination of Benefits

All benefits provided as described in this Manual are subject to Coordination of Benefits (COB). COB determines whether a benefit plan is the primary or secondary payor when a Covered Person is covered by more than one benefit plan.

COB affects benefits in the following manner when members are covered by more than one benefit plan:

- When this Plan is primary, payment of benefits will be made without regard to any Other Contract.

- When this Plan is secondary, the payment of benefits may be reduced and will not exceed what would have been allowed had the Plan been primary.

Primary or secondary coverage will be determined by using the first of the following rules that applies:

- Any Other Contract with no COB provision is always primary.
- The benefit plan covering an associate, Member or subscriber (other than a dependent) is primary
- When a dependent is covered by more than one plan of different parents who are not separated or divorced, the coverage of the parent whose birthday falls earlier in the calendar year (known as "the birthday rule") is primary. If both parents have the same birthday, the plan that covered the dependent longer will be primary. If a dependent is covered by two benefit plans and the Other Contract does not have this COB rule, the rule of the Other Contract will determine the primary and secondary contract. If the parents are separated or divorced, the following rules apply:
    1) If a court decree specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent is primary
    2) If the parent with custody has remarried, his or her coverage is primary, the stepparent's is secondary and the coverage of the parent without custody pays last
    3) If the parent with custody has not remarried, his or her coverage is primary
- A plan covers the member as an active employee or a dependent of such employee and the Other Contract covers the member as a laid-off or retired employee or as a dependent of such person, the plan that covers the member as an active employee or dependent of such employee is primary
- When the rules above do not apply, the plan that has covered the member longer is primary.

Coordination of Benefits Process

1. If the Plan is not the primary carrier, claims may be submitted simultaneously to both payers, or the physician may hold the Select claims until payment from the primary carrier has been received. At that time, the Explanation of Benefits (EOB) and claim should be submitted to the Plan's Administrator.
2. Upon receipt of the EOB and claim, the Plan will pay the lesser of the participating provider's usual fee or the amount specified in the maximum allowable schedule in accordance with the Plan's benefit.
3. Payment will be reduced by the amount paid by the other carrier

Medicare – For Employed Members and Retirees

Medicare is generally the secondary payor to the Plan for services provided to the following individuals:

1) Associates or spouses of associates who are 65 or older
2) Individuals with permanent kidney failure
3) Certain disabled people.

Associates or Spouses Age 65 or Older – When a Covered Person age 65 years or older is actively working and is eligible for Medicare coverage, the associate must make a choice concerning coverage under the Plan. The associate must elect to either continue to have the Plan remain as the primary payor, or may elect Medicare as the primary payor.

If the associate chooses the Plan as primary, coverage will continue as described in this Manual. Medicare will be considered the secondary payor to the Plan.

If the associate elects Medicare as the primary payor, any charges considered by Medicare to be allowable charges cannot be covered by the Plan. The Plan cannot (by law) coordinate benefits with Medicare or be the secondary payor for any charges that are allowable by Medicare.

Instead, the Covered Person will be responsible for any portion of a Medicare allowable charge that Medicare does not pay. However, for any services that are listed in this Manual as Covered Services, but not covered by Medicare, the Plan will cover such services as described in this Manual.

This section also applies to the spouse of a Covered Person who is age 65 or older. Therefore, the spouse must also make the election between the Plan and Medicare as primary payor.

Covered Persons With Permanent Kidney Failure – It is important for a Covered Person to apply for Medicare immediately following the diagnosis of chronic renal failure since there is a several-month waiting period before it goes into effect. Medicare is the secondary payor if the Covered Person is under age 65 and has Medicare due to permanent kidney failure for a period of 30 months, beginning with the earlier of the following dates:

1) The month in which the Covered Person begins a regular course of renal dialysis; or,
2) The first month in which the Covered Person becomes entitled to Medicare, if he or she receives a kidney transplant without first beginning dialysis.

After a period of up to 30 months following this date, Medicare will become the primary payor. Once Medicare becomes primary, the benefits of the Plan will be applied only to any unpaid balance after the Covered Person receives Medicare benefits. In this event, Medicare benefits available to the Covered Person will be subtracted whether or not a Medicare claim is filed.

Disabled Members – Medicare is the secondary payer for people under age 65 who have Medicare because of a disability (other than those with permanent kidney failure) and who are covered under the Alliance Select Plan. To be eligible under this provision, the associate must be actively working, even if the associate is the disabled Member.

All Other Medicare-Members, Including Grandfathered Retirees Age 65 or Over And Covered Under Alliance Select Plan – For all other Covered Persons eligible for Medicare, benefits are based on a carve-out approach. Under the carve-out approach, any payments received under Medicare will not be considered Covered Services under the Alliance Select Plan. This means that the Alliance Select Plan's Coverage will apply only to the unpaid balance after Medicare payments are received. When the Covered Person (Retiree) is eligible for Medicare, the amount received from Medicare will be subtracted whether or not a Medicare claim is filed. Again, payment made by the Alliance Select Plan will only apply to the amount not Covered by Medicare. The amount Covered by Medicare and the amount Covered by the Alliance Select Plan cannot exceed the amount that would have been paid by the Alliance Select Plan if there is no other insurance, or Medicare, involvement.

Retirees Coordinating Alliance Select Plan with Medicare - When a member is in need of any medical treatment, it is very important that they show their health care provider their Medicare and their Alliance Select Plan insurance cards. With the exception of prescription drug purchases, Medicare pays first on Covered healthcare services and the Alliance Select Plan pays next on amounts not paid by Medicare. Members must be sure to mention this to the health care Provider to lessen the chance for claims to be processed incorrectly and reduce the need to follow-up on inaccurately processed or unpaid claims.

SUMMARY TABLE OF BENEFITS

This section of the Manual is designed to highlight important payment details of the Alliance Select Plan. However, it is important that you read this Manual in its entirety to obtain a comprehensive understanding of the medical plan.

	Alliance Select	
	In-Network	**Out-of-Network**
Type of Plan:	Network-based managed care plan with limited benefits offered for Out-of-Network services.	
Levels of Coverage:	Single, double or family	
Level of Payment (Network Rate)	The Plan's reimbursement amounts are determined by the Health Alliance for payment of Covered Services rendered by Network Providers. Members are responsible for any amounts that exceed the Network Rate when an Out-of-Network provider renders treatment or care.	
Co-insurance:	Co-insurance is the percentage the member must pay on approved covered services. Member is responsible for the percentage amount that is not paid by the Plan. Co-insurance applies toward annual Out-of-Pocket maximums except as listed in the Annual Out-of-Pocket section below.	
Co-payment:	Co-payment (or Co-pay) is a fixed dollar amount the member must pay for each covered service.	
Annual Deductible:	Annual Deductible is the amount of money the member must pay each year on covered medical services before any benefits are provided by the Plan. (Does not apply to prescription drugs.) Applies to all covered Out-of-Network treatment or care.	
	None	Single: $500 Double: $1,000 Family: $2,000
Annual Out-of Pocket Maximum (including Annual Deductible): Note: Out-of-Pocket Maximums do not cross-apply when changing from In-Network to Out-of-Network providers or from Out-of-Network to In-Network providers.	Annual Out-of-Pocket Maximum is the maximum non-covered expense on covered services in which the member is responsible. (See exclusions below.)	
	Single: $3,000 Double: $6,000 Family: $10,000	Single: $6,000 Double: $12,000 Family: $20,000
	Exclusions: Annual Deductible and Co-insurance on Covered Services apply to Annual Out-of-Pocket Maximum except as follows: • Office & Prescription Co-payments or Co-insurance on prescription drugs, durable medical equipment and medical/surgical supplies for home use • Out-of-Pocket expenses above the Network rate or benefit limit • Out-of-Network mental health/substance abuse Co-payments or Co-insurance.	
Pre-authorization or Notification	Physician's responsibility	Member responsibility; required for all hospital admissions
Preexisting Conditions Limitation	There is no preexisting conditions limitation under the Plan	
Lifetime Maximum Benefit	$2 million per person	
See "Mental Health/Substance Abuse Treatment" section for specific requirements and Maximum Benefits		

PLAN BENEFITS

	Alliance Select	
Medical and Surgical Services	**In-Network**	**Out-of-Network**
Hospital – Inpatient: Pre-authorization is required for all hospital admissions.	Plan pays 100% : -University Hospital -Jewish Hospital -Ft. Hamilton Hospital -Drake Center -West Chester Medical Center Plan pays 90% -Childrens-Cincinnati -Childrens-Dayton Plan pays 90%-OB/GYN & Peds -Ste. Elizabeth Hospital -St. Luke Hospital Plan pays 90%-OB/GYN -Good Samaritan Hospital -Bethesda North Hospital Plan pays 80%-non OB/GYN & Peds -St. Elizabeth Hospital -St. Luke Hospital	*Plan pays 60% of Network/Reciprocal Rate -Christ Hospital -Mercy Health Partners -TriHealth Hospital for non OB/GYN & Peds services Plan may pay 90/10 of billed/MultiPlan/neg rates for Emergency Room admissions or based on the pre-authorization.
Surgery Hospital – Outpatient: • Radiation & Chemotherapy • Diagnostic testing including, X-ray, MRI, ultrasounds, EKG, etc. Laboratory testing and pathology services	Plan pays 100% : -University Hospital -Jewish Hospital -Ft. Hamilton Hospital -Drake Center -West Chester Medical Center Plan pays 90% -Univ Pointe Ambul Surgical Hospital -Childrens-Cincinnati -Childrens-Dayton Plan pays 90%-OB/GYN & Peds -Ste. Elizabeth Hospital -St. Luke Hospital Plan pays 90%-OB/GYN -Good Samaritan Hospital -Bethesda North Hospital Plan pays 80%-non OB/GYN & Peds -St. Elizabeth Hospital -St. Luke Hospital	*Plan pays 60% of Network/Reciprocal Rate -Christ Hospital -Mercy Health Partners -TriHealth Hospital for non OB/GYN & Peds services
Emergency Care (Physician Services)	Plan pays 90% of contractual amount.	Plan pays 90% of billed, Multiplan or negotiated rates.
***Annual Deductible must be met before any benefit is paid by the Plan on Out-of-Network Services.**		

	Alliance Select	
Medical and Surgical Services	**In-Network**	**Out-of-Network**
Emergency Care (Facility Services)	$100.00 Copayment, then Plan pays 100% -University Hospital -Jewish Hospital -Ft. Hamilton Hospital -Drake Center -West Chester Medical Center $100.00 Copayment, then Plan pays 90% -Children's-Cincinnati -Childrens's-Dayton -St. Elizabeth Hospital -St. Luke Hospital -Good Samaritan Hospital -Bethesda North Hospital -The Christ Hospital -Mercy Health Partners Copayment waived if patient admitted. Denied if not an emergency.	Plan pays 90% of billed, Multiplan or negotiated rates. Copayment waived if patient admitted. Denied if not an emergency.
Urgent care	$50 copayment, then Plan pays 80% of Network Rate	*Plan pays 60% of Network Rate
Physician Services – Inpatient: • Hospital visits for illness or injury • Surgery • Anesthesia for covered surgery • Maternity or newborn care Physician services – Outpatient: • Radiation & Chemotherapy • Surgery (hospital or office)	Plan pays 90% Plan pays 90%	*Plan pays 60% of Network Rate Plan may pay 90/10 of billed/MultiPlan/negotiated rates for Emergency Room Admissions or based on pre-authorization. *Plan pays 60% of Network Rate
Gastric Bypass and Gastroplasty	Plan pays 60%; Co-insurance does not apply to Out-of-Pocket maximum. Preauthorization Required.	Not covered
Office Visit Insurance/Co-insurance: • Evaluation and Management • Preventative Visit/Care • Laboratory Services • All other covered services for treatment of illness or disease •	$25 Co-payment, then plan pays 100% $25 Co-payment, then plan pays 100% Plan pays 100% Plan pays 90%	*Plan pays 60% of Network Rate Not covered *Plan pays 60% of Network Rate *Plan pays 60% of Network Rate
• Home visits	$25 Co-payment, then Plan pays 100%	Not covered
• Maternity Care	$25 Co-payment on first prenatal visit, then Plan pays 90%	*Plan pays 60% of Network Rate
***Annual Deductible must be met before any benefit is paid by the Plan on Out-of-Network Services.**		

PLAN BENEFITS

	Alliance Select	
• **Medical and Surgical Services**	**In-Network**	**Out-of-Network**
• Physician services – Outpatient skilled nursing facilities: • Routine physical exams • Well baby care	$25 Co-payment, then Plan pays 90% $25 copayment, then plan pays 100% $25 copayment, then plan pays 100%	*Plan pays 60% of Network Rate if approved in advance by Plan Not Covered *Plan pays 60% of network rate for services required under Ohio Revised Code
• Immunizations --General childhood & limited adult coverage	Plan pays 100% (Service is included with office visit Co-payment)	Not covered
Cancer Screening • Evaluation and Management • Testing • Colonoscopy and Sigmoidoscopy • Mammograms	$25 Co-payment, then Plan pays 100% Plan pays 100% Plan pays 100% every 10 years Plan pays 100%	Not covered Not covered Not covered
Allergy • Evaluation and Management • Testing • Injections provided by physician's office	$25 Co-payment, then Plan pays 100% Plan pays 90% Plan pays 90%	*Plan pays 60% of Network Rate *Plan pays 60% of Network Rate *Plan pays 60% of Network Rate
Birth control • Oral contraceptives and DepoProvera • IUD's • Vasectomy/tubal ligation • Elective abortions	Covered under prescription drug benefit; subject to Co-insurance Plan pays 90% $25 Co-payment, then Plan pays 90% Not covered	Covered under prescription drug benefit; subject to Co-insurance Plan pays 60% of Network Rate Not covered Not covered
Vision Care • Physician office visits for diseases of the eye other than the need for corrective lenses • Routine preventative examination/refraction • Glasses/frames/contacts or refraction surgery • All other covered services for treatment of illness or disease	$25 Co-payment, then Plan pays 100% $25 Co-payment, then Plan pays 100% (Limited to one per calendar year) Not covered Plan pays 90%	*Plan pays 60% of Network Rate Not covered Not covered *Plan pays 60% of Network Rate
Dental Dental Services/Oral Surgery	Limited to initial emergency treatment resulting from accidental injury. Claims that qualify are paid at the same benefit level as other regular inpatient, outpatient, or emergency care treatments.	
Dental Anesthesia and Operating Room	Plan pays 90% up to the maximum benefit of $1,000.00 per member per year, ages 12 years and younger	NOT COVERED
Chiropractic Care	$25 Co-payment, then Plan pays 90% (Annual maximum benefit $500)	* Plan pays 60% of Network Rate (Annual maximum benefit $500)
Pain Center Programs	$25 Co-payment, then Plan pays 90% Pre-authorization required.	Not covered
*** Annual Deductible must be met before any benefit is paid by the Plan on Out-of-Network Services**		

	Alliance Select	
Medical and Surgical Services	**In-Network**	**Out-of-Network**
Education/Training • Diabetes education • Other education/training	Limited to 8 hours per calendar year with an annual max of $520.00 Not covered	Not covered Not covered
Human Organ Transplant Limited to: human heart, lung, heart-lung, liver, kidney, bone marrow or pancreas transplants.	Plan pays 100%: -University Hospital -Jewish Hospital -Ft. Hamilton Hospital -Drake Center -West Chester Medical Center Plan pays 90%: -Children's – Cincinnati -Children's – Dayton Limited to 2 attempts per covered member.	Not covered
Physical, Occupational and Speech Therapies • Inpatient treatments	Prior Authorization Required. Plan pays 100%: -University Hospital -Jewish Hospital -Ft. Hamilton Hospital -Drake Center -West Chester Medical Center Plan pays 90%: -Children's – Cincinnati -Children's – Dayton Plan pays 90% - Peds -St. Elizabeth Hospital -St. Luke Hospital Plan pays 80% -St. Elizabeth Hospital -St. Luke Hospital	Prior Authorization Required *Plan pays 60% of Network Rate
• Skilled nursing facility or rehabilitation center	Prior Authorization Required Plan pays 90%	Prior Authorization Required *Plan pays 60% of Network Rate
Outpatient treatments	Plan pays 90% Maximum Benefit of 30 visits per year	*Plan pays 60% of Network Rate
Cardiac Rehabilitation – **Maximum Benefit of 30 visits per year**	Plan pays 90%	*Plan pays 60% of Network Rate
Hospice	Prior Authorization Required Plan pays 90%	Prior Authorization Required *Plan pays 60% of Network Rate
Home Health Care	Prior Authorization Required Plan pays 90%	Prior Authorization Required *Plan pays 60% of Network Rate
***Annual Deductible must be met before any benefit is paid by the Plan on Out-of-Network Services.**		

PLAN BENEFITS

	Alliance Select	
Med/Surg Services	**In-Network**	**Out-of-Network**
Skilled Nursing Facility	Prior Authorization Required Plan pays 90% Maximum Benefit: 100 days per episode.	Prior Authorization Required *60% of Network Rate Maximum Benefit: 100 days per episode.
Infertility Treatment • Office Visit evaluation and management • Office Visit lab testing • All other covered services - office visit, testing and procedures • All other covered services – hospital visit, testing, procedures	$25 Co-payment, then plan pays 100% Plan pays 100% Plan pays 90% Plan pays 100%: -University Hospital -Jewish Hospital -Ft. Hamilton Hospital -Drake Center -West Chester Medical Center $2,500 lifetime maximum for all infertility treatment, excluding prescription drugs. All donor expenses must be paid at the time of treatment by the member or donor, and then submitted to the Plan for reimbursement.	Not covered Not covered Not covered Not covered
Infertility Drugs	Drug coinsurance applies. Lifetime maximum benefit of $2,500.00 – no syringes or non-drug itens covered. All drugs obtained for donor use must be paid at the time of purchase by the member or donor, and then submitted to the Plan for reimbursement.	
Durable Medical Equipment (DME), Prosthetics and Orthotics for outpatient treatment of disease or injury and used as aid for a disability	Plan pays 80% of contracted discounted prices. Prior Authorization is required for purchase costing over $500 and for all equipment rentals. See Explanatory Notes for restrictions regarding long-term or permanent use as aid for member with a disability.	Not covered
Cranial Prosthesis (Wig)	Maximum lifetime benefit of $400	
In-shoe Orthotics	Maximum benefit of $100 per pair every 3-year interval	
Medical and Surgical Supplies for Home Use	Covered items included on the Prescription Drug Formulary are subject to prescription drug Co-insurance. Other approved supply items (oxygen, splints, surgical dressings, etc.) that serve only a medical purpose are covered if acquired from contracted Network suppliers and authorized in advance by the Plan. Plan pays 80% of contracted discounted prices; Member pays 20% of contracted prices. Items usually stocked in the home for general use (adhesive bandages, thermometers, etc.) are not covered.	
Breast Pump	Plan pays up to $300 toward the purchase or rental. Limit of one purchase per lifetime.	
***Annual Deductible must be met before any benefit is paid by the Plan on Out-of-Network Services.**		

	Alliance Select	
Med/Surg Services	**In-Network**	**Out-of-Network**
Ambulance Transportation		
• Emergency ground transportation	$100 Co-payment, then Plan pays 100% up to $300 per episode	
• University Air Care	$100 Co-payment, then Plan pays 90%	
• Transportation from Network facility to another Network facility or transportation from Out-of-Network facility to Network facility	Plan pays 90%. Requires Pre-authorization of transportation arrangements and payments	
Non-emergency transport	Not covered	
***Annual Deductible must be met before any benefit is paid by the Plan on Out-of-Network Services.**		

	Alliance Select
Prescription Drug Benefit	
Insurance card can be used at any Express Scripts network pharmacy or Health Alliance Hospital pharmacy (including the mail order programs) for a 31, 60 or 90 day supply. Coinsurance discounts apply to a 90-day supply.	

Copayment Types	Retail Coinsurance	Mail Order Coinsurance (90 day supply)
Tier 1 – Generic	25%	17%
Minimum	$10.00	$20.00
Maximum	$40.00	$80.00
Tier 2-Formulary	25%	22%
Minimum	$25.00	$60.00
Maximum	$60.00	$165.00
Tier 3-NonFormaulary	50%	50%
Minimum	$50.00	$150.00
Maximum	$100.00	$300.00

*Consult your panel pharmacist to see if a drug you are taking is included on the approved maintenance prescription drug listing.
**A formulary is a list of preferred drugs with prescribing guidelines from which your doctor can select. Non-formulary drugs are not included on the formulary listing.
† Member is responsible for brand name minimum Co-insurance regardless of generic drug unavailability. If a Member receives a brand name drug when a generic is available, the Member is also responsible for the difference in cost between the generic and brand name drug.

Infertility Drugs	Drug Copayment applies. Lifetime maximum benefit of $2,500 – no syringes or non-drug items covered. All drugs obtained for donor use must be paid at the time of purchase by the member or donor, and then submitted to the Plan for reimbursement.
Feeding Solutions/Supplements	Prior Authorization is required. $150.00 per month copay, then Plan pays 100% of Network Rate.

***Annual Deductible must be met before any benefit is paid by the Plan on Out-of-Network Services.**

Mental Health/Substance Abuse Treatment		
Hospital Inpatient All services must be authorized in advance by Alliance Behavioral Care (ABC) or at the time of emergency care. ABC phone # 513-475-8622	Plan pays 90%	*Plan pays 60% of Network Rate Out-of-Network Co-insurance does not apply to the Out-of-Pocket Maximum.
	Annual limit: 30 days	
Hospital Outpatient: Office Visit: • Approved Office Visit • Laboratory Services • All other covered services for treatment of illness or disease Services must be authorized in advance by Alliance Behavioral Care	Plan pays 90% $25 Co-payment, then Plan pays 100% Plan pays 100% Plan pays 90%	*Plan pays 50% of Network Rate *Plan pays 50% of Network Rate *Plan pays 50% of Network Rate *Plan pays 50% of Network Rate
	Annual limit: 30 days	
Lifetime substance abuse limit	1 course treatment for each covered person	
***Annual Deductible must be met before any benefit is paid by the Plan on Out-of-Network Services.**		

EXPLANATORY NOTES

These Explanatory Notes provide an illustration of certain benefits covered by the Plan and a general statement regarding the level of coverage. For more detailed information concerning the level of coverage, Co-payments, Co-insurance, Deductibles, and other charges and costs, you should refer to the "Summary Table of Benefits" section. In addition, the "Summary Table of Benefits" provides important information on benefit amount limits and/or day limits that apply to specific services.

(1) Description of Alliance Select Plan

Alliance Select is a managed care point-of-service plan that provides coverage through Network Providers, but also includes some Out-of-Network coverage. The Out-of-Network feature allows a member to receive some services at reduced levels of payment if they use a provider who is not part of the Alliance Select Network. **Please note that it is the member's responsibility to determine whether a Provider is in the Plan's Network or not before using that Provider's services**.

In order to administer the network feature of the Plan, members are required to choose a network doctor (family practitioner, *general* internist, or for minors, a *general* pediatrician) to serve as their Primary Care Physician (PCP). Members are not required to use their Network PCP or, for that matter, any Network Provider. However, members must choose a Network PCP even if they elect to utilize Out-of-Network services on a regular basis. The PCP is responsible for providing general care as well as to act as an advisor when members are in need of Emergency Care, Urgent Care, or care from a specialist.

Referrals from the member's PCP are not required to obtain care from a Network specialist, but members are strongly encouraged to consult with their PCP before obtaining any specialized care.

Pre-authorizations (a mandatory process for acquiring approval by the Plan) for most Medically Necessary surgical and diagnostic testing procedures are not required; however, Pre-authorizations are required for some services, equipment and drugs. Network providers are aware of services and treatments requiring Pre-authorization and in most cases they will handle this for the members. As a Network physician, discussing the member's treatment plan in advance will help to avoid non-covered and Out-of-Pocket expenses for that member. If the member chooses to use Out-of-Network Providers, they are responsible for all Pre-authorization requirements. If you have questions regarding whether a Pre-authorization is needed, you should contact the Alliance Customer Service Center at the number on the back of the member's insurance card. For more information on Pre-authorizations, see the "special Managed Care Provisions" section of this Manual. Pre-authorization is not a guarantee of benefit payment since all terms and conditions of the Plan apply in determining members' coverage for the procedure, service, supply or charge.

There is no preexisting condition limitation under the Alliance Select Plan. For both Network care and Out-of-Network care, there is a $2,000,000 Lifetime Maximum Benefit.

In-Network Care

When a member uses Network Providers, they do not have to meet an annual Deductible before the Plan begins to pay for covered care. Also, members **are not** responsible for billed charges that exceed the reimbursement amount determined by the Health Alliance for payment of covered services, referred to as the "Network Rate." However, there are some Out-of-Pocket expenses that members will pay for services that are not covered at 100% by the Plan.

- All Covered Services rendered in a hospital or emergency room are paid according to the facilty's Benefit Tier as outlined in the Summary Table of Benefits.. For Emergency services that are provided in an emergency room, members pay an additional $100 Co-payment that is waived if they are immediately admitted to the hospital. The Plan does not pay a benefit when treatment is given in an emergency room for non-emergent care. Urgent care treatment is paid by the Plan at 80% of the Network Rate. Members are responsible for an additional $50 copayment.

- Members pay a Co-payment on most office visits; then the Plan pays 100% on covered evaluation and management services, well care, preventative care, most cancer screenings and laboratory services. All other covered office testing and treatment for an illness, disease or injury are paid by the Plan at 90%. This includes all other diagnostic, therapeutic and surgical procedures. The Plan will not pay charges billed by a provider for both preventive care services and evaluation and management services that occur on the same day. Only the greater amount of the two charges will be reimbursed by the Plan. Members are not responsible for concurrent bill charges by an In-Network Provider.

- Prescription drug benefits may be obtained from retail pharmacies, Health Alliance Hospital pharmacies, and through mail delivery.

- Generally Members pay a 25% co-insurance on covered prescription drugs that are included on the Plan's list of preferred drugs, otherwise known as the "formulary." There is a minimum charge of $10 and maximum charge of $40 per each generic drug. There is a minimum charge of $25 and maximum charge of $60 per each brand name drug. A co-insurance is applied to each monthly dosage (or plan specific limited dosage) of a covered prescription drug. Non-formulary drugs may be purchased at 50% co-insurance (minimum charge of $50 and maximum of $100) for each non-formulary drug. If a Member receives a brand name drug for which there is a generic drug available, the Member will be responsible for the difference in cost between the generic and brand cost. The same dosage limitations apply for non-formulary drugs.

- Additional discounts for members may be available through use of the Health Alliance mail order or Express Scripts Home Delivery programs.

The Plan limits the annual Out-of-Pocket expenses on some Covered Services to $3,000 per Member, limited to $10,000 per family (three or more Members). The annual Out-of-Pocket maximum applies to most in-patient, outpatient and office visit Co-insurance amounts. However, it does not apply to all Co-payments, Co-insurance on prescription drugs, durable medical equipment, medical/surgical supplies for home use and mental health/substance abuse services. Members are responsible for all excluded Out-of-Pocket amounts as well as expenses applied to the annual Out-of-Pocket maximum.

Out-of Network Care

When a member goes Out-of-Network by using the services of Providers who do not participate in the Alliance Select Plan, they are required to pay an annual Deductible amount before the Plan begins to pay a benefit. Each year members pay the first $500 per Member, limited to $2,000 per family (three or more Members) of Covered Services. Members **are** responsible for billed charges that exceed the reimbursement amount determined by the Health Alliance for payment of Covered Services, referred to as the “Network Rate,” as well as any Out-of-Pocket expenses that are not covered at 100% by the Plan.

- All Covered Services rendered in a hospital, Urgent Care center or other outpatient setting are paid by the Plan at 60% of the Network Rate. For Emergency Care provided in an emergency room, the member pays an additional $100 Co-payment that is waived if they are immediately admitted to the hospital. The Plan does not pay a benefit when treatment is given in an emergency room for non-emergent care. If the member is admitted to the hospital as an emergency admission, benefits will be paid as In-Network as long as medical treatment in the Out-of-Network hospital is determined by the Plan to be Medically Necessary and until the Member is stable for transfer to an In-Network facility.

- The Plan pays 60% of the Network Rate on most office visit expenses that are necessary for the evaluation, testing, management, and treatment of a medical condition. This includes diagnostic, therapeutic and surgical procedures. The Plan will not pay charges billed by a provider for both preventive care services and evaluation and management services that occur on the same day. Only the greater amount of the two charges will be reimbursed by the Plan. Members may be responsible for concurrent billing charges by an Out-of-Network Provider. Among other services that are not covered by Out-of-Network Providers, the Plan does not cover most well care, preventative care and cancer screenings. Please refer to the ‘Summary Table of Benefits” for more details on services that are excluded from out-of-Network Coverage.

- If a member purchases prescription drugs that are included on the Plan’s formulary from an Out-of-Network pharmacy, they may submit charges to the Plan for reimbursement. The Plan reimburses the amount that it would have paid if they had purchased the drug from a Network pharmacy. This holds the member responsible for 25% Co-insurance (minimum charge of $10 and maximum of $40 for each generic drug and minimum charge of $25 and maximum charge of $60 for each brand name drug) plus any cost exceeding the Network Rate.

The Plan limits the member's annual Out-of-Pocket expenses on some Out-of-Network Covered Services to $6,000 per Member, limited to $20,000 per family (three or more Members). The annual Out-of-Pocket limit includes the applicable annual Deductible of $500 per Member, limited to $2,000 per family (three or more Members) and applies to most inpatient, outpatient and office visit Co-insurance amounts. However, it does not apply to all Co-payments, Co-insurance on prescription drugs, durable medical equipment, medical/surgical supplies for home use, mental health/substance abuse services and Provider charges that exceed the Network Rate. Members are responsible for all excluded Out-of-Pocket amounts as well as expenses applied to the annual Out-of-Pocket maximum.

(2) Inpatient Hospital Stays – Only inpatient hospital stays at hospitals in the Network are covered by the Plan at the Network rate unless hospitalization occurred as a result of Medically Necessary Emergency Care or was approved by the Plan in advance. Coverage resulting from Medically Necessary Emergency Care inpatient stays at Out-of-Network hospitals will be provided only until the patient, in the judgment of the Plan, is stable enough for transfer to a Network hospital and such transfer has been offered by the Plan. All other Out-of-Network benefits are available only at the Coverage amount stated in the above Explanatory Note and in the in the Summary Table of Benefits. Pre-authorization is required for all scheduled hospital admissions, and notification within 24 hours is required for all emergency admissions.

Special Rights Upon Childbirth. The Plan generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or her newborn's attending Provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not, under federal law, require that a Provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Services covered by this benefit are Medically Necessary services prescribed by the Member's physician and billed by the hospital for the inpatient stay. These services include room and board in a semi-private room, special care units, hospital-provided nursing services, operating and delivery room uses, medications administered in the hospital, care supplies, blood and blood services, diagnostic procedures, radiation therapy, chemotherapy, dialysis, physical therapy, occupational therapy and speech therapy. Please note that selected durable medical equipment (DME) is not covered as part of the inpatient hospital care benefit, but is covered by the Plan's DME benefit if determined by the Plan to be Medically Necessary. Typically, this will be equipment not owned or provided by the hospital that may be used in the hospital but will also be used at home. For more details, see the "Durable Medical Equipment (DME), Prosthetics and Orthotics" Note.

(3) Inpatient Newborn Care – Inpatient newborn care is the hospital care given to an infant from birth to the first discharge of the infant from the hospital to home. Although delivery charges are generally included as part of the mother's bill, all costs associated with the care and treatment of the infant is included on the infant's bill. Medically Necessary care and treatment charges for the infant are covered by the Plan provided the infant meets the eligibility requirements and is added to the Plan within 30 days of birth.

(4) Preventive Examinations, Well-Child Care and Immunization – The Plan covers generally recommended preventive and well-child examinations for individuals aged 18 or less. Preventive and well-child visits in excess of those recommended by the American Academy of Pediatrics are not covered. The Plan will also cover one preventive physical examination by a Network PCP per calendar year for individuals aged 19 and above. The Plan covers one preventive gynecological examination with Pap smear per calendar year when performed by a Network Provider.

Covered immunizations include:

- Generally recommended childhood immunizations to age 18 (DPT, polio, HIB, MMR, varicella, hepatitis B, pneumococcus, meningococcus)
- Tetanus (dT) for children and adults
- Varicella for susceptible adults
- Influenza vaccine and pneumococcus vaccine

Non-covered immunizations include:

- Vaccines related to travel for illnesses such as hepatitis A, typhoid, etc.
- Vaccines related to occupational illnesses such as hepatitis B (in adults)

Note: Hepatitis vaccines *may* be covered for patients with liver disease when the need is not travel-related.

Cancer Screening Tests Include:

- Screening X-ray Mammograms – yearly
- Pap Smears – yearly beginning at age 18
- PSA – yearly beginning at age 50
- Sigmoidoscopy – every 5 years, or screening colonoscopy every 10 years beginning at age 50 for average risk persons or at age 40 for *high-risk* persons.

As stated in the "Summary Table of Benefits" section, Out-of-Network preventive care is generally not covered by the Plan.

(5) Surgery to Treat Illness or Injury – Generally accepted surgical procedures to treat illness or injury are covered on an inpatient or outpatient basis. Reconstructive surgical procedures to correct significant congenital deformities are covered also. In this context, congenital deformity means a functionally significant anatomical defect present at birth. Surgical reconstruction of defects that are variations in anatomical structure and those defects that have no significant functional result are not covered except as listed in Explanatory Notes #6 & #7. In addition to the primary surgeon, the Plan covers the services of an assistant surgeon when it is determined by the Plan to be Medically Necessary. Anesthesia services performed by a professional other than the surgeon and as part of covered surgical procedures are covered. Second surgical opinions requested by the Member or his/her physician and performed by a Network physician will be covered. For detailed information on what the Plan will cover, see the "Summary Table of Benefits" section.

(6) The Women's Health and Cancer Rights Act of 1998 – Because the Plan provides Coverage for mastectomies as treatment for breast cancer, it is therefore required under the federal Women's Health and Cancer Rights Act of 1998 to provide Coverage for the following

additional services for Members who started receiving benefits in connection with a mastectomy on or after January 1, 1999:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment for physical complications of all states of mastectomy, including treatment of lymphedema (swelling of the arm as a result of removal of lymph nodes).

Coverage for these services is subject to all limitations, including applicable Deductible, Co-payment, or Maximum Benefit provisions of this Plan.

(7) Surgery to Change the Size, Shape, or Appearance of the Body – In general, surgery in which the primary purpose is to change the size, shape, or appearance of the body or of a body part is not covered. The Plan has identified a limited number of procedures that will be covered *in part* by the Plan, as follows:

- Breast reduction in females
- Laparoscopic Banded Gastroplasty and Roux-en-Y Gastric Bypass for purposes of weight loss (Panniculectomy and other similar procedures are not covered as part of or following eight loss procedures.) The plan limits coverage to one operation for purposes of weight loss.
- Various eyelid procedures for ptosis and dermatochalasis
- Orthognathic (jaw) surgery to correct significant congenital defects in children and adolescents
- Selected varicose vein procedures - only removal of the greater saphenous vein or other varicose veins one centimeter or more in diameter are eligible for coverage by the plan.

In order to be covered, Pre-authorization by the Plan must be received and the proposed procedure must meet the Plan's criteria for performance of that procedure. No Out-of-Network benefits are provided for surgical procedures to change the size, shape, or appearance of the body or a body part *regardless of the reason* and even if a particular technique is not available within the Network.

(8) Maternity Care – The first visit to an obstetrician to diagnose pregnancy and to initiate prenatal care is covered and handled as a regular physician's office visit. Subsequent regular prenatal visits are covered as part of the delivery charge (global delivery fee) and are not subject to individual Co-payments or Co-insurance. The member is responsible for the Co-insurance amount on the global delivery fee and Co-insurance amounts on additional medical services performed that are not included under the global delivery fee. It is important to understand that onset of labor and delivery is a *predictable* event that is reasonably likely to occur any time after the 34th week of gestation. Therefore, the Plan does not consider maternity care that occurs Out-of-Network as a result of the Member traveling out-of-area after the 34th week of gestation to be Emergency Care and will not be covered as such. For detailed information on what the Plan will cover, see the "Summary Table of Benefits" section.

(9) Emergency Care – Emergency Care is care provided by a hospital emergency room (ER) for symptoms or conditions that imminently threaten life or that could produce permanent disability if not treated immediately. Emergency Care may be sought and covered without a referral from a Network physician, though Members are encouraged to consult with their PCP whenever possible prior to seeking care in an ER. Services judged by the Plan to be Emergency Care will

be covered regardless of whether the hospital providing services is in the Network or not. The Member is responsible for the ER Co-payment and Co-insurance for each ER visit. The ER Co-payment is waived if the patient is admitted to the hospital from the ER. The Plan will evaluate whether each ER visit qualifies as Emergency Care or not.

The Plan uses a "reasonable layperson" standard when evaluating whether a service is an emergency. In other words, if a reasonable layperson considers the symptoms or circumstances of the patient to be a situation that threatens life or that could produce permanent disability if not treated immediately, then ER services will be covered subject to applicable Co-payments and Co-insurance. However, the Plan also considers the patient's behavior and condition carefully when applying the reasonable layperson standard. Documentation that symptoms responsible for the ER visit have been present for several days or weeks during which time care could have been sought from the patient's PCP or other non-ER physician, represents evidence that the patient did not consider his/her symptoms to be an emergency. If an ER visit or related services are judged by the Plan not to be Emergency Care, no coverage will be provided and payment for that care will be the sole responsibility of the Member. Approved Out-of-Network ER coverage ends when the patient is determined to be stable and suitable for transport to a Network hospital. In addition, coverage is not provided for out-of-area obstetrical care after the 34th week of pregnancy. In general, only services rendered by a hospital emergency room are considered to be Emergency Care. The Plan, at its option, may cover services provided in settings other than an ER. Coverage of such services will be subject to the ER Co-payment and Co-insurance.

(10) Urgent Care – Urgent Care is care provided by an Urgent Care facility for acute symptoms or illnesses that do not meet the definition of Emergency Care. Members are urged to call their PCP whenever possible when in need of Urgent Care, however a referral from the PCP is not required. Referral by a Network physician to an Out-of-Network facility does not constitute approval by the Plan for care and services will not be covered as a Network benefit

(11) Pain Center Programs – The Plans' Network includes a number of organized, multi-disciplinary programs devoted to the treatment of chronic pain. Coverage is provided for treatment rendered by these programs with the following limitations:

- Requires pre-authorization
- The Member must be referred for treatment by a Network physician
- Diagnostic work-ups must be performed and completed by the referring physician; Pain Center Programs are for treatment, not diagnosis, of chronic pain
- The office Co-payments apply to all physician or psychology office visits
- Network therapists must perform prescribed physical therapy unless authorized otherwise in advance. The overall 30-visit PT/OT benefit limit applies to therapies performed as part of pain center programs.
- Only well-accepted or proven treatment modalities are covered. New treatment modalities will not be covered unless, in the judgment of the Plan, placebo-controlled studies have demonstrated their effectiveness.
- Treatment programs that are primarily educational in nature or are provided in a group setting are not covered.

(12) Outpatient Physical, Occupational, and Speech Therapies and Cardiac Rehabilitation – Coverage of outpatient (any treatment not received during in-patient hospitalization) physical

(PT), occupational (OT), and speech therapies is limited to a Maximum Benefit of 30 visits, all therapies combined (exluding Cardiac Rehabilitation), per year. An additional 30 visits per year (60 visits total) may be allowed upon appeal to the Plan if the condition being treated is judged to be severe and there is a need for multiple modalities or, if in the judgment of the Plan, the additional therapy will reduce the need for other services. Coverage of Phase 2 cardiac rehabilitation is limited to 30 visits per year. The cardiac rehabilitation 30 visit limit is separate from the PT, OT and speech therapy limit.

It is important to understand that benefit limits apply regardless of circumstances or Medical Necessity. Members are financially responsible for therapies they use beyond the benefit limit. Therefore, Members for whom therapies are prescribed should plan their courses of therapy carefully with their physicians and therapists while keeping in mind the benefit limit. Many therapies can be taught to the patient and performed at home with periodic supervision by the therapist.

Therapies for developmental issues of childhood such as speech delays or learning problems that exist within the broad range of normal are not covered. Only therapies for children with severe handicaps that exist as part of well-defined genetic (e.g. – Down's Syndrome) or congenital (e.g. – Cerebral Palsy) syndromes are covered up to benefit limits.

(13) Infertility Services – Infertility services are the diagnostic and therapeutic services used to achieve pregnancy for Members diagnosed to have infertility. In addition to the general $2,000,000 Lifetime Maximum Benefit/Member, the Plan has a separate lifetime Maximum Benefit limit for covered infertility services and another lifetime Maximum Benefit limit for infertility drugs (drugs must be included on the drug formulary). Covered infertility services include office visits to infertility specialists, infertility-related laboratory tests and other diagnostic testing, artificial insemination, and all forms of in-vitro fertilization (IVF) including acquisition of donor eggs or the patient's eggs for IVF. Covered donor fees include injections, the drawing of blood, the diagnostic scan, and the charge for the retrieval of eggs. Donor sperm services are covered up to the Maximum Benefit amount. The cost involved for shipping is covered but the storage fee is not covered. The donor fee for participation is not covered. Any and all costs incurred by a donor must be paid by the Member or donor at the time of treatment. This includes any and all Covered treatment that is rendered in a hospital, office or other approved setting and all Covered prescription drugs purchased for the donor's use. Either the Member or Provider may submit Covered charges to the Plan for reimbursement. Fees for embryo storage greater than one year are not covered. Expenses related to Medically Necessary fetal reduction services that occur as a result of infertility treatment may be covered following Pre-authorization by the Plan. Expenses approved by the Plan relative to fetal reduction apply to the Maximum Benefit limit for covered infertility services. For detailed information on what the Plan will cover, see the "Summary Table of Benefits section.

(14) Durable Medical Equipment (DME), Prosthetics and Orthotics – Durable medical equipment (DME) and prosthetics prescribed *as a part of the treatment plan* for an acute injury or following surgery are covered up to the cost of a standard item/basic equipment, but subject to Pre-authorization for equipment costing over $500 and for all equipment rentals. Rental versus purchase of needed items occurs at the Plan's discretion.

Revision of prosthetics as a result of changes in medical status may be covered if Medically Necessary up to a limit of $1,500 per year. Replacement of DME or prosthetics as a result of

loss or damage, other than normal wear and tear, is not covered by the Plan. Replacement of DME or prosthetics sooner than the normal functional life (five years unless the Plan determined otherwise) of previously purchased equipment or prosthetics is not covered by the Plan.

Durable medical equipment that is *designed primarily to provide assistance* to a Member with a chronic disability rather than to treat the Member's acute illness or condition is not covered except for the items and circumstances listed below:

- Standard wheelchair for patients unable to walk more than 50 feet as a result of neurological or other illnesses; coverage of a light-weight wheelchair may be authorized when the patient's ability to propel a standard wheelchair is limited. Maximum benefit = one (1) wheelchair every 3 years.
- Motorized wheelchair – covered only for patients with quadriplegia (significant neurological weakness of both upper and lower extremities). Maximum Lifetime Benefit = one (1) purchase of a motorized wheelchair per lifetime.

Maintenance or modifications following the purchase are the Member's responsibility.

Three and four-wheeled motorized scooters are not covered for any reason. Seat-lift chairs are not covered. Other equipment or construction designed to compensate for disability (e.g. – bath seats) are not covered.

Plan pays up to $300.00 toward the rental or purchase of a breast pump with a limit of one purchase per lifetime.

Coverage of compression stockings for the treatment of chronic venous status, varicose veins, or other conditions is limited to two pairs per year.

Cranial Prosthesis (Wig) purchased due to hair loss resulting from treatment of cancer is limited to one per lifetime up to $400.00.

In-shoe orthotics coverage is limited to one pair every three-year interval.

Orthotic Provider Notice:
The Orthotics benefit provider for Alliance Select covered members allows for $100 per pair orthotics benefit every 3 years. This is the total amount of benefit that will be allowed by Alliance Select. Any amount above and beyond this amount is the responsibility of the member.

(15) Dental Services/Oral Surgery – Most dental and oral services are not covered by the Plan. The following explains the only exceptions:

- Expenses for dental work and oral surgery are covered if they are for prompt repair of an injury to the jaw, sound natural teeth, mouth, or face acquired as a result of an accident/injury. Covered Services are limited to the initial treatment of the injury rendered within 72 hours of the injury. Injury as a result of chewing or biting is not considered an accidental injury.
- Expenses for dental work and oral surgery are covered if services are Medically Necessary as part of the treatment for cancer or in preparation for organ transplantation.
- Anesthesia and hospital operating room services related to dental work are covered for Members 12 years of age or younger when those services cannot be performed in the

dentist's office because of the Member's age or medical condition. The Maximum Benefit is $1,000 per Member per year and limited to services performed at Health Alliance and Children's Hospitals.

- Orthognathic surgery (surgery to change the alignment of the jaws) is not covered except for reconstructive surgery for congenital defects in children.
- Consultations and diagnostic testing for jaw and facial pain are covered when performed by a Network Provider, however treatment of temporomandibular joint disorders (such as bite splints) is not covered.

(16) Prescription Drug Benefit Program Description – Prescription drug coverage is provided through a Network of pharmacies offering discounted prescription drug prices. The pharmacy Network is comprised of a variety of independent and chain store pharmacies, as well as the Health Alliance Hospitals' outpatient pharmacies. A complete listing of pharmacy Network Providers is available on the Express Script Internet site at www.ExpressScripts.com.

Covered drugs are drugs that require a prescription under federal law, are approved for general use by the Food and Drug Administration, and are included on the Plan's formulary. The formulary is a list of preferred drugs with prescribing guidelines from which your doctor can select. All prescriptions are subject to Co-insurance and Maximum Benefits as described in the "Summary Table of Benefits" section. Generic drugs are federally controlled to meet the same standards of composition, safety, strength, purity and quality as brand-name drugs. Affiliated pharmacies will dispense a generic drug whenever possible. The Member is responsible for brand name minimum Co-insurance regardless of whether a generic drug is available or not. In addition, if a Member receives a brand name drug when a generic drug is available, the Member is also responsible for the difference in cost between the generic and brand name cost. Coverage is provided for prescriptions for infertility as described in the Summary Table of Benefits. Injectable drugs (excluding allergy shots provided by and given in the physician's office), whether administered at home or in a physician's office, are subject to the prescription Co-insurance. Injectable insulin that does not require a prescription is considered to be a covered drug. No coverage is provided for the administration of any drug or for syringes, except as prescribed for insulin. The Plan generally does not cover drugs in which there are over-the-counter drugs available. The Plan reserves the right to apply manufacturer recommended dosing limits and may establish quantity limits for certain prescription drugs. Members are financially responsible for purchasing drugs above the monthly quantity limits. The Plan does not cover replacements for lost or stolen prescription drugs. Prescription drugs must be dispensed for outpatient use by a licensed pharmacy on or after the member's effective date of coverage. The Plan reserves the right to restrict the purchase of certain maintenance prescription drugs to Health Alliance Hospital pharmacies or the Mail Order Program when it proves to be a significant savings to the Plan and the member.

Mail Order Prescription Drug Program - Any individual covered under the Alliance Select Medical Plan is eligible to participate in the Mail Order Prescription Drug Program. The mail order program is a convenient and less expensive way for the member to obtain formulary maintenance drugs.

How to Purchase Prescription Drugs from Out-of-Network Pharmacy – Members are permitted to purchase prescription drugs at Out-of-Network pharmacies. However, the Member is required to pay the full cost of the Covered drug at the time of purchase, and then submit a

completed claim form and drug receipt to the Plan for reimbursement. The Plan only reimburses the Member up to the Network Fee Schedule amount of the drug, less the applicable pharmacy Co-insurance. Members are responsible for all non-covered drug expenses. A prescription drug reimbursement form is available through your human resources department or on the Alliance Intranet or Internet Web sites.

(17) Nutritional Supplements and Feeding Solutions – Nutritional supplement products are not covered. Feeding solutions that are administered via a tube into the stomach or small bowel are covered if the feeding solution is determined by the Plan to be a Medically Necessary part of the Member's treatment plan and the feeding solution is the sole or primary source of the Member's nutrition. The Member pays the first $150 each month of the feeding solution expense.

(18) Mental Health and Substance Abuse Coverage – Behavioral health services for the care and treatment of mental illness and alcohol dependence/drug addiction are covered on an inpatient, partial (day) hospital (using the inpatient benefit), and outpatient basis. Substance abuse/chemical dependency services for the care and treatment of alcoholism and drug addiction are also covered on an inpatient or outpatient basis.

A Network of mental health and substance abuse/chemical dependency Providers is available to the Plan's members. The Network Providers include licensed psychiatrists, licensed clinical psychologists, independently licensed social workers and counselors, and certified chemical dependency counselors. The Network is provided through Alliance Behavioral Care. Please note that all care that is reimbursed, whether In-Network or Out-of-Network, must be provided by a provider independently licensed in a behavioral health specialty or certified Provider.

In-Network coverage is only available through Alliance Behavioral Care Network Providers and requires pre-authorization for treatment. Out-of-Network coverage is available, but also requires pre-authorization for treatment. The first step in obtaining care from the mental health and substance abuse/chemical dependency Network Providers is for the member to call Alliance Behavioral Care at the phone number on the back of their insurance card (513-475-8622 or 800-926-8862). An experienced mental health professional will answer the call. He or she will discuss the member's problems and make an appropriate referral for evaluation, and/or treatment to a Network Provider who best meets your needs based on clinical assessment, your personal preference and the availability of the Network Provider. There is a limit for mental health and substance abuse/chemical dependency benefits, which are combined for an annual maximum as described in the Summary Table of Benefits. The member's Provider should send claims for covered mental health and substance abuse treatments to Alliance Behavioral Care, P.O. Box 19947, Cincinnati, OH 45219. For more detailed information on what the Plan will cover, see the "Summary Table of Benefits" section.

(19) Emergency Care for Mental Health and Substance Abuse
For purposes of this Explanatory Note, an emergency is when immediate care is necessary to prevent placing life or health in jeopardy. If members need emergency care for a psychiatric or substance abuse/chemical dependency condition, they are to go to the nearest Emergency room or to a Psychiatric Emergency Service (PES) at University Hospital, or call Alliance Behavioral Care at 513-475-8622 or 800-926-8862. Alliance Behavioral Care provides a 24-hour/day screening and assessment service staffed by experienced clinical professionals. All admissions,

including admission through an emergency room, require prior authorization from Alliance Behavioral Care.

(20) Mental Health Coverage While Traveling

When a member is traveling, benefits may be paid for urgent/emergent conditions if:

- Member could not have reasonably foreseen the condition
- Member could not reasonably return to receive treatment from an Alliance Behavioral Care Provider
- Alliance Behavioral Care determines that the treatment was Medically Necessary
- if Member or their representative called Alliance Behavioral Care prior to receiving treatment.

(21) Exclusions or Limitations of Mental Health and Substance Abuse Coverage

The Plans do not cover the following services, supplies or charges for mental health and chemical dependency treatment:

1) For health services that are not Medically Necessary

2) For mental health and substance abuse services, when such services extend beyond the period necessary for short term evaluation, diagnosis or crisis intervention; and mental health and/or substance abuse services for the treatment of conditions that are not subject to favorable modification according to generally acceptable standards of psychiatric care

3) For mental health/substance abuse services for the treatment of the following disorders, disabilities or addictions described in the following diagnostic categories of the International Classification of Diseases, Ninth Revision:
   - Dementia and other organic disorders, except for acute management and stabilization of behavioral symptoms by a mental health provider and facility
   - Nicotine and caffeine use problems
   - Neurological disorders (e.g. autism, tourettes, developmental delays and mental retardation
   - Conduct and impulse control disorders
   - Antisocial personality disorder
   - Sexual deviations and disorders (except gender identity disorders)
   - Insomnia and other sleep disorders.

4) For relationship, marriage, academic and other counseling when not attributable to mental disorder

5) For mental health and substance abuse services for the following:
   - Treatment for pain with physiological origins, unless the Alliance Behavioral Care determines that such pain has psychological or psychosomatic components
   - Services utilizing methadone treatment, L.A.A.M., Cyclazocine or their equivalents
   - Services and treatment provided in connection with or to comply with involuntary commitments, police detentions, court ordered treatment and other similar arrangements unless authorized by Alliance Behavioral Care as Medically Necessary
   - Services for patients who are consciously and deliberately noncompliant with recommended treatment, when such noncompliance is not a direct result of a mental illness
   - Inpatient treatment for co-dependency and halfway house services

- Sex therapy
- Neurophysiciologic/Neurofunctional Imaging
- Speech therapy
- Remedial education, including services for learning and behavioral disabilities
- Nutritionally based therapy for alcoholism or chemical dependency

6) For mental health and substance abuse services provided on an inpatient or transitional care basis by a chemical dependency/substance abuse treatment or rehabilitation program, except as specified in the Summary Table of Benefits

7) For psychiatric or psychological examinations or testing not otherwise covered under the Plan, when such services are for the purposes of obtaining, maintaining or otherwise relating to employment insurance, marriage or adoption or relating to judicial or administrative proceedings or orders which are conducted for purposes of medical research or to obtain or maintain a license of any type.

8) For health services and associated expenses for outpatient hospital and hospital ER services obtained during normal physician office hours, unless necessary because of an emergency or as specified in the "Summary Table of Benefits" section, or when authorized in advance in writing by Alliance Behavioral Care

9) For health services otherwise covered under the Plan related to a specific condition when a Covered Person has refused to comply with or has terminated the scheduled service or treatment against the advice of a participating Provider or Alliance Behavioral Care

10) For health services that may be Medically Necessary but which are not medically appropriate for the treatment of a particular condition, as determined by Alliance Behavioral Care

11) For mental health/substance abuse services for which the Covered Person has no legal obligation to pay or for which a charge would not ordinarily be made in the absence of Coverage under the Plan

12) For mental health/substance abuse services for which Coverage is available, when claims are filed properly, by worker's compensation, occupational disease law or similar legislation, or health services arising out of or in the course of any occupation for wage or profit when claims are filed properly

13) For treatment of eating disorders except for in-hospital treatment programs for purposes of short-term stabilization, but will be considered for coverage on a case-by-case basis using either the medical or the behavioral health benefit. Coverage will only be considered for short-term crisis stabilization; long-term residential services are <u>not</u> covered by either the medical or behavioral health benefit. Short-term treatment, if approved, will be covered by the behavioral health benefit when services are provided on a behavioral health unit or by the medical benefit when services are provided on a medical unit.

Exclusions or Limitations of Coverage of the Alliance Select Plan

The Alliance Select Plan is designed to cover a predetermined range of medical services at a budgeted expense to the Health Alliance and Health Alliance associates. The Plan is not designed and does not promise to cover every service that is health-related. The following is a non-exhaustive list of services not covered by the Alliance Select Plan. Please note that the services listed are excluded from coverage because of the design of the Plan and because of budgetary constraints. The services listed as exclusions are not covered by this Plan regardless of Medical Necessity. Exclusions include, but are not limited to, the following:

1) Services not specified explicitly as Covered Services in this Summary Plan Description

2) Services received prior to the Member's effective date or after the Member's coverage ends. Service or supplies furnished in connection with or during an inpatient hospital or skilled nursing facility stay that began before the Covered Person became covered under the Plan

3) Services that must be Pre-authorized by the Plan are not covered if the Provider fails to get needed authorizations by the Plan prior to the Member receiving the service. Network Providers have been given a list of services requiring Pre-authorization, however Members are encouraged to remind their Providers about the possible Pre-authorization requirement.

   Members using Out-of-Network services should instruct their physician to obtain a list of services requiring Pre-authorization by calling the Alliance Customer Service Center at the phone number on the back of their insurance card. Members are responsible for all Pre-authorization requirements when using Out-of-Network Providers

4) Services that are not Medically Necessary for the diagnosis or treatment of a significant congenital defect, disease, injury, or pregnancy are not covered except for those periodic preventive examinations listed as covered services in this Manual. For the purposes of the Plans, the definitions of significant congenital defect, disease, and injury do not include developmental issues and delays or alterations in the size or appearance of a part of the body that fall within the broad range of normal and that do not produce a significant functional deficit

5) The Plan bases decisions on Coverage of diagnostic tests and treatments on scientific evidence of effectiveness. Services that do not have credible scientific evidence of effectiveness or that are not well established as a standard of care in the community are not covered. This includes services that are experimental or investigative medical, surgical and mental health treatment, pharmacological regimens, health services and supplies

6) Services whose primary purpose is to change the appearance, size, or shape of the body or a part of the body are not covered except as specified explicitly in this Manual

7) Reconstructive surgery following previous surgery to change the appearance, size, or shape of the body or a part of the body unless the original surgery was authorized by the Plan and the sole purpose of the additional surgery is to correct a significant functional problem.

Reconstructive surgery to correct keloids or other consequences of body or ear piercing are not covered. Panniculectomy and similar procedures are not covered

8) Services for the diagnosis or treatment of childhood developmental issues or delays except as a part of routine well-child visits or for Members who have severe functional deficits as a result of well-defined and functionally severe genetic (e.g. - Down's Syndrome) or congenital (e.g. - Cerebral Palsy) syndromes

9) "Alternative" health services such as acupuncture, massage therapy, aroma therapy

10) Electrolysis, for any reason

11) Services that are primarily educational or training

12) Services that are primarily for getting or maintaining a job, hobby, or related type of activity. Services or equipment primarily used to allow an early return to work and are not necessary for the treatment of an injury or disease

13) Except as specified in the "Summary Table of Benefits" section, all services for dental problems and services provided by a Doctor of Dental Surgery (DDS) or by a physician licensed to perform dental services, whether the services are considered to be medical or dental in nature. Excluded services include orthodontia, orthognathic surgery, physician or ER visits for pain of dental origin, occlusal splints and related devices for the treatment of temporomandibular joint dysfunction (TMJ) and facial pain, and hospitalization or other services related to the provision of dental services except as specified.

14) Services to correct visual acuity including surgery, eye glasses, or contacts except for soft lenses or scleral shells intended for use as corneal bandages in aphakic patients or when needed because of an injury to the eye. Contacts to correct visual acuity in patients with keratoconus are not covered

15) Hearing aids or services related to the prescribing or fitting of hearing aids, as well as other devices designed to affect hearing such as personal FM devices for auditory processing problems

16) Immunizations, medications, and other services needed primarily for travel, for residence outside of the Cincinnati area, or because they are required by a third party. Any immunization specifically listed as non-covered or those not specifically listed as covered in Explanatory Note #4

17) Services and associated expenses for removal of an organ or for removal of bone marrow from a Covered Member for purposes of transplantation into another person; or services and associated expenses for transplants involving mechanical or animal organs

18) Elective abortions

19) Surgery or services for reversal of sterilization

20) Services and expenses associated in any way with surrogate parenting

21) Transsexual surgery and any services related to transsexual surgery

22) External devices and pharmacological agents whose primary purpose is to allow or to improve sexual performance

23) Growth hormone treatments for conditions other than proven growth hormone deficiency in children and pan-hypopituitarism in adults

24) Services for the treatment of obesity including any consultations or care primarily given for dieting or weight loss; or exercise programs or prescription drugs for the purpose of weight loss, except as specified elsewhere in this Manual

25) Services, equipment, or supplies in which the primary purpose is to promote good personal hygiene, fitness or improved appearance, convenience or comfort. Non-covered items include, but are not limited to, air conditioners, humidifiers, de-humidifiers, exercise equipment, and lift chairs. Nutritional supplements are not covered except as specified in Explanatory Note #17

26) Transportation or travel other than use of an ambulance in an emergency situation even if the Plan has authorized Out-of-Network care for which travel is required. The Plan, at its sole discretion, may authorize coverage for ambulance or air transportation to transfer a hospitalized patient from an Out-of-Network hospital to a Network hospital or from one Network facility to another

27) Custodial and respite (interval or relief) care

28) Charges for telephone consultations with physicians, missed appointments, or completion of claims forms

29) Services that are provided for the care of injuries or disease arising as a result of employment. This applies to whether or not you claim any compensation or recover losses from a third party

30) Services for which governmental units provide benefits except for non-covered Co-payments, Deductibles or Co-insurance amounts that would have been covered if the Member carried only the Health Alliance Plan. This exclusion does not apply to active associates who decline Medicare Part B while still employed and are covered under the Alliance Select Plan (in compliance with TEFRA Law) as their primary coverage

31) Services received from a member of the patient's immediate family (spouse, parent, sibling, child) or household

32) Services for the care of injury or disease that is the result of any act of war, declared or undeclared, or service in the armed forces of any country when care of such injuries or disease is provided through a governmental plan or program

33) Services for the care of injury or disease that is the result of a Covered Person's voluntary involvement or participation in a felony or an illegal activity, including a riot or act of civil disobedience

34) Service, equipment or supplies for which you have no legal obligation to pay in the absence of this or like coverage; or for which would not have been made in the absence of coverage by this Plan

35) Services or equipment which local, state, or federal laws prevent the Plan from providing

36) Services, equipment, or supplies in excess of the Maximum Benefits listed in this Manual and the "Summary Table of Benefits" section regardless of Medical Necessity

37) Replacement of prescription drugs, durable medical equipment, prosthetics or other covered items due to theft, loss, damage or wear requiring replacement sooner than the normal functional life of the item

38) Charges incurred for a dependent of a dependent child Member, unless the dependent of the dependent child Member is covered as allowed by the Plan.

39) For any services for mental health or substance abuse except as specified as covered in Explanatory Notes #18 – #21

40) For any services for mental health, smoking cessation, or other substance abuse except as specified in the Explanatory Notes #18 – #21

41) Forensic medical services or medical services requested by a court of law or performed as a result of a legal action

42) For services normally covered by the Plan, but denied due to the Covered Person's refusal to comply with the Provider's treatment orders, or terminates or cancels scheduled service or treatment.

Special Managed Care Provisions

Pre-authorization Requirements

Pre-authorization is a determination of whether the proposed service, procedure, supply or charge is a Covered Service and whether it is Medically Necessary. It is also a mandatory process of acquiring approval by the Plan before receiving some forms of health care treatment. For services requiring Pre-authorization, payment for services will be denied by the Plan if

required Pre-authorization is not obtained. Pre-authorization is not a guarantee of benefit payment. All terms and conditions of the Plan apply in determining the member's coverage for the procedure, service, supply or charge.

The Plan must be notified before every hospital, skilled nursing facility, rehabilitation facility, or other facility admission, except Maternity Admissions and Emergency Care. For elective admissions, Pre-authorization requests should be submitted in advance to allow the plan to make a determination in accordance with the Plan's Claims procedure (see Claims Information and Appeal Procedures" section.). For Maternity and admissions due to Emergency Care, notification to the Plan must occur within 24 hours of admission (or by the end of the next business day if the admission occurs on a weekend or holiday). It is the Network Provider's responsibility to notify the Plan or to obtain Pre-authorizations. However, if a member chooses to use Out-of-Network Providers, THEY are responsible for ALL Pre-authorization requirements. If the Plan is not notified of a Covered Person's admission as described above, payment of benefits for all physician and hospital expenses may be denied.

Pre-authorization must also be obtained by the member's Network Provider, or the Member when using Out-of-Network services, before receiving the following Services:

Services That Require Pre-Authorization
Health Services
Ambulance transportation (non-emergency)
Blepharoplasty (eye lid surgery)
Breast implant removal or revision
Dental-related anesthesia and hospital services
Dental care related to accidents/medical conditions
EECP Therapy
Experimental or Investigational tests/treatments
Genetic Testing
Home infusion/injection services
Hyperbaric oxygen therapy
IDET Therapy
Keloid removal/Scar revision surgery
Neuropsychological testing
Oral and oro-maxilofacial surgical procedures
Out-of-Network services with Coverage at In-Network benefit levels
Pain control programs and services
PET scans
Penile prosthesis surgery
Plantar fasciotomy/fasciectomy/heel spur surgery
RAST testing (allergies)
Retisert™ (fluocinolone acetonide intravitreal implant)
Septoplasty surgery
TMJ procedures (devices are not covered)
Transplants, solid organ and bone marrow
Varicose vein surgery and procedures
Voice therapy
Weight loss surgical procedures
Wound therapy programs and clinics
Supplies and Equipment
Bone growth stimulators
Durable medical equipment purchases > $500
Durable medical equipment rentals
Neuromuscular stimulator devices
Oxygen
Prosthetic device purchases greater than $500

Prescription Drugs and Injectables
Botox
Enteral and parenteral feeding solutions
Growth hormone
Interferons
Certain specific prescription medications as determined by the Plan
Palivizumab (Synagis) and RSV immune globulin
Retin A for Members over age 25
Facility Notifications
Home Health Care Services
Hospice Care (Inpatient and Outpatient)
Inpatient Admissions (including OB)
Rehabilitation Admissions
Skilled Nursing Facility Admissions

The list of services requiring Pre-authorization is subject to change without notice and may not list every service that requires Pre-authorization. If in doubt about whether a service, item of equipment, or drug requires Pre-authorization, please call the Alliance Customer Service Center at the number on the back of the member's insurance card.

Continued Stay Review

During a Covered Person's hospital stay, a continued stay review will be conducted by the Plan. This review applies to all hospital admissions. The purpose of the continued stay review is to provide the Plan with an update as to the Covered Person's condition and progress; and, if necessary, enable the Plan to re-evaluate the Medical Necessity of a continued hospital stay.

Individual Case Management

Individual Case Management is a program designed to inform Members of cost-effective alternatives for treatment. On an exception basis, subject to the Plan's prior approval, benefits may be provided for settings and/or procedures not expressly provided for in this Manual when the Plan determines the provision of such benefits will reduce the need or cost of other Covered Services.

The Plan reserves the right to deny extensions of benefits under Individual Case Management. The Plan also has the right to administer benefits pursuant to the terms of the Plan, exclusive of this provision.

Quality Improvement and Medical Management Programs

The Plan's administrator is committed to monitoring standards of medical care that, when provided in a medically appropriate and cost-effective manner, contribute to the health and well being of members. In practice, this means providing the right care from the right provider at the right time in the right place. We accomplish this objective through our Quality Improvement Committee overseeing the program of ongoing utilization management and quality improvement activities.

Medical Management Department

The Plan's Medical Management Department is primarily responsible for managing the utilization of the health care services provided to members. Registered Nurses, under the supervision of a Medical Director, ensure that each treatment plan is medically appropriate and provided in the most cost-effective setting.

The Medical Director

The Medical Director is responsible for directing the development and implementation of all health care policies as they affect the product, the physician and the patient. The Medical Director provides day-to-day operational oversight, advice in matters of physician performance, and serves as a key liaison between the Plan's administrator and the medical community.

Medical Management Clinical Nurse Reviewers

The Plan's Administrator employs Registered Nurses to perform pre-authorization and case management services. Experienced in multiple specialty areas, they work under the direction and supervision of the Medical Director and physician advisors. Case managers pre-authorize such health care services as inpatient hospitalization, out-of-network referrals, and other selected services listed in this manual.

Authorizations are considered valid for 90 days form the date of approval, as long as the member remains eligible for coverage. Offices must re-submit requests for pre-authorizations, if the service is not initiated within 90 days of approval. The member must be eligible for coverage when services are provided.

The Medical Director reviews any service not meeting criteria. If authorization is denied by the Medical Director, the member or physician has the right to appeal by phone, fax, or in writing. The normal appeal process can take up to 30 days. However, if the physician feels the procedure is urgent or requires special consideration, the physician can ask to speak to the Medical Director or fax the information. In urgent situations, we will notify the physician and the member of the decision within one business day of receiving the required information.

Availability of Criteria

Case Managers use established criteria developed and approved by the Quality Improvement Committee in determining medical appropriateness of both inpatient and outpatient services and length of stay for in-patient admissions. These criteria are available through the medical management department at the request of the provider.

Emergency Room Services

The Plan is responsible only for payment of emergency room visits that meet the criteria for emergencies and/or are authorized by the member's PCP. Emergency medical care is defined as a serious medical condition resulting from injury, sickness, or mental illness, which arises suddenly and requires immediate care. Treatment is generally received within 24 hours of onset to avoid threat to the life or health of the patient. Patients are encouraged to call their PCP prior to receiving Emergency Room Services.

Emergency Admissions Notification

The hospital must notify Alliance Partners of an emergency admission by the next business day after the admission to receive authorization.

If a nonparticipating physician admits the member through the emergency room, every effort should be made to assign a participating physician to the member's case in a timely fashion. If the member or the physician chooses not to accept the reassignment to a participant physician, the hospital stay may not be covered.

We consider maternity admissions for delivery the same as emergency admission.

If an inpatient admission from the emergency room is necessary:

- The member's emergency room co-payment is waived.
- The hospital staff should follow the procedures listed under inpatient admissions.
- The hospital should notify medical management at the time of admission or on the next business day.
- The hospital will attempt to reassign the patient to a participating physician if the admitting physician in non-participating.

Mental Health/Substance Abuse Services

All patients requiring mental health/substance abuse services must use our psychiatric designee, Alliance Behavioral Care (ABC). The primary care physician can make behavioral health referrals by calling ABC at (513) 475-8622. If the member prefers, they can access the behavioral health network by calling 475-8622 or, if out of area, 800-926-8862

Behavioral Health providers should refer to ABC's managed behavioral health provider guide for further direction.

Emergencies

If a mental health/substance abuse emergency occurs, immediately notify ABC at (513) 475-8622 or 800-926-8862. ABC representatives are available this number seven days a week.

All inpatient admissions must be pre-authorized by ABC. Situations that warrant an emergency are those in which there is a clear and immediate risk to the safety of the member or others as a

direct result of mental illness or substance abuse. Requests to initiate inpatient substance abuse treatment/rehabilitation are not considered emergencies and will be evaluated on the next business day.

Mental Health/Substance Abuse Hospitalization

All inpatient MH/SA admissions must be pre-authorized by ABC. Participating physicians should not refer members to a MH/SA facility for hospitalization. Instead, he or she should contact ABC at (513) 475-8622 for authorization and referral.

Mental Health/Substance Abuse Inpatient Consultation

If a participating provider determines that a member who is hospitalized with a medical/surgical diagnosis requires a consult, the participating provider must contact ABC to obtain pre-authorization and a referral for the consult services.

Upon notification, ABC will arrange the consult by a designated MH/SA provider. The designated MH/SA provider must report his or her findings and recommendations to ABC and the referring physician.

Sanctions (ABC)

If a participating provider fails to comply with ABC's requirements for pre-authorization for all services, the following sanctions may apply:

- Written warning with the first violation.
- Thereafter, ABC will be under no obligation to reimburse the physician for services provided.

Laboratory Services

The Plan has a laboratory management program to cover all routine ambulatory and non-emergency services. Physicians are required to use the participating labs.

If a Plan member requires laboratory services, the following options are available within the plan:

Offices may give the patient a prescription to take to any one of the approved sites (See Ancillary Services in your Alliance Select Physician Directory) to have their lab work drawn.

Offices that provide phlebotomy services are expected to offer phlebotomy services to Plan members and arrange for pick-up from the participating labs courier services. The courier services will be available to retrieve samples and provide your office with collection supplies and request forms. A phlebotomy fee will be paid to those offices that provide the service.

Some non-emergency lab tests may be performed at participating hospitals. These include standard tests for pre-admission, pre-op testing for outpatient surgery, post-discharge bilirubins on newborns and lab service in conjunction with an emergency room visit.

In addition, physician offices may perform the approved in-office laboratory tests listed below:

CPT CODE	DESCRIPTION
36415	VENAPUNCTURE
80048	LAB BASIC METABOLIC PANEL
80051	LAB ELECTROLYTE PANEL
80053	LAB COMPREHENSIVE METABOLIC PANEL
80061	LAB LIPID PANEL
80069	LAB RENAL PANEL SST
80076	LAB HEPATIC FUNCTION PANEL
80162	LAB DIGOXIN ASSAY
81000	URINALYSIS NON AUTO W/SCOPE
81001	LAB URINALYSIS DIP STICK AUTOMATED W/MICROSCOPY
81002	URINALYSIS NON AUTO W/O SCOPE
81003	LAB URINALYSIS DIP STICK AUTO W/O MICROSCOPY
81005	URINALYSIS
81015	LAB URINALYSIS MICRO ONLY
81025	LAB URINE PREGNANCY TEST
82040	LAB ALBUMIN SERUM
82043	LAB ALBUMIN URINE MICROALBUMIN QUANTITATIVE
82044	LAB ABLUMIN URINE MICROALBUMIN SEMI QUANTITATIV
82150	LAB AMYLASE
82247	LAB BILIRUBIN TOTAL
82248	LAB BILIRUBIN DIRECT
82270	LAB BLOOD OCCULT
82272	BLOOD OCCULT FROM DIGITAL RECTAL EXAM
82310	LAB CALCIUM TOTAL
82374	LAB CARBON DIOXIDE (BICARBONATE)
82435	LAB CHLORIDE BLOOD
82465	LAB CHOLESTEROL TOTAL
82550	LAB CREATINE KINASE (CPK) TOTAL
82565	LAB CREATININE BLOOD
82570	LAB CREATININE OTHER SOURCE
82607	LAB CYANOCOBALAMIN (VITAMIN B-12)
82728	LAB FERRITIN
82746	LAB FOLATE
82947	LAB GLUCOSE QUANTITIVE BLOOD
82948	REAGENT STRIP/BLOOD GLUCOSE
82950	LAB GLUCOSE 2 HR PP SST
82951	LAB GLUCOSE TOLERANCE TEST 3 SPECIMENS
82952	LAB GLUCOSE TOLERANCE TEST 4+ SPECIMENS EA ADDL
82962	LAB GLUCOSE FINGER STICK
82977	LAB GGT SST
83036	LAB HEMOGLOBIN GLYCATED (A1C)
83540	LAB IRON
83718	LAB HDL CHOLESTEROL
83721	DIRECT LDL CHOLESTEROL
83735	LAB MAGNESIUM SST
83880	LAB NATRIURETIC PEPTIDE
84075	LAB PHOSPHATASE ALKALINE
84100	LAB PHOSPHORUS SST
84132	LAB POTASSIUM SERUM
84153	LAB PSA TOTAL
84155	LAB PROTEIN TOTAL
84295	LAB SODIUM SERUM
84436	LAB T4 TOTAL SST
84439	LAB THYROXINE FREE
84443	LAB THYROID STIMULATING HORMONE (TSH)
84450	LAB TRANSFERASE ASPARTATE AMIN (AST) (SGOT)
84460	LAB TRANSFERASE ALANINEAMINO (ALT)(SGPT)
84478	LAB TRIGLYCERIDES
84520	LAB UREA NITROGEN QUANTITATIVE(BUN)
84550	LAB URIC ACID BLOOD
84702	Pregnancy (blood)
85007	LAB BLOOD COUNT MANUAL DIFFERENTIAL WBC COUNT
85008	NON-DIFFERENTIAL WBC

85009	DIFFERENTIAL WBC
85013	HEMATOCRIT
85014	LAB BLOOD COUNT HEMATOCRIT
85018	LAB COUNT HEMOGLOBIN
85025	LAB BLOOD COUNT HEMOGRAM PLATELET COUNT AUTO
85027	COMPLETE CBC AUTOMATED
85032	MANUAL CELL COUNT, EACH
85041	RBC
85048	LAB WBC
85049	LAB PLATELET COUNT
85610	LAB PROTHROMBIN TIME
85651	LAB SEDIMENTATION RATE ERYTHROCYTE NON-AUTO
85652	AUTOMATED SED RATE ERYTHROCYTE NON AUTOMATED
86308	LAB HETEROPHILE ANTIBODIES
86403	PARTICLE AGGLUTINATION TEST
86580	LAB SKIN TEST TUBERCULOSIS INTRADERMAL
86585	TB TINE TEST
86677	LAB H PYLORI SST
87081	BACTERIA CULTURE SCREEN
87210	LAB SMEAR WET MOUNT INFECTIOUS AGENTS
87220	LAB TISSUE EXAM KOH
87880	LAB STREP SCREEN
89300	SEMEN ANALYSIS
89310	SEMEN ANALYSIS
89320	SEMEN ANALYSIS
89330	SEMEN ANALYSIS
G0107	LAB OCCULT BLOOD MEDICARE SCREEN

Fees for these services will be paid according to the Plan allowable fee. Claims submitted by physicians' offices for unapproved in-office tests will be denied.

Please refer to the Alliance Select Provider Directory for a complete listing of the Alliance Select Laboratory Services Network.

Alliance Partners (AP) Provider Network

Alliance Partners (AP) is certified as a Physician Organization in credentialing and recredentialing by the National Committee for Quality Assurance (NCQA). AP credentials all providers (physicians and allied health providers that submit claims for direct services) that participate in the Alliance Select Network in accordance with our credentialing program, which is reviewed on an annual basis. Generally, an AP provider must have privileges at a network hospital and have Board Certification or be in active pursuit of Board Certification in his/her specialty. AP has developed its credentialing program to bring maximum efficiency to physician and allied health providers by utilizing a single re-appointment application process for Alliance Select and for hospital privileges at an Alliance Hospital.

Please contact the MSO offices listed below for any specific issues relating to each hospital.

Medical Staff Offices

Drake Center	(513)418-2622
Fort Hamilton Hospital	(513) 867-2248
Jewish Hospital	(513) 686-5447
University Hospital	(513) 584-2607
West Chester Medical Center	(513) 585-6804

Office Site Surveys

The overall objective of the office site survey is to assess the extent of the provider's compliance with applicable standards of practice, which has been chosen by the Plan's Administrator's Quality Improvement Committee and Medical Management staff because of their association with quality of care. The site survey includes site standards and a medical records audit. Following a site survey, the physician practice will receive a report of findings and recommendations. The office is required to receive a site survey if the Plan receives a member complaint. Please contact the Credentialing Department for more information on the office site surveys.

Credentialing Process for New Applicants

Requests for participation in the Alliance Select Plan should be directed to your Provider Network Representative. They will need the following:

- The name of the provider.
- The group name of the provider.
- The specialty of the provider.
- The correspondence address.
- The name and phone number of a contact person.
- Hospital affiliations

If applicable, the Network Services Representative will request the provider to submit a copy of the CAQH application via email, fax or certified mail. It is important that the provider reattests before printing the CAQH application.

The CVO will determine whether the practitioner has submitted a complete application. The application packet is considered to be complete if:

- All questions are answered and all forms are signed and dated where applicable.
- All blanks on the application form are filled in and necessary additional explanations are provided. A narrative is required for gaps in training or practice experience (six months or more), malpractice claims history, and disciplinary actions.
- Delineation of Hospital Privilege Form is complete and signed (if applicable).
- Requested documentation is attached (i.e. DEA, License, Liability Insurance, Certificates, etc.)
- All date fields must have the month and year.

CVO will assign the date the application must be taken to the Credentialing Committee to meet the timeline for HB 125. This date will not exceed 73 days from the date the CVO receives the application. If the provider has NOT submitted a complete application, they will be notified by fax, email or certified letter within 21 days of the CVO receiving the application. Subsequent follow up will occur if the information is not received. If the application remains incomplete, it will be presented to the credentialing committee on the assigned date and denied. This will be considered an administrative denial and not reported to licensing boards or NPDB.

If the practitioner has submitted a complete application packet, the processing of the application will begin.

The processing of the application is considered to be complete when the following requirements are met:

- Provider information has been entered into the credentialing database
- Provider Information has been verified. Meaning, all information necessary to properly evaluate a provider's qualifications has been received from the primary source and is

consistent with the information provided in the application (i.e. National Practitioner Data Bank, Board Status, Medical Degree/training, peer references, etc.).
- All blanks on the application form are filled in and necessary additional explanations are provided.

If the provider is requesting to be credentialed for Alliance Partners, final determination will be made at the AP Credentials Committee, which generally meets on the 4th Tuesday of each month. All approved providers will receive written notification of their approval as an AP provider.

Alliance Partners Credentialing Application

Council for Affordable Qualty Healthcare (CAQH)Credentialing Form
This is the standard credentialing form adopted by the Ohio Department of Insurance (ODI). House Bill 125 requires all contracting entities to use this form for initial credentialing and recredentialing activities. AP cannot obtain the CAQH application. Providers need to print their CAQH application from the CAQH database (www.caqh.org/credapp/) and then send it to AP via email, fax or certified mail.

Provider Re-credentialing/Reappointment Process

The Credentials Verification Organization (CVO) will request a copy of the CAQH form from participating providers approximately six months prior to the expiration date of the provider's credentialed status. The provider should review their information on the form and reattest prior to printing the CAQH application.

If the application is not received by the CVO after 45 days, a certified letter will be sent to the provider. If the application is not received within 7 days of receiving the certified letter, the provider's name will be forwarded to the Credentialing Committees of Alliance Partners and the Health Alliance Hospital(s), as applicable. This could result in the termination from the Alliance Select Plan and hospital privileges.

Upon receipt of the application, the CVO specialist will identify whether the practitioner has submitted a complete application packet. The application packet is considered to be complete if:

- All questions are answered and all forms are signed and dated where applicable.
- All blanks on the application form are filled in and necessary additional explanations are provided. A narrative is required for malpractice claims history issues and disciplinary actions. (Please note: If a case has been reported to the NPDB, and explanation is required regardless of the age of the case.)

If the provider has NOT submitted a complete application packet, they will be notified via email, fax or certified letter of the missing items/information. Subsequent follow up will occur if the information is not received. If the application remains incomplete at the time of appropriate

Credentialing Meeting, the applicant will be denied. This is an administrative denial that is not reportable to licensing boards or to the NPBD, but this will terminate participation in the Alliance Select Network.

If the practitioner has submitted a complete application packet, the processing of the application begins.

The processing of the application is considered to be complete when the following requirements are met:

- Provider information has been entered/updated into the credentialing database.
- Provider Information has been verified. Meaning, all information necessary to properly evaluate a provider's qualifications has been received from the primary source and is consistent with the information provided in the application (i.e. National Practitioner Data Bank, Board Status, Licensing Board, peer references, etc.).
- All blanks on the application form are filled in and necessary additional explanations and attachments are provided.

If the provider is being reappointed for hospital privileges, the application will be forwarded to the appropriate hospital's medical staff office for further processing and determination. For specific information regarding the requirements and timeframe for hospital reappointments, contact the Medical Staff Office of the hospital for which you are applying.

If the provider is being recredentialed for Alliance Partners, final determination will be made at the AP Credentials Committee, which generally meets on the 4th Tuesday of each month. All approved providers will receive written notification of their approval as an AP provider.

The Network Services Department represents the interests of participating physicians and their office staffs, and carries out the administrative functions associated with physician enrollment and participation. The primary responsibilities of the department include provider contracting, physician file maintenance, physician office staff orientation and education, electronic data interchange activities, and receiving and responding to physician concerns related to policies and procedures.

Network Services is the primary liaison between Alliance Partners, Alliance Select Plan and the physicians and their offices. A network representative is assigned to your office and will keep you updated of Alliance Partners' news and communications on a regular basis.

Physician Changes and Updates

To ensure that you receive correct and timely reimbursements and correspondence, we need to stay apprised of any status changes in your practice, which would include physicians joining or leaving the practice and any changes in group name, tax id number, location(s), phone/fax number, and/or remit address. Notify your Network Services Representative with any changes and updates that will be occurring within your provider group. Notification is optimal if received within sixty (60) days prior to the effective date of the change.

Please send the appropriate information by email, mail or fax to your Provider Network Representative as listed on page 62.

Accepting New Select Members

Participating physicians who are open to any new patients are required to accept new Select members into their practices. In the event that a physician becomes closed to new members in general, an "Acceptance of New Members" form, **Attachment B**, must be completed and returned to Alliance Partners as soon as possible. This form can also be used when a closed practice re-opens to the acceptance of members.

Please mail or fax form to:
Alliance Partners
Network Services Department
3120 Burnet Avenue
Suite 203
Cincinnati, OH 45229
513-585-7915 (Fax)
(An electronic version of this form is available by e-mail. Contact your Representative for more details.)

Physician Back-up & Cross-Coverage

Participating physicians must provide back up and cross-coverage to ensure physician services are available 24-hours per day, 365 days per year. An Alliance Select participating physician or

a physician contracted for "Coverage" with Alliance Partners should provide this back-up coverage.

Questions

Please contact the Network Services Department at Alliance Partners with any questions or concerns you may have with the administration of the Alliance Select policies and procedures. You can reach Network Services by contacting your Network Services Representative directly.

Pat VanOver
Provider Network Representative
3120 Burnet Avenue
Suite 203
Cincinnati, OH 45229
(P)513-585-7910
(F)513-585-7915
Pat.Van_Over@healthall.com

David Hammons
Provider Network Representative
3120 Burnet Avenue
Suite 203
Cincinnati, OH 45229
(P)513-585-7115
(F)513-585-7915
David.Hammons@healthall.com

ATTACHMENT A:

Sample Alliance Select Remittance Advice

Provider Remittance Advice

Pay Date January 3, 2007

Program: Health Alliance Select

CINCINNATI, OH 45219

Line	Svc Date	Rev Code	CPT - Mod	Pri Diag	Amt Billed	Not Allowed	Contract Paid	Patient Portion	Benefit Amt	Other Disc	Discount / Penalty	Amt Withheld	Refund Amt	Amt Paid
10					Claim 07001E00158		Status PAID		Patient # 23005					
1	12/13/06		99214		125.00		103.95	25.00	78.95				0.00	78.95
2	12/13/06		76857		272.00		106.69	10.67	96.02				0.00	96.02
	Paid at 90% of contract amount.													
					397.00	0.00	210.64	35.67	174.97	0.00	0.00	0.00	0.00	174.97
11					Claim 07001E00161		Status PAID		Patient # 23006					
1	12/22/06		36415		10.00		5.00	0.00	5.00				0.00	5.00
2	12/22/06		99000		15.00		0.00	0.00	0.00				0.00	0.00
	Non covered charges. Provider responsibility.													
					25.00	0.00	5.00	0.00	5.00	0.00	0.00	0.00	0.00	5.00
12					Claim 07001E00163		Status PAID		Patient # 23063					
1	12/27/06		99203		136.00		122.29	25.00	97.29				0.00	97.29
2	12/27/06		90782		23.00		0.00	0.00	0.00				0.00	0.00
3	12/27/06		90649		120.00		120.00	0.00	120.00				0.00	120.00
					279.00	0.00	242.29	25.00	217.29	0.00	0.00	0.00	0.00	217.29

Line 2. - Payment denied because this procedure code/modifier was invalid on the date of service or claim submission.
Line 2. - Missing\Incomplete\Invalid procedure code(s) and\or rates

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ATTACHMENT B:
Acceptance Of New Members
<u>Alliance Select</u>

Acceptance of New Members

Provider Group Name: ____

Tax ID Number: ________________________

Location: ____________________________

____

____

Phone: ____________________________

Fax: ____________________________

Physicians Included: ______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

☐ **Closed** to new members effective: ___________

☐ **Open** to new members effective: __________