



Employer Administrative Handbook



P. O. Box 44365
Madison, WI 53744-4365
Phone 608.276.6620
Fax 608.276.6626
www.the-alliance.org



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Introduction to The Alliance

The Alliance is a not-for-profit employer-owned cooperative, that is owned by employers across the Midwest. We give our clients the power to improve employee access to care, improve quality, and reduce costs.

This section details the steps involved in preparing to join The Alliance, including:

- **Questions - Who to Contact**
- **The Alliance Employer Responsibilities and Commitments**
- **Other Network Options**
- **The Alliance Identification & Find a Doctor Website**
- **Notifying Reinsurers & Utilization Review Firms**

Questions – Who to Contact

Account Management: 608.276.6620 or accountmanagement@the-alliance.org

- Accessing The Alliance Services
- Benefits of Membership in The Alliance
- Plan Administrator Coordination
- Health Plan Reports
- Custom Data Requests
- The Alliance Directory or Identification Card Needs
- Employee Orientations
- The Alliance Workers' Compensation Program
- Monthly Invoices

Customer Service: 608.276.6630 or 800.223.4139, csr@the-alliance.org

Health Plan, Provider, and Third-Party Administrator Questions Regarding:

- Network Eligibility Status
- Claims Repricing
- Employee Questions Regarding Participating Providers





The Alliance Employer Responsibilities and Commitments

Each employer of The Alliance agrees to abide by the policies, rules, and requirements of the cooperative as established by the bylaws and the Board of Directors. If you would like a copy of The Alliance Articles of Incorporation & Cooperative Bylaws, please contact The Alliance at 800.233.4139 or salesupport@the-alliance.org. The policies, rules, and requirements of the cooperative are listed in the cooperative bylaws, application, stock subscription, enrollment contract, access agreement, and as follows:

- A** The Alliance employer facilitates and directs cooperative efforts between The Alliance and the employer's third-party plan administrator and the corresponding claims departments.
- B** Becoming an employer-member of The Alliance requires each employer to supply The Alliance with one valid, primary contact person to receive pertinent communications from The Alliance. By joining the cooperative, the assigned primary contact is agreeing to opt in to receive The Alliance communications.
- C** The Alliance employer or their plan administrator provides appropriate biographical information regarding eligible employees/dependents with updates at least monthly, including new hires, additions, and terminations. (See Employee/Dependent Eligibility on page C-1.)
- D** The Alliance employer distributes one of the following types of identification to employees accessing The Alliance network:
 - Insurance cards with The Alliance logo, name, mailing address, and payer identification number prominently displayed.
 - The Alliance stickers (logo & claims address) for current health plan ID cards prior to a reprint.
- E** The Alliance employer informs employees that they must show The Alliance identification at the time of service or risk losing The Alliance negotiated rate for those services.
- F** The Alliance employer provides information on participating providers to each employee accessing The Alliance. Participating providers can be found on The Alliance Find a Doctor website.
- G** The Alliance employer will provide The Alliance any internal communications and/or marketing pieces advising on the benefit plan details, incentives, or network access.
- H** The Alliance employer is financially responsible for the payment of claims incurred by employees/dependents.





- I** The Alliance provides the plan administrator with the negotiated fee to pay the participating provider. It is the responsibility of the plan administrator to ensure the payment to the provider is made at the negotiated rate, regardless of if the employer group is paying primary or secondary.
- J** It is prohibited to use The Alliance fee schedule or repriced amounts for any purpose other than administration of services for the employer. Use of such information by the plan administrator, its subsidiaries, affiliates, entities with an equity interest in the plan administrator, or employer's consultants for the purpose of gaining insight into The Alliance's agreements with participating providers, or for negotiating their own agreement with participating providers, constitutes a breach of membership
- K** The plan administrator is required to clearly state reduction in price is based on contracted arrangements on the explanation of benefits and remittance advices of The Alliance, or when appropriate, a national wrap network.
- L** The Alliance employer instructs the plan administrator that The Alliance negotiated fee for participating providers supersedes any existing or future arrangements negotiated by or applied by other entities. Notwithstanding the foregoing, however, federal and state regulations, such as Medicare eligibility rules, are specifically not superseded by The Alliance negotiated fees.
- M** The Alliance employer encourages the plan administrator to pay all claims in a timely manner (within 30 days is considered an industry standard), noting that some contracts of The Alliance with participating providers state that claims that remain unresolved for over 30 days may result in the loss of The Alliance negotiated fee to the employer/employee. If an employer consistently fails to pay in a timely manner, they can be excluded from certain provider contracts at the provider's request.
- N** The Alliance employer submits payment of The Alliance's monthly invoice upon receipt with the understanding that a 1.5 percent finance charge per month will be applied to all accounts over 30 days past due.
- O** The Alliance employer provides or instructs the plan administrator to provide a copy of the Summary of Benefits and Coverage (SBC), the Summary Plan Design (SPD), ID card proofs, and any other documentation supplied to plan participants that explains how to utilize the plan on an annual basis. The employer promptly notifies The Alliance of any substantial revisions.
- P** The Alliance employer informs The Alliance of other contract arrangements which may be in direct conflict with The Alliance.
- Q** If The Alliance employer engages in Health Plan steerage, the employer must provide applicable steerage documentation and/or materials to The Alliance prior to the effective date.





Network Options

Trilogy Health Network

Trilogy Health Solutions is an independent organization collaborating with The Alliance to offer an extensive provider network throughout Wisconsin and Northern Illinois. If an employer utilizes this network option, their plan participants will have access to providers participating in both The Alliance and Trilogy's Health Networks. Medical claims are routed to The Alliance for repricing; all in-network claims are repriced and sent to the employer's third-party administrator, along with any out-of-network claims, repriced at 100%. All out-of-network claims are then sent to Trilogy Health Solutions to be evaluated for their in-network repricing, if applicable. Any remaining, true out-of-network claims are sent back to the third-party administrator to be processed per the health plan's obligations.

Ancillary Networks

Chiropractic, Mental Health/Substance Abuse, Home Health, and Oral Surgery Networks

In addition to a comprehensive medical/surgical network, The Alliance offers chiropractic, mental health/substance abuse, home health, and oral surgery networks. The Alliance contracts with chiropractic, mental health, home health providers, and oral surgeons as it does with providers in the medical/surgical network to determine fair market value for their services.

Because of the variety of health benefit plans sponsored by The Alliance employers, The Alliance Board of Directors agreed to an optional status for these networks. In doing so, they set the following parameters:

Employers' health plans may "opt-in" to any network at any time; however, once an employer has chosen to access an ancillary network, the employer must remain in that network for a minimum of one calendar year.





The Alliance Premier Networks

The Alliance Premier Networks offer employers the flexibility of a multi-tier benefit plan that features lower costs at certain hospital health systems. Utilization of The Premier Networks is a great way to direct your employees to lower-cost, high-value providers without limiting their provider options.

The Alliance Premier Networks support up to four customizable benefit tiers. By offering different tiers, you incentivize your employees to choose cost-effective providers. This reduces your plan spend and saves your employees money.

Premier Network Ruby Option:

- Plan design requires multi-tiers that encourage The Alliance Eligible Employee/ Dependents to seek care from Preferred-Value Providers.
- Benefit plan must provide a plan tier that includes the Premier Network designated providers where coverage offers a minimum 10% differential in patient responsibility from other plan tiers in deductible, coinsurance, and maximum out of pocket (MOOP).
- Service area counties include Portage, Barron, Sawyer, Dodge, Clark, Marathon, Price, Rusk, Oneida, Chippewa, Eau Claire, Taylor, Wood, Dane.

Premier Network Emerald Option:

- Plan design requires multi-tiers that encourage The Alliance Eligible Employee/ Dependents to seek care from Preferred-Value Providers.
- Benefit plan must provide a plan tier that includes the Premier Network designated providers where coverage offers a minimum 10% differential in patient responsibility from other plan tiers in deductible, coinsurance, and maximum out of pocket (MOOP). Mayo Health System must be offered in a lower plan tier than the Premier Network designated provider's plan tier.
- Service area counties include: Adams, Boone, Buffalo, Columbia, Crawford, Dane, Dodge, Grant, Jackson, Jefferson, Juneau, La Crosse, Marquette, Monroe, Ogle, Richland, Rock, Sauk, Trempealeau, Vernon, Winnebago, Allamakee (IA), Fayette (IA), Winneshiek (IA), Houston (MN), Wabasha (MN), Winona (MN).





The Alliance Workers' Compensation Program

The objective of The Alliance Workers' Compensation program is to provide a network of participating providers who deliver Workers' Compensation medical care for The Alliance employers enrolled in the program. If The Alliance employer's Workers' Compensation program is administered by a Workers' Compensation carrier, The Alliance must establish an agreement with the carrier before the employer can access the network. In a limited number of cases, provider agreements do not allow the application of preferred pricing to Workers' Compensation claims. Check with The Alliance's Account Management staff to assess how these limitations might impact the plan.

Optional Services

Preferential pricing is available to The Alliance employers for dental, vision, national provider network, and prescription benefit management services.

The Alliance Identification

Employees and family members participating in a plan accessing The Alliance networks must identify themselves as such to all providers when accessing physician or hospital services.

Employees should be instructed to notify the clinic or hospital billing office of their participation in The Alliance each time they seek care by verbally confirming their participation and showing proper identification.

If an eligible employee or family member does not show proper identification, claims may not be sent through The Alliance for repricing and data collection, and the patient may lose the benefit of The Alliance contracted rates. To guarantee appropriate The Alliance preferred pricing and accurate data, it is critical that employees have proper identification and inform their healthcare providers of their participation.

Identification cards should indicate that providers should submit all medical claims, except those for prescription drugs, as well as dental and vision (if a carve-out), to The Alliance directly. This provision applies to all healthcare providers, whether they are The Alliance providers.

If a preferred national network of The Alliance is utilized, you will be advised on proper medical ID card needs.

For The Alliance provided logos, please visit the-alliance.org/idcard.





The Alliance Find a Doctor Website

The Alliance Find a Doctor website is a complete listing of The Alliance participating providers, available via fad.the-alliance.org.

Upon visiting the site, users will be asked to enter in their address and select their employer or plan options. The directory includes searches by doctor's name or specialty, places by name, or places by type with multiple specialty options. Doctors can be compared by multiple criteria.

Customer Service staff can provide information about The Alliance participating providers. The Customer Service Department can be reached at 608.276.6630 or 800.223.4139.

Notifying Reinsurers and Utilization Review Firms

It is important that The Alliance employers notify their reinsurance and utilization review firms of their participation in The Alliance, as employers' contracts with these firms may explicitly require such notification.

Impact of The Alliance Participation on Reinsurance

The Alliance employers may be able to renegotiate their reinsurance premiums when accessing The Alliance network. The claims savings realized through participation in The Alliance may slow accumulation of the specific stop-loss deductible, benefiting the reinsurer as well as the employer. The Alliance has worked with reinsurance carriers in evaluating our contracts with healthcare providers and facilities. Based on their evaluations, carriers have agreed to offer additional discounts on reinsurance rates for employers that access The Alliance.

Impact of The Alliance Participation on Utilization Review

The Alliance employers may wish to renegotiate their utilization review fees because The Alliance negotiated fees with hospitals are based on Diagnostic Related Groups (see definition page F-1). Utilization review can be redundant.

For a Sample Letter to Reinsurers (for Employer-Members of The Alliance) visit

<https://the-alliance.org/employers/>





ADMINISTRATIVE POLICIES

Included in this section are The Alliance policies regarding the following:

- **The Alliance Proprietary Information**
- **Confidentiality of Employer, Health Plan, and Patient-Specific Information**
- **Use of Names and Logos**
- **Termination of Contract**
- **Procedure for Customer Concerns**

The Alliance Proprietary Information

The Alliance fee schedule and provider contracts are the proprietary information of the Employer Health Care Alliance Cooperative (The Alliance) and will not be published, disclosed, or disseminated, except as required by law. The Alliance employers, employees/dependents, and plan administrators have access to information on the repricing of individual claims and The Alliance cost of medical care comparisons by calling the Customer Service Department at 608.276.6630 or 800.223.4139. Use of The Alliance fee schedule or repriced amounts for any purpose other than administration of The Alliance employer by plan administrator is not permitted. Unauthorized use of The Alliance fee schedule, pricing information or other confidential information of The Alliance by the plan administration may result in the termination or suspension of any further access or disclosure of such confidential information to the plan administrator. To the extent The Alliance employer becomes aware of any unauthorized use or disclosure of The Alliance's confidential information by itself or any plan administrator, the employer shall report such use or disclose to The Alliance as soon as reasonably practical. Use of such information by the plan administrator, its subsidiaries, affiliates, entities with an equity interest in the plan administrator, or employer's consultants for the purpose of gaining insight into The Alliance's agreements with participating providers, negotiating their own agreement with participating providers, or other unauthorized use of such information constitutes a breach of membership. The Alliance employers acknowledge that The Alliance may upon request by The Alliance employer enter into agreements with The Alliance employer's plan administrators regarding the use and disclosure of The Alliance's proprietary information as well as other confidential information (other pricing information or protected health information, subject to the requirements provided herein The Alliance Employer Administrative Handbook).





The Alliance Employer Administrative Handbook (the “Handbook”) is considered proprietary information of The Alliance and is provided as a resource to the employer. At no time should the handbook be published, disclosed, or disseminated outside The Alliance employers. Failure to abide by this request will result in a Board of Director’s review.

All rights, title, and interest in any aggregate de-identified health information produced by The Alliance as part of its de-identification and data aggregation services to its membership shall be the sole and exclusive property of The Alliance. The decision whether to share such information with any third parties, including any issues of format and price, is exclusively within the discretion of The Alliance.

Confidentiality of Employer, Health Plan, and Patient-Specific Information

In general, The Alliance will maintain the confidentiality of information relating to the employer, including the description of its health plans and all statistical data.

The Alliance activities described in this section of the Handbook shall be those of a “Business Associate” and shall be performed on behalf of the employer’s “Health Plan,” in compliance with (1) the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (“HIPAA”) as amended to incorporate Subtitle D of the Health Information Technology for Economic and Clinical Health Act, Title XIII of Public Law 111-005 (42 U.S.C.A. Section 17921 et seq., subchapter III, Privacy) (“HITECH”). Collectively, HIPAA, HITECH and the implementing regulations shall be referred to in the Handbook as the “HIPAA Regulations.”

The Alliance activities described in this section of the Handbook may be performed from time to time on behalf of the Health Plan include, but are not limited to, the following activities:

- A. Processing the Health Plan’s claims for payment, including claims repricing activities;
- B. Performing administrative functions relating to the administration of claims;
- C. Contracting with providers for discounted reimbursement rates and/or quality medical services;
- D. Performing data analysis as part of the Health Plan’s quality initiatives, utilization review and benefits management;
- E. Performing administrative services, including creation of de-identified health information and limited data sets, relating to data aggregation;
- F. Aggregating the data of all The Alliance employer-members as part of such quality initiatives, utilization review and benefits management;





- G. Performing research on behalf of the Health Plan;
- H. Performing research on behalf of The Alliance, itself.

Regarding these activities, The Alliance and the Health Plan shall comply with the HIPAA Regulations.

Definitions

Capitalized terms not otherwise defined in this section of the Handbook shall have the meanings given to them in the HIPAA Regulations, which are incorporated herein by reference.

Use and Disclosure of Protected Health Information

The Alliance shall use and/or disclose the Protected Health Information created for or received from or on behalf of the Health Plan, including electronic Protected Health Information (“PHI”), only to the extent necessary to satisfy The Alliance’s obligations as described in this section of the Handbook and as otherwise agreed between The Alliance and the Health Plan. The Health Plan shall not instruct The Alliance to use or disclose PHI in any manner that would otherwise violate the HIPAA Regulations.

Prohibition on Unauthorized Use or Disclosure of PHI

The Alliance shall not use or disclose any PHI except as permitted or required by this section of the Handbook, the HIPAA Regulations and as required by law or as otherwise authorized in writing by the Health Plan. The Alliance shall comply with the applicable provisions of the HIPAA Regulations and state laws, rules, and regulations applicable to individually identifiable health information that are not preempted by federal law. The Alliance may use, maintain, and disclose data contained in a limited data set as set forth in this section of the Handbook. The Alliance may maintain, use, and disclose identified information as permitted by law.





The Alliance's Operations

The Alliance may use PHI it creates for or receives from the Health Plan, in its capacity as Business Associate, to the extent necessary for The Alliance's proper management and administration or to carry out its legal responsibilities. The Alliance may also disclose PHI for such reasons, if:

- A. The disclosure is required by law; or
- B. The Alliance obtains reasonable assurance, evidenced by written contract, from any person or organization to which The Alliance shall disclose such PHI that such person or organization shall:
 - a) Hold such PHI in confidence and use, or further disclose it, only for the purpose for which The Alliance disclosed it to the person or organization or as required by law; and
 - b) Notify The Alliance (who shall promptly notify the Health Plan) of any instance of which the person or organization becomes aware in which the confidentiality of such PHI was breached as soon as possible.

Creating De-Identified Health Information

The Alliance may de-identify health information, as necessary, to perform services for employer-member Health Plans, including but not limited to Data Aggregation Services.

Data Aggregation Services

The Alliance may aggregate PHI of the Health Plan with the Protected Health Information of the health plans of other employer-members of The Alliance to provide data aggregation services related to the health plan's healthcare operations.

Limited Data Set

The Alliance may create a limited data set from the PHI on behalf of the Health Plan. In doing so, The Alliance shall abide by the following terms, which constitute a Data Use Agreement between Health Plan and The Alliance:

- A. The Alliance agrees to not use or further disclose the limited data set other than in compliance with its mission statement and organizational purpose. Its use and disclosure include disclosure to The Alliance's tax-exempt research foundation whose mission includes the aggregation and analysis of data for quality initiatives, utilization review, and benefits management.





- B. The Alliance agrees to use appropriate safeguards to prevent use or disclosure of PHI and the limited data set, other than in activities in compliance with its mission statement and organizational purpose.
- C. The Alliance agrees to report to the Health Plan any use or disclosure of the limited data set not provided for by the Handbook.
- D. The Alliance agrees to ensure that any agent, including a subcontractor to whom it provides the limited data set data, agrees in writing to the same restrictions and conditions that apply through this section of the Handbook to The Alliance with respect to such information.
- E. The Alliance agrees not to use the limited data set in such a way as to identify any individual and further agrees not to contact any individual whose health information may be included in the limited data set.
- F. The Alliance may use the limited data set to provide Data Aggregation services to the Health Plan.

PHI Safeguards

The Alliance shall develop, implement, maintain, and use appropriate administrative, technical and physical safeguards to prevent the improper use or disclosure of any PHI relating to the Health Plan.

Electronic Health Information Security and Integrity

The Alliance has developed and implemented, and maintains and uses appropriate administrative, technical, and physical security measures consistent with and in compliance with applicable portions of the HIPAA Regulations, to preserve the confidentiality, integrity and availability of all electronic PHI that it creates, receives, maintains or transmits on behalf of the Health Plan. The Alliance shall document and keep these security measures current, in accordance with the HIPAA Regulations (including 42 U.S.C.A. section 17931).

Protection of Exchanged Information in Electronic Transactions

If The Alliance conducts any Standard Transaction for or on behalf of the Health Plan, The Alliance shall comply, and shall require any subcontractor or agent conducting such Standard Transaction to comply, with each applicable requirement of the HIPAA Regulations. The Alliance shall not, and shall not permit its subcontractors or agents, to enter into any trading partner agreement in connection with the conduct of Standard Transactions for or on behalf of the Health Plan that:





- A. Changes the definition, Health Information condition or use of a Health Information element or segment in a Standard Transaction;
- B. Adds any Health Information elements or segments to the maximum defined Health Information set;
- C. Uses any code or Health Information elements that are either marked “not used” in the Standard’s Implementation Specification or are not in the Standards Implementation Specification(s); or
- D. Changes the meaning or intent of the Standard’s Implementation Specification(s).

Subcontractors and Agents

The Alliance shall require each subcontractor or agent to whom The Alliance may provide PHI that is received from, or created or received by, The Alliance on behalf of the Health Plan to agree to written contractual provisions that impose at least the same obligations to protect such PHI as are imposed on The Alliance in this section of the Handbook and the HIPAA regulations.

Access to and Amending PHI

If The Alliance maintains a Designated Record Set on behalf of the Health Plan, The Alliance shall, at the written request and direction of the Health Plan, (1) provide access to such PHI in order to assist the Health Plan in meeting its obligations under the HIPAA Regulations and (2) make any amendment(s) to such PHI as the Health Plan directs or agree to pursuant to the HIPAA Regulations.

Accounting of Disclosures of PHI

So that the Health Plan may meet its disclosure accounting obligations under the HIPAA Regulations, The Alliance shall document disclosures of PHI made by The Alliance which are not excepted from disclosure accounting requirements under the HIPAA Regulations. The Health Plan shall be solely responsible for tracking and providing Individuals an accounting of any disclosures made by Health Plan to The Alliance.

Access to Books and Records

The Alliance shall make its internal practices, books and records relating to the use and disclosure of PHI received from or on behalf of the Health Plan, available to the Health Plan and to the Secretary of the U.S. Department of Health and Human Services (“DHHS”), for the purpose of determining the Health Plan’s compliance with the HIPAA Regulations. The Health Plan’s access shall be upon reasonable notice to The Alliance, at its place of business and during business hours.





Reporting

The Alliance shall report to the Health Plan any Event (defined as a Successful Security Incident, or any use, access, modification, disclosure, or destruction of PHI not authorized by this section of the Handbook, by law or in writing by the Health Plan, including Breaches of Unsecured PHI as required by 45 CFR §164.510). This shall include Events discovered by The Alliance or by any subcontractor of The Alliance. The Alliance shall meet its reporting obligations as follows:

- A. The Alliance shall provide preliminary notice of the discovery of the Event to the Health Plan's Privacy Official without unreasonable delay and in no event later than fifteen (15) calendar days after discovery of the Event. This notice shall identify a contact person at The Alliance with whom the Health Plan Privacy Official may correspond regarding the Event.
- B. The Alliance shall, without unreasonable delay and in no event later than thirty (30) calendar days after discovery of the Event, provide the Health Plan Privacy Official a written report that will:
 - a. Identify (if known) each individual whose Unsecured Protected Health Information has been, or is reasonably believed by The Alliance to have been accessed, acquired, or disclosed;
 - b. Identify the nature of the non-permitted access, use or disclosure, including the date of the incident and the date of discovery;
 - c. Identify the PHI accessed, used, or disclosed (e.g., name; social security number; date of birth; etc.)
 - d. Identify what corrective action The Alliance (or The Alliance's subcontractor) took or will take to prevent further non-permitted access, uses, or disclosures;
 - e. Identify what The Alliance (or The Alliance's subcontractor) did or will do to mitigate any deleterious effect of the non-permitted access, use, or disclosure; and
 - f. Provide such other information as the Health Plan Privacy Official may reasonably request.





- C. The Alliance shall assist the Health Plan in performing (or at Health Plan's direction, perform) a risk assessment to determine if there is a low probability that the PHI has been compromised, with the understanding that the Health Plan shall make the final determination of whether a Breach has occurred.
- D. The Alliance shall cooperate with the Health Plan in meeting the Health Plan's obligations under the HIPAA Regulations with respect to Breach notification.
- E. Unsuccessful Security Incidents shall include, but not be limited to, pings and other broadcast attacks on the firewall, port scans, unsuccessful log-on attempts, denials of service, and any combination of the above, so long as such incidents do not result in unauthorized access, use or disclosure of Health Plan's electronic PHI. Unsuccessful Security Incidents are not "Events" subject to the reporting procedures outlined above. The Alliance and Health Plan acknowledge the ongoing existence and occurrence of attempted but unsuccessful security incidents. Upon written request by the Health Plan, The Alliance shall provide a report that:
 - a. Identifies the types of Unsuccessful Security Incidents experienced by The Alliance during a specified period; and
 - b. Indicates whether The Alliance believes its current defensive security measures are adequate to address all Unsuccessful Security Incidents, given the scope and nature of such attempts; and
 - c. Identifies the measures The Alliance will implement to address any security inadequacies it identifies in this process.

Sale of PHI

The Alliance shall not receive direct or indirect payment in exchange for any PHI created, received, maintained, or transmitted for or on behalf of Health Plan or its Individuals, including Electronic Health Records, unless The Alliance receives authorization by all affected Individuals, except as permitted under the HIPAA Regulations.

Marketing

The Alliance shall not receive direct or indirect Financial Remuneration for Marketing communications, as the terms are defined by the HIPAA Regulations, which include the use or disclosure of PHI created or received from or on behalf of the Health Plan without authorization from the affected Individuals unless such communication and receipt of payment is permitted under





the HIPAA Regulations.

Restrictions on Uses, Disclosures and Requests

The Alliance will limit all uses, disclosures and requests of PHI, including electronic PHI, to the limited data set to the extent possible or, if that is not sufficient, then to the minimum necessary to accomplish the intended purpose of such use, disclosure, or request to the extent required by the HIPAA Regulations. The Health Plan shall maintain a written policy delineating the standards it will use in determining the minimum necessary information for its uses and disclosures of PHI in accordance with the HIPAA Regulations. In creating limited data sets, The Alliance will follow the provisions set forth in this section of the Handbook. Upon the request of an Individual, The Alliance will not disclose such Individual's PHI for purposes of Payment or Healthcare Operations, if the Individual paid in full out of pocket for the healthcare item or service to which the PHI relates, in accordance with 45 C.F.R. section 164.522.

Mitigation

The Alliance shall mitigate, to the extent practicable, any harmful effect known to The Alliance of a use or disclosure of PHI by The Alliance in violation of the requirements of this section of The Handbook.

Termination for Cause

In addition to any other termination provisions set forth in this section of the Handbook, and as required by the HIPAA Regulations, if the Health Plan or The Alliance ("Non-Breaching Party") becomes aware that the other party has engaged in a material breach ("Breaching Party"), then the Non-Breaching Party shall:

- A. Provide an opportunity for the Breaching Party to cure the breach or end the violation and terminate employer's participation in The Alliance if the Breaching Party does not cure the breach or end the violation within the time specified by the Non-Breaching Party.
- B. Immediately terminate employer's participation in The Alliance if cure is not possible.

Return or Destruction of Health Information

Upon termination, cancellation, expiration, or other conclusion of the employer's participation in the The Alliance, if feasible, shall return to the Health Plan or destroy all PHI held in any form or media, including PHI that is in the possession of subcontractors or agents of The Alliance. In the





event that returning or destroying the PHI is infeasible, The Alliance shall retain the PHI, extend the confidentiality protections of this section of the Handbook to all such retained PHI and maintain the confidentiality of all such PHI for so long as The Alliance maintains such PHI.

Independent Contractor

The Alliance and the Health Plan are and shall remain independent contractors throughout the course of their relationship. Nothing in this Handbook or otherwise shall be construed to constitute The Alliance and the Health Plan as partners, joint ventures, agents, or anything other than independent contractors.

Automatic Amendment

Upon the effective date of any amendment to the HIPAA Regulations, this section of the Handbook shall automatically be deemed to be amended to incorporate such amendment so that The Alliance and the Health Plan remain in compliance with the HIPAA Regulations.

Release of Health Plan Data to Employer

Under the HIPAA Regulations, an employer must implement adequate separation between it and the Health Plan it sponsors, including restricting access to PHI to those of its employees performing administrative functions on behalf of the Health Plan. The Alliance shall disclose, therefore, PHI to the employer only at the direction of the Health Plan, and the Health Plan shall ensure that any such disclosure meets one or more of the following conditions:

- A. The Health Plan receives written authorization from an Individual to disclose that Individual's PHI to the employer;
- B. The Health Plan discloses information to the employer on whether an individual is participating in the Health Plan;
- C. The Health Plan provides the employer with PHI in the form of summary health information for the purpose of obtaining premium bids from health insurance issuers;
- D. The Health Plan provides the employer with PHI in the form of summary health information for the purpose of assessing, modifying, amending, or terminating the Health Plan;
- E. The Health Plan receives certification from the employer that the plan documents have been modified as required by the HIPAA Regulations, and the uses and disclosures of PHI by the employer will be restricted to plan administration functions performed by the employer on behalf of the Health Plan in accordance with the plan document;





- F. The Health Plan receives certification from the employer that the employer will not use the PHI for any employment-related decisions and that plan documents have been amended as required before disclosing PHI to the employer;
- a. The Health Plan includes a separate statement in its Notice of Privacy Practices informing participants that PHI may be disclosed to the employer; or
 - b. The Health Plan only discloses the minimum necessary amount and type of PHI to the employer.

Complaints

If the Health Plan has concerns or complaints about The Alliance's use and disclosure of PHI, the Health Plan is encouraged to contact The Alliance's Privacy Officer at 608.276.6620.

Use of Names and Logos

The content and design of all materials containing The Alliance name and/or logo which will be distributed by The Alliance employer, or their plan administrators, must be reviewed and approved by The Alliance prior to distribution.

The Alliance will not use an employer's name or logo in any marketing materials without prior approval.

Termination of Contract

As stated in the cooperative membership agreement:

“The term of this Agreement and the first month of The Alliance's services as described in the Handbook shall commence on the Effective Date and shall continue for an initial term of 12 months, renewing thereafter for consecutive annual terms unless written notice of termination is received by the Cooperative not less than 30 days nor more than 60 days prior to the anniversary of the Effective Date or earlier terminated pursuant to the Handbook or applicable law.”

The Alliance reserves the right to charge retainage if not notified of termination within these time limits. The Alliance reserves the right to charge access fees based on a six-month moving average for the remainder of the specified contract arrangement if an employer fails to provide appropriate termination notification.





Unless The Alliance employer specifies otherwise, claims with dates of service prior to the employer's termination date will continue to be repriced for 12 months after termination. Because retainage is due on these run-out claims, invoices may continue to be generated after the employer's termination date. After this 12-month period, all eligibility information will be removed from The Alliance database, and no claims will be repriced.

Invoices for access and retainage are issued monthly. Payment is due upon receipt of the invoice. A 1.5 percent finance charge per month will be applied to all accounts over 30 days past due. Monthly access will continue to be assessed for all accounts 60 days past due; however, claims repricing will be discontinued.

The Alliance also reserves the right to terminate an employer's access to the network or membership in the cooperative upon failure to meet the financial terms outlined in the access and retainage invoicing process. (See Retainage and Invoicing on page E-1.)

Retirement of Equity upon Termination of Contract

Upon joining The Alliance, each employer-member purchases one share of capital stock per enrolled employee at a one-time fee of \$10 per share, which becomes the member's capital equity stock in The Alliance cooperative. Throughout membership, each group benefits from the cooperative's success through allocated equity, which is part of the patronage distribution The Alliance makes at the end of a fiscal year, when an operating surplus remains after expenses and other obligations are met.

Retirement of equity is considered by The Alliance management and acted on by the Board of Directors annually. The cooperative typically retires (i.e., pays back) the equity that has been on the books the longest; in other words, by the oldest year first. Former members' equity is retired on an accelerated basis relative to current members. Please note that the cooperative's bylaws do not set a timeframe for equity payouts. There are no requirements to redeem equity, and there are no time periods established for its payout. All payout decisions are made by The Alliance Board of Directors based on the cooperative's financial well-being. Issues that are weighed typically include operating reserves, operational plans, and long-term financial needs.

Employers are welcome to check annually to learn the board's current position on equity payouts.





Procedure for Customer Concerns

The Alliance has established a procedure for addressing customer concerns related to any aspect of services provided by The Alliance. Employees/employers are encouraged to bring their concern to The Alliance staff.

Informal Procedure

The Alliance representatives will assist the employee/employer on an informal basis. If a satisfactory resolution cannot be reached, The Alliance representative will advance the concern to the formal procedure. The employee/employer is encouraged to bring their concern to The Alliance CEO if a satisfactory resolution is not reached.

Formal Procedure

Depending on the nature and extent of the concern, it will be reviewed by the appropriate management at The Alliance and/or The Alliance Board of Directors. A formal written response will be provided to the initiating party within 30 days of resolution. The employee/employer is encouraged to advance their concern to The Alliance Board of Directors if a satisfactory resolution is not reached.

CEO Contact Information

- Curt Kubiak- The Alliance President & CEO: 608.210.6603, ckubiak@the-alliance.org

Board Member Contact Information

- A current listing of The Alliance Board of Directors can be found on The Alliance website here: <https://the-alliance.org/about/people/>
- Wendy Collins (Board Secretary) - The Alliance Executive Assistant/Office Manager: 608.210.6632, wcollins@the-alliance.org. Wendy can coordinate connections with Board members upon request.





EMPLOYEE AND FAMILY MEMBER ELIGIBILITY

The Alliance employers and/or their plan administrators must supply The Alliance with accurate and current employee and family member biographical information on an ongoing basis. Claims for individuals not in The Alliance database will be repriced according to The Alliance backdating policy detailed in this section.

Included in this section are:

- **Eligibility Information - Procedure and Enrollment Form**
- **Backdating**
- **Out-of-Area Employees/Dependents**
- **ZIP Codes**

Eligibility Information- Procedure and Enrollment Form

Eligibility Information- Who Is Responsible

For The Alliance employers to take full advantage of useful and necessary claims information and benefit from The Alliance preferred pricing negotiated on their behalf, The Alliance must have accurate and current eligible employee and family member biographical information. This information may be provided to The Alliance by the third-party administrator or the employer's human resources department, but the ultimate responsibility for keeping The Alliance informed of additions, deletions, and changes in eligibility rests with the employer.

Initial Eligibility

The "first eligible" date for all employees/dependents is The Alliance employer's effective date listed on The Alliance membership agreement.





Providing Updates

Updates should be provided to The Alliance on an ongoing basis (monthly at a minimum). Information about the following should be provided in a timely manner so employees/dependents can benefit from The Alliance repricing:

- A.** New hires (with effective date);
- B.** Terminations (with termination date); and
- C.** Changes in status (name, address, family status, etc.) should be provided in a timely manner.

All additions and/or changes in employee and family member status must be accompanied by an effective date determined by the employer. The effective date is the date the employee and family member are eligible for The Alliance services, which may or may not be the date of hire. The Alliance claims department will contact the employer's designated representative in human resources or the Health Plan to obtain an effective date for additions or changes not dated.

Employee and family member terminations should be accompanied by a termination date. When submitting eligibility information electronically, it is important that "termed" employees and dependents appear in the electronic file with their termination date so The Alliance can update its biographical database.

Electronic submission of eligibility information is preferable, but it may be submitted on paper by providing a copy of the insurance application or completing The Alliance Employee Enrollment Form (sample included in this section).

Requesting Rosters for Review

The Alliance employers may request a hard copy or an electronic copy roster of employees and family member in The Alliance database at any time for verification. Contact Account Management at 608.276.6620 or 800.223.4139 for details.





Backdating

“Backdating” refers to the act of adding eligibility information to The Alliance database for employees and family members accessing The Alliance after care has been rendered. The following policy applies in cases in which an employee or family member is not in The Alliance database due to an oversight or error on the part of The Alliance employer or third-party administrator:

“Upon The Alliance notification, backdating of all eligibility shall not exceed 90 days. The courtesy of backdating within 90 days will be extended to employees who were eligible to use The Alliance at the time services were rendered but were not in The Alliance database due to the employer’s or third-party administrator’s failure to notify The Alliance. A copy of the original application/enrollment form must be submitted to The Alliance.”

The enrollment form included in this section may be copied by the employer or third-party administrator to update The Alliance database.

Out-of-Area Employees and Family Members

Employees and family members who are not enrolled in The Alliance due to their geographic location may choose to receive medical services in The Alliance service area.

Eligibility information about these employees and family members should be received by The Alliance before medical services are rendered, for the employee and employer to benefit from The Alliance negotiated fee. Claims will be repriced until the employer, or third-party administrator notifies The Alliance that the individual is no longer accessing one of The Alliance participating provider. The Alliance employer will be billed monthly access fees for these employees and family members during this time. The Alliance employer will also be billed retainage on the employee’s and family member’s claims for that period.

Employers should remind out-of-area employees and family members to identify themselves as working with The Alliance at the time they receive services in The Alliance service area.

Zip Codes

A list of The Alliance service area ZIP codes provided upon request to assist employers when determining Alliance eligibility by residence.





CLAIMS PROCESSING

This section provides basic information about The Alliance claim repricing system. Detailed information for third-party administrators may be found in The Alliance Third-Party Administrator Kit, distributed to administrators working with The Alliance or via The Alliance website.

This section includes:

- **Provider Contractual Arrangements**
- **Electronic Claim Transmission**
- **Incoming Claims**
- **The Alliance Claim Cover Sheet**
- **Coordination of Benefits**
- **Non-Covered Services**

Provider Contractual Arrangements

The Alliance Provider Fees

The Alliance has negotiated a reimbursement schedule which represents a local “fair market value” fee for the services of hospitals, physicians, and other healthcare providers in The Alliance service area.

The Alliance negotiated fee represents the maximum allowable payment for physician services. Payment is made based on the original billed charge or The Alliance negotiated fee, whichever is less.

Making Payment Based on The Alliance Negotiated Fee

On behalf of The Alliance employers, third-party administrators must pay The Alliance eligible employee and family member claims according to The Alliance repricing system. The Alliance participating providers will accept only The Alliance negotiated fee for The Alliance eligible employees and family members, regardless of other contractual arrangements that may be in place. To reinforce accurate and appropriate payment, claims payers must refer to the payment directive on The Alliance cover sheet attached to paper claims (see “The Alliance Claim Cover Sheet” later in this section on page D-4) or for electronic claims, in the appropriate claim status field.





As an employer-member of The Alliance, in the event of a billing, pricing, or rate calculation error for which correcting individual claims is not an appropriate remedy, The Alliance and contracted network providers may agree to adjust the reimbursement rates temporarily until the over/under allowance has been resolved.

Claim Submission to The Alliance

Hospital and physician claims incurred by The Alliance eligible employees and family members are submitted to The Alliance by participating providers within 45 days of the date of service. Hospital claims are submitted on a UB04 format and physician claims are submitted on a HCFA-1500 format. Claims may be submitted electronically or on paper.

UW Timeliness Provision

Per The Alliance's contract with the University of Wisconsin Hospitals and Clinics, there is a 40-day timeliness provision in place. If payment is not received by UW Hospitals and Clinics from the employer's Third-Party Administrator within 40 days of receipt of the claim at The Alliance, half of the discount is lost.

Electronic Claim Transmission

The Alliance works with several clearinghouses allowing transmission of repriced claims to plan administrators. More than 90% of the claims received and repriced by The Alliance are submitted electronically to The Alliance by the provider of service.

The Alliance employers whose third-party administrators are not currently capable of or willing to receive repriced claims electronically, are urged to encourage them to explore the opportunity for electronic claim transmission from The Alliance. For more information about electronic claim transmission, contact The Alliance at 608.276.6630 or 800.223.4139.

Incoming Claims

All incoming paper claims are date stamped as they are received (claims received after noon are date stamped for the following day). Claims are then distributed among The Alliance claim processors. Each processor verifies that the patient is an eligible employee or family member of The Alliance before processing the claim.





Non The Alliance Employee/Dependent

Claims received for individuals not in The Alliance biographical database are stamped “Non The Alliance Member” and forwarded to the third-party administrator for:

- A. Verification of The Alliance eligibility; and
- B. Processing of the claim as usual if the patient is not eligible for The Alliance; or
- C. Re-submission of the original claim with a completed eligibility form to The Alliance for repricing and data collection if the patient is eligible as of the date of service (see “Backdating” in Employee/Dependent Eligibility on page C-3.)

The Alliance Claim Cover Sheet

The Alliance cover sheet is printed and attached to each paper claim before it is mailed to the appropriate payer. The status message of the cover sheet contains instructions which are essential in determining payment of claims. The payment directive is relayed in the appropriate claim status field of an electronically transferred claim. (A separate cover sheet is not generated for electronic claims.) A sample cover sheet is included in this section.

Three-Day Turnaround Required by Contractual Obligation

The Alliance maintains a claims data entry and repricing system with a turnaround time of no more than three working days, per contractual obligation with providers.





The Alliance Claim Cover Sheet

Below is a reduced sample of a claim cover sheet that may be provided to an employer’s health plan. Also included is a key to reading The Alliance cover sheets. Please note that the status message of the cover sheet contains instructions, which are essential in determining payment of claims.

HCFA REPRICING SHEET

(A) 53 Payer:
(B) Employer:
(C) Insured: **LAST, FIRST**

Group# _____ ID# _____ Patient: _____
(D) _____ **(E)** **LAST, FIRST** **(F)** _____
 Covers Period: 01/16/2023 thru 01/16/2023

(G) 187 PROVIDER: 111111111 Associated Pathologists, SC

PHYSICIAN	RENDERING LOCATION	BILLING ADDRESS
LAST, FIRST	700 S Park St Madison, WI 53715	PO Box 628215 Middleton, WI 53562
MD Degree Level	NPI: 1111111111	NPI: 1111111111

Condition related to: Employment? **N** Auto accident? **N** Other Ins? **N**
 Ill/Inj date: _____ Other date: _____ Unable to work: _____ to _____
 Local Use: _____ Hospitalization: _____ to _____
 Diag codes: A. **Z1211** B. **D124** C. **D122** D. _____
 ICD Ind: 0 E. _____ F. _____ G. _____ H. _____
 I. _____ J. _____ K. _____ L. _____

Pat acct#: **(H)** Prior Pmt: 0.00

DOS From	POS	CPT/HCPCS	Diag	Charge	Units	Repriced	Repricing Codes
(I) 01/16/2023	22	88305 26	ABC	1182.00	3	535.58	

Submitter's claim#: 5856150089A1

CLAIM SUMMARY

Signed: 02/07/2023 Charges: **(J)** 1182.00 Status: PARTICIPATING PROVIDER
 Received: 02/07/2023 Reprice: **(K)** 535.58 **(L)** Pay "Repriced" amount
 Entered: 02/07/2023 EDICUM Savings: 646.42

202302070003358

This confidential document is intended only for the individual or entities named above. Eligibility and benefit designations are determined by the paying agent. scarney 1/1

The Alliance
Self-Funding Smart

PO Box 44365
 Madison, WI 53744
 608-276-6620 (ph)
 608-210-6677 (fax)

Alliance Cover Sheet Key

(A) Third Party Administrator (TPA) Name	(E) TPA Assigned ID Number	(I) Date of Service
(B) Employer Name	(F) Patient Name	(J) Total Charges billed by Provider
(C) Policyholder Name	(G) Provider Tax ID, Name & Location	(K) Total Alliance Repriced Amount
(D) TPA Designated Group Number	(H) Provider Account Number	(L) Status Message Payment Instructions

Sample payment instructions which may appear under “L” on The Alliance Claim Cover Sheet (previous page). This list is not all inclusive*:

- “National network provider, pay repriced amount”
- “Non-participating provider, repricing not applicable”
- “Employer has not elected coverage in this network”





Coordination of Benefits

The Alliance does not coordinate benefits. However, The Alliance provider contracts contain the following, or similar, language regarding secondary claims:

“Provider agrees to accept The Alliance repriced amount as full reimbursement, regardless of whether the employer is the primary or secondary payer. Medicare claims are excluded from The Alliance repricing.”

All secondary claims are repriced as though they are primary to determine the “total” reimbursement amount. The Alliance fee reflects The Alliance contracted fee based on total billed charges. Payers should use this information when determining the balance due to the provider after the primary payer has made payment.

Examples

	Example A	Example B
Billed charge	\$2,000	\$2,000
The Alliance fee (“total” payment)	1,600	1,600
Primary payment	<u>- 1,300</u>	<u>- 1,700</u>
Secondary payment	\$300	none

Note that in Example B, the primary payment exceeded The Alliance repriced fee, so no payment is due from the employee’s secondary carrier.





Non-Covered Services

Medical/Surgical Network

Virtually all of The Alliance's participating providers have agreed to accept The Alliance negotiated fees for non-covered services. These agreements may benefit employees of The Alliance employers with benefit plans which exclude routine office visits and other non-elective services.

Participating providers will not, however, accept The Alliance negotiated fees for some elective services which are not medically necessary, such as cosmetic surgery (breast augmentation, rhinoplasty, face lifts), infertility treatment (tubal reanastomosis and HIPA tests), vasectomy reversal, smoking cessation programs, and special programs such as mammogram screenings offered through the American Cancer Society. The services excluded are contract specific.

Administration

Third-party administrators continue to be responsible for determining the medical necessity of services provided. Employees and family members receiving medically necessary services not covered under the employer's benefit plan, should be advised of The Alliance negotiated fee (repriced amount) in the explanation of benefits so they may submit payment to the provider based on this amount. The Alliance employers should verify with their third-party administrator that an explanation of benefits forms and remittance advices referencing The Alliance repriced amount will be sent out for non-covered charges.

Virtually all providers will accept The Alliance negotiated fee as full payment, regardless of whether the service is a covered benefit under the plan, or whether The Alliance employer, third-party administrator, or employee is the responsible party. The Alliance employers should encourage employees to request that The Alliance negotiated fees be considered full payment for non-covered services.





RETAINAGE AND INVOICING

This section includes:

- **Monthly Fees**
- **Invoicing Process and Sample Monthly Invoice**
- **The Monthly Summary of Utilization & Savings Report**

Monthly Fee

Access and Retainage

“Access” refers to the per employee per month fee assessed for members enrolled in The Alliance. Monthly fees are calculated on the 15th of each month. The fees will be based on the number of employees listed within the eligibility file received.

“Retainage” refers to the share of The Alliance members’ claims savings retained by The Alliance for operating expenses. A retainage invoice is issued monthly, reflecting savings generated from claims repriced during the previous month. **Retainage is owed on all claims, even those exceeding the employer-member company’s specific stop-loss limit.** (For information about negotiating with reinsurers, see “Notifying Reinsurers and Utilization Review Firms” in The Alliance Implementation on page A-7.)

Retainage is calculated as a percent of gross claims savings.

Payment is due upon receipt of the invoice. A 1.5 percent finance charge per month will be applied to all accounts over 30 days past due.

Employer-members will find their specific agreed upon fees in the signed executed Standard Equity Agreement. Fees are governed by the current, enforceable Standard Equity Agreement and may only be modified through the execution of a new, duly signed agreement.





Invoicing Process and Sample Monthly Invoice

Monthly Invoice and Reports

An invoice will be issued monthly to each employer of The Alliance. The invoice is accompanied by reports illustrating the previous month’s claims savings as a result of The Alliance repricing. (See “The Monthly Summary of Utilization and Savings Report” on page E-4.)


Payment Due Upon Receipt

Payment is due upon receipt of the invoice. A 1.5 percent finance charge per month will be applied to all accounts over 30 days past due. Monthly access will continue to be assessed for all accounts over 60 days past due; however, claims repricing will be discontinued. Providers and the employer will be sent a notice that claims repricing has been discontinued. When payment of the entire past due amount has been received, claims repricing will resume, and the appropriate parties will be notified.

Right of Termination for Nonpayment

The Alliance Board of Directors reserves the right to terminate any employer of The Alliance from the cooperative for failure to pay fees according to the terms indicated. (See “Termination of Contract” in Administrative Policies on page B-11.)

Example Invoice

	<i>Employer Health Care Alliance Cooperative, Inc. PO Box 44365, Madison, WI 53744 Tax ID # 39-1675538</i>																								
INVOICE																									
<i>Copy do not pay-fees paid thru Benefit Plan Administrators (TPA)</i>																									
<<Contact Name>>, <<Contact Title>> <<Company Name>> <<Street 1>> <<Street 2>> <<City>> <<State>>, <<Zip>>																									
<i>Invoice Date:</i> 8/1/2022 <i>Invoice Number:</i> 1234-567	<i>Company Number:</i> <<EmployerID#>> <i>Period Covered:</i> July 2022																								
<table border="0" style="width: 100%;"> <thead> <tr> <th style="text-align: left;"><u>Transaction Description</u></th> <th style="text-align: right;"><u>Amount Due</u></th> </tr> </thead> <tbody> <tr> <td colspan="2"><hr/></td> </tr> <tr> <td colspan="2"><<Employer Name>></td> </tr> <tr> <td colspan="2"> </td> </tr> <tr> <td>July Access <<##> Employees @ \$8.00</td> <td style="text-align: right;">\$XXXX.00</td> </tr> <tr> <td>July Retainage</td> <td style="text-align: right;">\$XXXX.00</td> </tr> <tr> <td colspan="2"> </td> </tr> <tr> <td colspan="2"><hr/></td> </tr> <tr> <td style="text-align: right;">GRAND TOTAL DUE:</td> <td style="text-align: right;">\$XXXX.00</td> </tr> <tr> <td colspan="2" style="text-align: center;"><i>COPY DO NOT PAY</i></td> </tr> <tr> <td colspan="2"> </td> </tr> <tr> <td>DATE PREPARED: 8/1/2022</td> <td>PERIOD COVERED: July 2022</td> </tr> </tbody> </table>		<u>Transaction Description</u>	<u>Amount Due</u>	<hr/>		<<Employer Name>>				July Access <<##> Employees @ \$8.00	\$XXXX.00	July Retainage	\$XXXX.00			<hr/>		GRAND TOTAL DUE:	\$XXXX.00	<i>COPY DO NOT PAY</i>				DATE PREPARED: 8/1/2022	PERIOD COVERED: July 2022
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DATE PREPARED: 8/1/2022	PERIOD COVERED: July 2022																								





The Monthly Summary of Utilization and Savings Report

Summary of Savings and Utilization

This report summarizes the month's claim activity based on claims entered during the previous month.

"The Alliance In-Network Claims"

This section of the report summarizes all claims by department. For each department the report states:

- A. Department number
- B. Department name
- C. Total charges
- D. Total repriced amount
- E. Total savings both in dollars & percentage

A grand total for all departments is listed at the bottom of the section.

"Secondary Claims"

Secondary claims are In-Network claims that are submitted to The Alliance that indicate a previous payment by another group health insurance plan. Secondary claims are repriced, but The Alliance does not charge fees to the employer for this service. This section lists Total Claim Charges only.

"Out-of-Network Claims"

The number of out-of-network claims for the month and the total charged will be at the bottom of Summary of Utilization and Savings.





Summary of Savings and Utilization Example



*Employer Health Care Alliance Cooperative, Inc.
PO Box 44365, Madison, WI 53744
Phone 608-276-6620 Fax 608-276-6626*

TERMS: NET DUE UPON RECEIPT
A 1.5% finance charge will be assessed on balances over 30 days old.

SUMMARY OF UTILIZATION AND SAVINGS

<i>ALLIANCE IN-NETWORK CLAIMS</i>		<i>CHARGES</i>	<i>REPRICED</i>	<i>NETWORK SAVINGS</i>		<i>RETAINAGE</i>
9999-127	Employer XYZ	\$128,895.91	\$76,460.02	\$52,435.89	40.7%	1.9% \$996.28
<i>GRAND TOTAL</i>		<i>\$128,895.91</i>	<i>\$76,460.02</i>	<i>\$52,435.89</i>	<i>40.7%</i>	<i>1.9% \$996.28</i>
<i>OUT OF NETWORK CLAIMS</i>			<i># OF CLAIMS</i>	<i>CHARGES</i>		
9999-127	Employer XYZ		5			\$1,719.00
<i>GRAND TOTAL</i>			<i>5</i>	<i>\$1,719.00</i>		

* "Retainage" is not charged for The Alliance employers who are invoiced on a PEPM model.





DEFINITIONS

Many of the terms used in this handbook are defined in this section. For more information, see related sections (referenced in parentheses).

The Alliance Eligible Employee and Family Member

An eligible employee or family member of The Alliance is an employee or family member of The Alliance employer who resides in, is employed, or is accessing healthcare in The Alliance service area. Each The Alliance employer determines which employees are eligible for The Alliance services. Each employee or family member becomes eligible for The Alliance repricing services only when the following biographical information is in The Alliance database: name, insured's social security number, birth date, gender, and date of The Alliance eligibility. (See Employee/Dependent Eligibility on page C-1.)

The Alliance does not determine benefit eligibility.

The Alliance Fee Schedule

The Alliance fee schedule represents a local, negotiated “fair market value” for hospital, physician, and other network options (ancillary networks: chiropractic, mental health/substance abuse, home health, oral surgery; Exclusive Provider Organization; and workers' compensation) in The Alliance service area. The Alliance participating providers have agreed that The Alliance fee schedule represents total compensation for covered services. The Alliance negotiated fee for participating providers supersedes any existing or future arrangements negotiated by other entities.

The Alliance Fee Schedule for Non-Covered Services

Virtually all of The Alliance's participating providers have agreed to accept The Alliance negotiated fees for non-covered services. (See “Non-Covered Services” in Claims Processing on page D-5)

The Alliance Participating Provider

The Alliance participating providers have entered into a contractual agreement with The Alliance to provide healthcare services to eligible employees and family members of The Alliance on a non-exclusive basis. The Alliance participating providers have agreed that The Alliance fee schedule represents total compensation for covered services. They will accept only The Alliance negotiated fee for services rendered to eligible employees and family members, regardless of other contractual arrangements which may be in place.





The Alliance Find a Doctor Website

To obtain the most current listing of The Alliance participating providers, The Alliance Find a Doctor website can be accessed at fad.the-alliance.org. Monthly participating provider updates are published in The Alliance's newsletter for employers.

The Alliance Service Area

The Alliance Service Area currently includes Wisconsin, Illinois, Michigan, Minnesota, and Northeast Iowa and is updated periodically.

Anniversary Date

Each employer-member's anniversary date is the annual anniversary of the effective date of The Alliance employer's contract.

Backdating

Backdating refers to the act of adding eligibility information to The Alliance database for employees and family members accessing The Alliance after care has been rendered. (See "Backdating" in Employee and Family Member Eligibility on page C-3.)

Biographical Data

Biographical data about eligible employees and family members must be maintained by each employer of The Alliance, employer-sponsored group health plan, or third-party administrator, and communicated to The Alliance. This information must include the employee's name, address, birth date, social security number, gender, and eligible dependent information. (See Employee and Family Member Eligibility on page C-1.)

Coordination of Benefits

The Alliance does not coordinate benefits. (See "Coordination of Benefits" in Claims Processing on page D-5.)

Diagnostic Related Group (DRG)

DRGs are an inpatient hospital patient classification scheme factoring in case mix, severity of illness, prognosis, and treatment difficulty for purposes of standardizing reimbursement mechanisms.





Effective Date

The Alliance employer's effective date is the date the employer initiates access to The Alliance services.

Non The Alliance Employees and Family Members

Non–Alliance employees and family members include any person for whom The Alliance has received a claim whose biographical information is not in The Alliance database. (See “Incoming Claims” in Claims Processing on page D-3.)

Non-Covered Services

Virtually all of The Alliance participating providers have agreed to accept The Alliance negotiated fees for non-covered services. (See “Non–Covered Services” in Claims Processing on page D-6.)

Out-of-Area Claims

Claims for services rendered outside The Alliance service area are entered and repriced for data collection and cost comparison only. The plan administrator should apply its “usual and customary” fee unless instructed otherwise by the employer. The Alliance claim cover sheet indicates repricing is not applicable. Plan administrators should be aware of this process for out–of–area claims to avoid incorrect payment. (See “The Alliance Claim Cover Sheet” in Claims Processing on page D-4.)

Out-of-Area Employees and Family Members

Employees and family members that are not enrolled in The Alliance due to their geographic location may choose to receive medical services in The Alliance service area. (See “Out–of–Area Employees/Dependents” in Employee/Dependent Eligibility on page C-3.)

Retainage

Retainage refers to the share of The Alliance members' claims savings retained by The Alliance for operating expenses. (See “Retainage” in Retainage and Invoicing on page E-1.)

Termination-Patient

The Alliance will reprice claims for dates of service prior to the patient's termination date (the date the employee or family member is no longer eligible). Claims for dates of service up to 90 days after the termination date will be forwarded to the plan administrator without repricing.



