Land of Lincoln Health
Provider Manual

For all healthcare providers
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Overview</strong></td>
<td>4</td>
</tr>
<tr>
<td>1.1 Company History</td>
<td>4</td>
</tr>
<tr>
<td>1.2 Mission Statement</td>
<td>5</td>
</tr>
<tr>
<td>1.3 Vision Statement</td>
<td>5</td>
</tr>
<tr>
<td>1.4 Values</td>
<td>5</td>
</tr>
<tr>
<td>1.5 Complaints to Land of Lincoln Health</td>
<td>6</td>
</tr>
<tr>
<td><strong>2. Purpose of the Provider Manual</strong></td>
<td>6</td>
</tr>
<tr>
<td><strong>3. Responsibility for Provision of Medical Services</strong></td>
<td>6</td>
</tr>
<tr>
<td>3.1 Provider Responsibility</td>
<td>6</td>
</tr>
<tr>
<td><strong>4. Health Plans and Network Composition</strong></td>
<td>7</td>
</tr>
<tr>
<td>4.1 Preferred Partner PPO Plans</td>
<td>7</td>
</tr>
<tr>
<td>4.2 Traditional PPO Plans</td>
<td>7</td>
</tr>
<tr>
<td>4.3 Family Health Network (FHN)</td>
<td>8</td>
</tr>
<tr>
<td>4.4 PHCS</td>
<td>8</td>
</tr>
<tr>
<td><strong>5. Contact LLH</strong></td>
<td>8</td>
</tr>
<tr>
<td>5.1 Email</td>
<td>8</td>
</tr>
<tr>
<td>5.2 Fraud and Abuse</td>
<td>8</td>
</tr>
<tr>
<td>5.3 Mail</td>
<td>9</td>
</tr>
<tr>
<td>5.4 Phone</td>
<td>9</td>
</tr>
<tr>
<td>5.5 Provider Portal</td>
<td>9</td>
</tr>
<tr>
<td><strong>6. Demographic Information Changes/Adds/Deletes/Terminations</strong></td>
<td>9</td>
</tr>
<tr>
<td>6.1 Demographic Changes</td>
<td>9</td>
</tr>
<tr>
<td>6.2 Effective Dates</td>
<td>10</td>
</tr>
<tr>
<td>6.3 Termination Dates</td>
<td>10</td>
</tr>
<tr>
<td><strong>7. Claims and Customer Service Procedures</strong></td>
<td>11</td>
</tr>
<tr>
<td>7.1 EDI</td>
<td>11</td>
</tr>
<tr>
<td>7.2 EFT and ERA</td>
<td>11</td>
</tr>
<tr>
<td>7.3 Mailing</td>
<td>11</td>
</tr>
<tr>
<td>7.4 Checking Member Eligibility</td>
<td>11</td>
</tr>
<tr>
<td>7.5 Member Identification (ID) Card</td>
<td>12</td>
</tr>
<tr>
<td>7.6 Copayments</td>
<td>12</td>
</tr>
<tr>
<td>7.7 Pass Through Billing</td>
<td>12</td>
</tr>
</tbody>
</table>
Land of Lincoln Health Provider Manual
Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>8. Office Procedures</strong></td>
<td></td>
</tr>
<tr>
<td>8.1 Office Appointment and Wait Times</td>
<td>13</td>
</tr>
<tr>
<td>8.2 Medical Records</td>
<td>14</td>
</tr>
<tr>
<td>8.3 Processing of Grievances and Appeals</td>
<td>14</td>
</tr>
<tr>
<td>8.4 Protected Health Information (PHI)</td>
<td>15</td>
</tr>
<tr>
<td>8.5 Charges for Copying Medical Records</td>
<td>15</td>
</tr>
<tr>
<td><strong>9. Covered Services</strong></td>
<td>15</td>
</tr>
<tr>
<td><strong>10. Medical Management</strong></td>
<td>16</td>
</tr>
<tr>
<td>10.1 Utilization Management</td>
<td>16</td>
</tr>
<tr>
<td>10.2 Goals of the UM Program</td>
<td>16</td>
</tr>
<tr>
<td>10.3 Drug Formulary</td>
<td>16</td>
</tr>
<tr>
<td>10.4 Utilization Management Decisions, Inquiries and Appeals</td>
<td>16</td>
</tr>
<tr>
<td>10.5 Reconsideration and Appeal Processes</td>
<td>17</td>
</tr>
<tr>
<td>10.6 Grievances</td>
<td>20</td>
</tr>
<tr>
<td>10.7 Precertification</td>
<td>20</td>
</tr>
<tr>
<td>10.8 Quality Improvement</td>
<td>21</td>
</tr>
<tr>
<td>10.9 Disease Management</td>
<td>21</td>
</tr>
<tr>
<td>10.10 Case Management</td>
<td>21</td>
</tr>
<tr>
<td>10.11 Complaints About Providers</td>
<td>22</td>
</tr>
<tr>
<td><strong>11. Member Rights and Responsibilities</strong></td>
<td>22</td>
</tr>
<tr>
<td>11.1 Member Rights</td>
<td>23</td>
</tr>
<tr>
<td>11.2 Member Responsibilities</td>
<td>23</td>
</tr>
<tr>
<td><strong>12. NCQA</strong></td>
<td>24</td>
</tr>
<tr>
<td>12.1 Accreditation</td>
<td>24</td>
</tr>
<tr>
<td>12.2 HEDIS</td>
<td>24</td>
</tr>
<tr>
<td><strong>13. Credentialing</strong></td>
<td>25</td>
</tr>
<tr>
<td>13.1 CAQH - Council for Affordable Quality Health Care</td>
<td>25</td>
</tr>
</tbody>
</table>

Member ID Card Samples – Refer to end of manual

Quick Reference Guide (QRG) – contacts and precertification list – Refer to end of manual
1.0 Overview

1.1 Company History

Land of Lincoln Health, Inc. (LLH) is a “Consumer Operated and Oriented Plan”, or CO-OP. CO-OPs were established under the Patient Protection and Affordable Care Act (PPACA) as an alternative to current health insurance plans in the industry today. Individuals, businesses or groups can purchase health insurance at affordable prices through CO-OPs -- both inside and outside of health care exchanges – starting with open enrollment on October 1st, 2013, and become effective January 1, 2014.

CO-OPs are member-based and required to use any revenues, after expenses, towards improving the overall quality of health care coverage, including lowering insurance premiums and enhancing health benefits. We also are committed to working with Providers to share in our success via a collaborative contracting model.

LLH was sponsored by Metropolitan Chicago Healthcare Council (MCHC) as the first and only CO-OP in Illinois to receive approval by the U.S. Department of Health and Human Services (HHS). With an innovative, consumer-focused health care delivery model, Land of Lincoln Health is designed to provide Illinois communities with insurance options tailored to meet specific health and budgetary needs.

Another key differentiator for LLH is our approach to Provider relationships. LLH represents an opportunity for health systems to be rewarded for their clinical integration efforts and investments, and, among other things, will provide an opportunity to health systems to partner with LLH on developing and marketing products specific to your health system in your community.
On December 21, 2012, Land of Lincoln Health received a $160 million loan from the federal government to create a new kind of health insurance company; the first and only health insurance CO-OP in Illinois. A CO-OP is another way of saying that the company is governed by its customers and the decisions that are made are to improve services for them. Additionally, any extra revenue that the CO-OP takes in is reinvested for its customer’s benefit – by improving coverage, controlling premiums, and expanding benefits.

On April 29, 2013, Land of Lincoln Health earned its mutual insurance license from the state. Today, Land of Lincoln Health stands alone as the first new mutual health insurance company to be licensed in Illinois in more than 25 years.

1.2 Mission Statement
Land of Lincoln Mutual Health Insurance Company is a nonprofit, consumer governed cooperative that creates value by simplifying consumers’ access to high quality, affordable care and services by collaborating with health care providers to provide innovative insurance and wellness solutions.

1.3 Vision Statement
We will be the health insurance partner of choice as a result of our relentless commitment to innovation and to empowering all of our stakeholders to experience maximum value in the rapidly evolving health care delivery system.

1.4 Values
- We believe in innovation, diversity, and teamwork, bringing together communities to create solutions that positively impact the health and well-being of our members.
- We are committed to transparency in our operations as a consumer operated and oriented plan.
- We expect excellence and integrity in all aspects of our operations and relationships.
1.5 Complaints to Land of Lincoln Health

LLH is a new health plan and we are committed to providing the best customer service possible to our members and Providers. If you have a complaint about our business processes, please report to 844-674-3838.

2. Purpose of the Provider Manual

In accordance with the Policies and Procedures clause of the participating Provider agreements, a Provider that has a contract with Land of Lincoln Health shall comply with applicable written policies and procedures as established or modified by LLH from time to time. The Provider Manual outlines those policies and procedures but is not all inclusive.

3. Responsibility for Provision of Medical Services

3.1 Provider Responsibility

Providers are independent contractors and are solely responsible to members for the provision of health services and the quality of those services. This means Providers and LLH do not have an employer-employee, principal-agent, partnership, joint venture, or similar arrangement. It also means that Providers have a duty to exercise independent medical judgment to make health care treatment decisions regardless of whether a health service is determined to be a Covered Service.

LLH requires precertification with respect to certain services and procedures. LLH's precertification determination relates solely to administering its Plans and is not, nor should it be construed to be, a medical decision. The Provider, along with the member, makes the decision as to whether the services or procedures are provided.
4. Health Plans and Network Composition

LLH provides PPO health insurance plans to members residing within the state of Illinois. New plans and networks have been created for 2015.

4.1 Preferred Partner PPO Plans

We created new plans for our members. The Preferred Partner Plans are backed by prominent health systems to give the best benefits to members when they seek care within the Preferred Partner network. Members will also have access to Land of Lincoln Health’s In-Network doctors and hospitals within Illinois and nationally. The Preferred Partner PPO Plans are listed below and will be displayed on the member’s ID card:

- Adventist Land of Lincoln PPO
- Centegra Land of Lincoln Health
- Chicago Health System Land of Lincoln PPO
- Illinois Health Partners Land of Lincoln
- Land of Lincoln 360 (large group only)
- Land of Lincoln Champion PPO
- LLH Family Health Network
- NorthShore Land of Lincoln (large group only)
- Presence Health Land of Lincoln
- Swedish Covenant Land of Lincoln

4.2 Traditional PPO Plans

Traditional PPO Plans are also offered to our members. These plans offer 2 tier or 3 tier networks for the best benefits and also other network options to meet member needs. There are HSA-compatible options as well. The traditional PPO Plans are listed below and will be displayed on the member’s ID card.

- CO-OPTions Land of Lincoln National Elite Multi-State Plan
- Land of Lincoln Freedom PPO
- Land of Lincoln Preferred PPO Plan
- SBAC
4.3 Family Health Network (FHN)

LLH is utilizing the Family Health Network solely for the LLH Family Health Network plan and for the members that select this plan.

Providers directly contracted with Family Health Network for exchange plans are Preferred for this plan and the FHN contract supercedes any direct contract with LLH and/or PHCS. Some providers contracted with LLH and not directly with FHN may also be considered Preferred for the FHN plan.

- Family Health Network (FHN) will process inpatient admissions and inpatient surgery for FHN members. Providers will call the standard provider number 844-674-3838, select the option for precertification and will be transferred to FHN.
- Family Health Network will also manage case management and disease management for FHN members.
- Family Health Network will administer all member inquiries. The phone number for members is 888-FHN-4YOU (888-346-4968).

4.4 PHCS

LLH is utilizing PHCS providers within Illinois and nationally for all of the plans to supplement access for our members. Note that a direct contract with Land of Lincoln Health (or FHN for exchange plans for the FHN plan only) supercedes a PHCS contract for providers that are contracted with both or all three networks.

5. Contact LLH

5.1 Email

For contract and demographic updates only:

Providercontracts@landoflincolnhealth.org

5.2 Fraud and Abuse

Providers are responsible for complying with all applicable laws and regulations. Any instance of suspected fraud, waste or abuse should be reported to LLH immediately. Suspicions, allegations, concerns, questions and complaints can be made anonymously.

LLH Compliance Hotline: 855-638-6242
5.3 Mail

Health care providers may send written correspondence to LLH Network Management staff regarding any questions regarding their direct agreement with LLH, demographic updates and changes and requests to join the LLH network.

Attn: Network Management
222 South Riverside Plaza, Suite 1900
Chicago, IL 60606

5.4 Phone: 844-674-3838

5.5 Provider Portal

Instructions to obtain log in information and how to access the provider portal will be posted to the Land of Lincoln Health website.

6. Demographic Information Changes/Adds/Deletes/Terminations

6.1 Demographic Changes

Providers that are directly contracted with LLH are required to immediately notify LLH of any changed demographic information and any other Provider information that impacts directory publication, patient access and/or claim processing. All changes are to be sent in writing to: LLH, Network Management, 222 S. Riverside Plaza, Suite 1900, Chicago, IL 60606. The documentation of the changes can be mailed to the above address or e-mailed to Providercontracts@landoflincolnhealth.org.

The contracted entity must notify LLH of the changes for all participating Providers covered under the Agreement. Changes cannot be accepted if received directly from the participating Provider unless the contracted entity approves changes only (not adds/terminations) can be received directly.
Changes that require notice to LLH include, but are not limited to, the following:

- Adding a Provider – Provider joining the hospital/ancillary/practice/group
- Address
- Change in services provided
- Change in acceptance of new patients
- Change in legal entity
- Closed facility sites
- National Provider indicator (NPI)
- New facility sites
- Phone number
- Provider information
- Provider name
- Provider terminations – Provider no longer participating with the hospital/ancillary/practice/group
- Tax identification number

Certain changes may require an amendment, assignment or new Agreement depending on the reason for the change. Check with the LLH Network Management staff for specific information.

All new participating Providers (including new ancillary and facility locations) must be credentialed before rendering treatment to any LLH member.

6.2 Effective Dates

Notice of new providers should be provided at least 30 days prior to the effective date.

- Delegated groups: Effective dates provided by the delegated groups will be honored when possible. Please note that LLH cannot give an effective date more than 30 days retroactive from the date of receipt of the new provider.
- Non-delegated groups: The effective date will be 30 days from the credentialing approved date.

6.3 Termination Dates

Notice of terminated providers should be provided at least 30 days prior to the termination date.

Termination dates will always be assigned a future date (generally 5 days from the date LLH receives claim utilization data) unless the termination is due to a quality issue. LLH will notify members that have received care from a terminated provider.
7. Claims and Customer Service Procedures
Valence Health is the administrator for processing enrollment, claims and customer service. There is one phone number for providers to call for all inquiries. Claims for 2014 dates of service should be submitted in accordance with the 2014 Provider Manual.

7.1 EDI: Submit claims electronically within 90 days of service: EDI Vendor #90096

7.2 EFT and ERA
Electronic Funds Transfer and Electronic Remittance Advice - Register with Emdeon is one option for EFT and ERA or your own clearinghouse can be used.

7.3 Mailing: Claims can also be mailed to:
Land of Lincoln Health
Attn: Claims
PO Box 618357
Chicago, IL 60661-8357

7.4 Checking Member Eligibility
Except in the case of provision of Emergency Services, prior to: (i) admitting members as inpatients; and (ii) performing outpatient services that are included as Covered Services for members, Provider shall:

- Contact LLH and obtain an authorization number during normal business hours, authorizing the performance of Covered Services and confirming the member’s eligibility to receive Covered Services and any limitations or conditions on such Covered Services; and
- Verify the identity of the member by requiring the member to produce his/her Identification Card and a second form of photo identification whenever possible. If member is a minor, parent or legal guardian identification will be acceptable if member’s eligibility is verified with LLH as set forth in this section.
7.5 Member Identification (ID) Card
All members enrolled in the LLH plan receive a LLH Identification (ID) Card. This card has important information on how to contact LLH or vendor partners and instructions for filing claims. It is the Provider’s responsibility to obtain the Member Identification Card prior to delivering services.

Examples of our ID Cards are added at the end of the manual.

The co-payment amount reflects any reductions of member responsibility covered by the cost share reduction for eligible members.

7.6 Copayments
Copayments collected from the member at the time of service. Copayments for office visits and prescriptions are listed on the Member’s ID Card. Since copayments vary with plans, copayments may be verified by calling the number listed on the back of the Member’s ID Card.

7.7 Pass-Through Billing
LLH prohibits pass-through billing. Pass-through billing occurs when the ordering Provider requests and bills for a service, but the service is not performed by the ordering Provider or those under their direct employ. Provider agrees that services related to pass-through billing will not be eligible for reimbursement from LLH and Provider shall not bill, charge, seek payment or have any recourse against LLH or members for any amounts related to the provision of pass-through billing.
8. Office Procedures

8.1 Office Appointment and Wait Times

In part to coincide with Providers’ commitment to assist LLH with its performance and quality management, Providers shall implement procedures and make reasonable efforts as follows:

<table>
<thead>
<tr>
<th>TYPE OF CARE</th>
<th>TYPE OF APPOINTMENT</th>
<th>SCHEDULING TIME FRAME</th>
</tr>
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<tbody>
<tr>
<td>MEDICAL</td>
<td>Preventive Care</td>
<td>Within 3 weeks of the request</td>
</tr>
<tr>
<td></td>
<td>Regular and routine care</td>
<td>Within 10 business days of the request</td>
</tr>
<tr>
<td></td>
<td>Urgent</td>
<td>Within 24 hours of the request</td>
</tr>
<tr>
<td></td>
<td>Emergency</td>
<td>Immediately or referred to an emergency room</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>Annual Well Woman Exam</td>
<td>Within (3) weeks of request</td>
</tr>
<tr>
<td>PRE NATAL</td>
<td>Initial visit in first trimester</td>
<td>Within 10 business days of the request</td>
</tr>
<tr>
<td></td>
<td>Second trimester</td>
<td>Within 5 business days of the request</td>
</tr>
<tr>
<td></td>
<td>Third trimester</td>
<td>Within 4 business days of the request</td>
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<tr>
<td></td>
<td>High risk</td>
<td>Within 24 hours of identification of high risk to maternity care Provider, or immediately if an emergency exists.</td>
</tr>
<tr>
<td></td>
<td>Emergency</td>
<td>Immediately or Refer to Emergency Room</td>
</tr>
<tr>
<td>SPECIALIST</td>
<td>Routine</td>
<td>Within 10 business days of the request</td>
</tr>
<tr>
<td></td>
<td>Urgent</td>
<td>Within 24 hours of the request</td>
</tr>
<tr>
<td></td>
<td>Emergency</td>
<td>Immediately or referred to an emergency room</td>
</tr>
<tr>
<td>BEHAVIORAL HEALTH</td>
<td>Routine Office visit</td>
<td>Within 7 calendar days of the request</td>
</tr>
<tr>
<td></td>
<td>Urgent</td>
<td>Within 24 hours of request</td>
</tr>
<tr>
<td></td>
<td>Non-life threatening emergency</td>
<td>Within 1 hour of the request</td>
</tr>
<tr>
<td></td>
<td>Emergency</td>
<td>Immediately or referred to emergency room</td>
</tr>
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</table>
8.2 Medical Records:

LLH and Government Access to Records
All records, books, and papers of Provider pertaining to members, including without limitation, electronic records, books and papers relating to professional and ancillary care provided to members and financial, accounting, electronic records and administrative records, books and papers, shall be available for inspection and copying by LLH or during Provider’s normal business hours. In addition, Provider shall allow LLH to audit Provider’s records for payment and claims review purposes, including for the purposes of determining, on a concurrent or retrospective basis, the medical necessity and appropriateness of care provided to members and determining Provider compliance with applicable State and federal laws related to privacy and confidentiality of medical records.

Government Access to Records
All records, books, and papers of Provider pertaining to members, including without limitation, electronic records, books and papers relating to professional and ancillary care provided to members and financial, accounting, electronic records and administrative records, books and papers, shall be available for inspection and copying by appropriate state and federal authorities and their agents involved in assessing the accessibility and availability of care or investigating member grievances or complaints and determining Provider compliance with applicable state and federal laws related to privacy and confidentiality of medical records.

8.3 Processing of Grievances and Appeals
The participating Provider must respond to the LLH member grievance and appeal unit expeditiously with submission of the required medical records to comply with time frames established by CMS and/or the state department of insurance for the processing of grievances and appeals. Only those records for the time period designated on the request should be sent. A copy of the request letter should be submitted with the copy of the record. The submission should include test results, office notes, referrals, telephone logs and consultation reports. Medical records should not be faxed unless Provider can ensure confidentiality of those medical records.
8.4 Protected Health Information (PHI)
To be compliant with HIPAA, Providers should make reasonable efforts to restrict access to and limit routine disclosure of protected health information (PHI) to the minimum necessary to accomplish the intended purpose of the disclosure of member information.

8.5 Charges for Copying Medical Records
Medical records are considered a part of office overhead and are to be provided at no cost to members and LLH, unless state regulations or the Agreement stipulate otherwise.

9. Covered Services
A service must be medically necessary and covered by the member’s contract to be paid by the Plan. The Plan determines whether services are medically necessary as defined by the member’s certificate of coverage. To verify covered or excluded services, call LLH Customer Service at the number listed on the back of the Member’s ID Card. All services are subject to applicable copayments, deductibles, and coinsurance.

LLH uses InterQual nationally approved criteria for and general medical necessity criteria for medical necessity reviews as required. LLH makes coverage determinations, including medical necessity determinations, based upon its members’ certificates of coverage. However, LLH is not a Provider of medical services and it does not control the clinical judgment or treatment recommendations made by the Provider in its networks or who may otherwise be selected by members. Providers make independent health care treatment decisions.
10. Medical Management

10.1 Utilization Management
The LLH Utilization Management (UM) program supports an evidence based medical method to manage the utilization of services provided to members. Potential care is evaluated for medical necessity and appropriateness of services before, during, and after the care is performed. The UM program supports the Quality Improvement program goals of fulfilling the LLH mission to improve health and wellness of our members while keeping costs affordable. The UM process is continuously evaluated for improvement to provide optimal health outcomes.

10.2 Goals of the UM program are: to facilitate the provision of appropriate medical and behavioral healthcare and services to LLH Members and to improve the quality of care provided to Members.

The Objectives of the UM Program include:
- Managing, evaluating, and monitoring the provision of healthcare services rendered to Members to enhance access to, and provision of, appropriate services.
- Facilitating communication and developing partnerships between Members, Practitioners, and Providers.
- Developing and implementing programs to encourage preventive health behaviors which can ultimately improve quality outcomes.
- Facilitating continuity and coordination for Members.
- Maintaining and improving UM processes that are effective and efficient.
- Ensuring that UM decisions are made independent of financial incentives.

10.3 Drug Formulary
The drug formulary is updated monthly for newly FDA-approved drugs.

10.4 Utilization Management Decisions, Inquiries and Appeals
LLH is committed to assisting our Providers to obtain services for our members. Our Customer Service team is available to assist you with any questions or concerns. If you have a problem that has not been resolved, let us know. LLH will make every effort to solve the issue in a satisfactory way.
10.5 Reconsideration and Appeal Processes

Claim processed incorrectly or denied in error – Contact a claim specialist at 844-674-3838 option 1 for reconsideration of the claim. Provide the reason the claim has not been processed correctly or denied incorrectly.

A benefit pre-determination is denied in error – Contact a claim specialist at 844-674-3838 option 1 for reconsideration of the benefit denial. Provide the reason the benefit has been denied in error.

A medical necessity denial of a service - Contact a claim specialist at 844-674-3838 option 1 for reconsideration of the medical necessity denial. Provide the reason the service is medically necessary.

- If the provider is not satisfied with the response given after following the above steps, send a written appeal with reason for appeal and necessary documentation to:

Medical Necessity Appeals
Land of Lincoln Health
Attn: Medical Necessity Appeals
222 S Riverside Plaza
Chicago, IL 60606

Benefit Pre-determination Error or Incorrectly Processed/Denied Claim
Land of Lincoln Health
Attn: Claim Appeals
PO Box 618357
Chicago, IL 60661-8357

Appeals

The Member, a Physician, or another person designated by the Member may submit an appeal to LLH in the event that they are dissatisfied with the resolution of a complaint. In most cases, the provider requesting the service can file an appeal on the Member’s behalf, but they have the right to file on their own. Members, Physicians or authorized representatives have the right to appeal any decision or action taken by LLH to deny, reduce or limit payment services received, the appropriateness and level of care or the health care setting.
The routine appeal process requires that a decision be made within 15 calendar days after receipt of the appeal. Providers will be sent written notification of the decision. If the denial is upheld, you may request another review by an independent reviewer. The appeal decision letter will include instructions on how to request this appeal.

**Administrative Appeal**

Complaint is filed when the member or provider disagrees with the decision

- Member or provider feels the treatment or medication that has been authorized for you is not the best course of treatment, after receiving a second opinion
- Denial of access to medical services or specialists

**Benefits Determination Appeal**

- Claims of treatment that is experimental
- A benefit in question is not covered or applicable limits have been reached
- Member was not eligible for the benefit in question
- Precertification denial

**Adverse Determination Appeal**

- Claim denied for reasons as stated on the Explanation of Benefits (EOB)
- Health care services, including but not limited to procedures or treatments, for an enrollee with an ongoing course of treatment ordered by a health care provider, the denial of which could significantly increase the risk to an enrollee’s health
- A treatment referral, service, procedure, or other health care service, the denial of which could significantly increase the risk to an enrollee’s health
- Complaint regarding benefits was filed before services have been rendered and Member or Provider did not agree with the result
**Expedited Appeal**

If a requested precertification/preauthorization of a treatment or service, continued stay during an inpatient admission, or ongoing course of treatment has been denied and the physician believes the routine appeal process timeframe will significantly put the member’s health at risk by waiting for 15 calendar days, a request can be made by the Member, Physician, or authorized representative for an expedited appeal.

The expedited appeal for services the member has not started must be processed within 72 hours after all information needed to make the decision is received. If the expedited appeal is for ongoing treatment or for continued hospitalization, the decision must be processed within 24 hours of the request.

**External Appeal**

Under certain circumstances, Members have the right to an External Appeal for a denial of coverage. Specifically, if the LLH denial was because the service was not medically necessary or was experimental or investigational, the Member or authorized representative may appeal the denial to an External Appeal Organization that is certified by the Illinois Department of Insurance.

The circumstances to request an External Appeal for medical necessity are the service, procedure, or treatment must be a covered benefit in the member’s policy (or Certificate of Coverage if a group plan); and their appeal has been through the full internal health plan appeal process and was still denied.

Also, if the denial was because the service is an experimental or investigational treatment, the physician must certify that the member has a life-threatening condition or a disabling condition or disease. The physician must certify that the condition or disease is one for which standard health services are ineffective or medically inappropriate, or one for which there is not a more beneficial standard service or procedure, and the condition or disease has a high probability of death without the treatment.
Land of Lincoln Health requests will be reviewed within 5 days for eligibility for an External Review. If the request is not eligible for an external review, LLH will provide notification to the requesting provider and Member in writing within one business day of the determination. An External Appeal can also be made directly from the Illinois Department of Insurance at:

Illinois Department of Insurance
Consumer Division
320 West Washington Street
Springfield, Illinois 62767
1-877-527-9431

Expedited External Appeal
If your physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health, you may request an Expedited External Appeal. The external physician reviewer must make a determination within 2 days after receiving all the necessary information to make a decision. Upon reaching a decision, the external reviewer must advise the appealing provider and Member of the decision by telephone or facsimile. The determination must also be provided in writing within 2 days of the decision.

10.6 Grievances
LLH strives to meet its members' expectations for care and services. Members have the right to submit a complaint in writing or to Customer Service about LLH or one of our network Providers or pharmacies; including complaints concerning the care provided.

10.7 Precertification
Valence Health administers pre-certification for services. Please refer to the Quick Reference Guide (QRG) included at the end of the manual for the pre-certification list and contact information.

PsychHealth administers mental health pre-certification and management of services. They also provide a 24 hour hotline for members or providers.
10.8 Quality Improvement

LLH’s Quality Improvement Program is designed to help ensure that our members receive high quality, appropriate, efficient and cost-effective health care. Our goal is to have a continuous process to objectively measure, monitor, evaluate and improve the quality of clinical care and services delivered to our members. We promote quality care at all levels and work with health care Providers to measure quality and safety. We work closely with physicians through our Provider Advisory Council and use their feedback to improve our quality programs.

10.9 Disease Management

LLH members have access to our disease management programs, which are designed to meet each member's unique health support and educational needs. Diabetes and Asthma are the main conditions for which disease management programs are currently offered. We identify program participants in many ways including practitioner claims and practitioner referrals. Members may also self refer for the programs. If you would like to refer a member for disease management, call 844-674-3845.

10.10 Case Management

LLH’s case managers work with Members after a hospitalization or procedure, and help members coordinate practitioner visits, appointments and inpatient and through the various levels of medical care and treatment ensure they are treated in an appropriate setting with disease education, non-hospital support services, and monitored to achieve an improved health outcome.
<table>
<thead>
<tr>
<th>Data Source</th>
<th>Referral Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims or encounter data</td>
<td>Data supplied by members and caregivers</td>
</tr>
<tr>
<td>Hospital discharge data</td>
<td>Health Information Line referral</td>
</tr>
<tr>
<td>Pharmacy data</td>
<td>DM Program Referral</td>
</tr>
<tr>
<td>Data collected from UM management such as members with high numbers of hospital admissions and ER visits</td>
<td>Discharge Planner Referral</td>
</tr>
<tr>
<td>Data supplied by purchasers (such as state and federal agencies, employers)</td>
<td>Member or Caregiver Referral</td>
</tr>
<tr>
<td>Practitioner Referral</td>
<td></td>
</tr>
</tbody>
</table>

Case managers will set goals and a care plan with members and will include collaboration with the member and/or caregiver to identify the best way to fill any identified gaps or barriers in order to improve access care and adherence to the adherence to the Provider’s plan of treatment.

**10.11 Complaints About Providers**
LLH conducts office site visits for practitioners if either of the following occurs: (i) in any given 6 month period, there are at least three complaints against the practice related to physical accessibility, physical appearance and adequacy of waiting room space and office space; or (ii) if at any time a complaint is received about a practitioner’s physical site that is considered, in LLH’s sole discretion, to be a potential threat to Member care and/or safety, LLH will conduct an office site visit based upon that complaint. The office site visit includes an assessment of the physical site and of the Medical/Treatment Record Keeping Practices of the Practitioner. Office site visits and the Medical/Treatment Record Keeping Practices are assessed against LLH’s standards.

**11. Member Rights and Responsibilities**
LLH’s goal is to treat all members with respect. LLH is dedicated to keeping members educated and informed of their rights and responsibilities while maintaining a high level of confidentiality with due consideration for dignity and privacy. LLH member Rights and Responsibilities can be accessed on our website at: [www.landoflincolnhealth.org](http://www.landoflincolnhealth.org).
11.1 Member Rights:
As a member of LLH you have the right to:
1. Receive information about your health plan, including its services, health plan staff and their qualifications, contractual relationships, health care Providers, member rights and responsibilities, policies and procedures.
2. Get information in an easy form that takes into consideration the special needs of those who may have problems seeing or reading.
3. Be informed by your doctor or other health care Provider regarding your diagnosis, treatment and prognosis in terms you can understand.
4. Receive sufficient information from your health care Providers to enable you to give informed consent before beginning any medical procedure or treatment.
5. Have a candid discussion of appropriate or medically necessary treatment options for your condition regardless of cost or benefit coverage.
6. Participate with Providers in decisions about your health, and participate in developing mutually agreed-upon treatment goals.
7. Be treated courteously, respectfully and with recognition of your dignity and need for privacy.
8. Refuse treatment, drugs or other procedures recommended by your Providers to the extent permitted by law and be informed of the potential medical consequences.
9. Be covered for emergency services in cases where a prudent layperson, acting reasonably, would believe that an emergency medical condition exists.
10. Have reasonable access to essential medical services
11. Obtain a copy of your medical records from your Providers in accordance with the law.
12. Call Member Services to file a complaint/grievance about LLH or file an appeal if you are not happy with the answer to your question, complaint/grievance or care given.
13. Make recommendations regarding LLH’s rights and responsibilities policies.
14. All covered services described in your certificate of coverage.
15. Find in-network Providers using the LLH website or by requesting a directory in writing from LLH Member Services.

11.2 Member Responsibilities
As a member of LLH you have the responsibility to:
1. Review and understand the benefit structure, both benefits and exclusions, described in your certificate of coverage and the member handbook.
2. Pay copayments or coinsurance and deductible payments as described in your Summary of Benefits, and give Providers current information regarding your membership status.
3. Follow established procedures for filing complaints or appeals concerning clinical or administrative decisions you believe were in error.
4. Supply information (to the extent possible) that LLH and your physicians and other Providers need to provide care.
5. Understand your health issues and participate in developing a mutually agreed upon treatment plan.
6. Follow plans and instructions for care that has been agreed upon with Providers.
7. Tell LLH how we can work better for you.

12. NCQA

12.1 Accreditation

In accordance with ACA requirements for Qualified Health Plans, LLH is accredited by the National Committee for Quality Assurance (NCQA). Accreditation is a mark of LLH’s commitment to quality improvement and providing excellent care and service. The NCQA Accreditation Survey review process examines the organization’s quality improvement program structure, tests quality improvement processes, and looks for evidence that quality improvement activities have resulted in measurable improvement in the organization’s performance in both clinical and service areas.

12.2 HEDIS

HEDIS is designed to measure plan and Provider performance on a number of measures to produce a consumer report card. The information collected from health plans is published to assist consumers in choosing a health care plan, physicians and other health care Providers. Specific HEDIS measures may change annually to reflect medical advances and to identify new areas in which to focus improvement efforts. Per Federal Requirements, LLH is also required to report a subset of HEDIS, Consumer Assessment of Health Plans and other measures as part of the Quality Rating System reporting process, QRS Reporting follows the same data collection timeframe processes as HEDIS reporting.

Periodically, LLH may request medical records or visit Provider offices to review medical records of members and to collect data.
13. Credentialing

Credentialing and re-credentialing is performed for all Providers requesting participation in the LLH network. LLH credentialing policies and procedures are based on NCQA requirements.

13.1 CAQH - Council for Affordable Quality Health Care

LLH is a member of the Council for Affordable Quality Health care ("CAQH"). We do require practitioners that are not credentialed through an approved delegated entity to submit their application to CAQH.
This card is for identification ONLY. It is NOT a guarantee of eligibility.

PRECERTIFICATION 844.674.3845
You must call for precertification prior to a scheduled admission or within 48 hours after an emergency admission.

Member Services 844.674.3844
Pharmacy Services 855.577.6551
Behavioral Health 800.753.5456

Important Provider Information:
Provider Inquiries or to Verify Eligibility/Benefits/Claim Status 844.674.3838

MAIL MEDICAL CLAIMS TO: Land of Lincoln Health
P.O. Box 618357
Chicago, IL 60661-8357

DentalGuard Preferred
Select Network
NOTE: Vision & Dental Benefits are only available to dependents 18 years old and under.

Send Electronic Claims To:
EDI Vendor #: 90096
EDI Clearinghouse: Emdeon

RX Bin: 610011
PCN: IRX
RX Group: LOLH

Centegra Land of Lincoln Health Plan Gold

Member Name: 001 CHARLES BURNS
Member ID #: 0000015285

PCP: Specialist:
$10/$40
$40/$85

No charge if service is provided by Indian Health Service, Indian Tribe or Indian Tribal Organization.

RX Bin: 610011
PCN: IRX
RX Group: LOLH

Preferred/In-Network

002 MAXINE LOMBARD
003 LARRY BURNS

Providers: Register Patient as Land of Lincoln Health
www.landoflincolnhealth.org
Land of Lincoln Health
Sample Member ID Cards

UTILIZATION REVIEW PROGRAM
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Land of Lincoln Health
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P.O. Box 618357
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### UTILIZATION REVIEW PROGRAM

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<table>
<thead>
<tr>
<th>Service</th>
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<tbody>
<tr>
<td>Member Services</td>
<td>844.674.3844</td>
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**Important Provider Information:**

Provider Inquiries or to Verify Eligibility/Benefits/Claim Status 844.674.3838

**MAIL MEDICAL CLAIMS TO:**

Land of Lincoln Health
P.O. Box 618357
Chicago, IL 60661-8357

**SEND ELECTRONIC CLAIMS TO:**

EDI Vendor #: 90096
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800.753.5456

Important Provider Information:
Provider Inquiries or to Verify Eligibility/Benefits/Claim Status
844.674.3838

MAIL MEDICAL CLAIMS TO:
Land of Lincoln Health
P.O. Box 618357
Chicago, IL 60661-8357

DentaGuard® Preferred
Select Network

NOTE: Vision & Dental Benefits are only available to dependents 15 years old and under

Land of Lincoln Health
Sample Member ID Cards
Land of Lincoln Health
Sample Member ID Cards

**UTILIZATION REVIEW PROGRAM**

**PRECERTIFICATION**

- 844.674.3845

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**Member Services**

- 844.674.3844

**Pharmacy Services**

- 855.577.6551

**Behavioral Health**

- 800.753.5456

**Important Provider Information:**

Provider Inquiries or to Verify Eligibility/Benefits/Claim Status

- 844.674.3838

**MAIL MEDICAL CLAIMS TO:**

- Land of Lincoln Health
- P.O. Box 618357
- Chicago, IL 60661-8357

**SEND ELECTRONIC CLAIMS TO:**

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- EDI Clearinghouse: Emdeon

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UTILIZATION REVIEW PROGRAM
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Pharmacy Services 855.577.6551
Behavioral Health 800.753.5456

Important Provider Information:
Provider Inquiries or to Verify Eligibility/Benefits/Claim Status 844.674.3838

MAIL MEDICAL CLAIMS TO:
Land of Lincoln Health
P.O. Box 618357
Chicago, IL 60681-8357

SEND ELECTRONIC CLAIMS TO:
EDI Vendor #: 90096
EDI Clearinghouse: Emdeon

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Pharmacy Services 855.577.6551
Behavioral Health 800.753.5456

Important Provider Information:
Provider Inquiries or to Verify Eligibility/Benefits/Claim Status 844.674.3838

MAIL MEDICAL CLAIMS TO:
Land of Lincoln Health
P.O. Box 618357
Chicago, IL 60661-8357

DentalGuard Preferred
Select Network

NOTE: Vision & Dental Benefits are only available to dependents 15 years old and under.
UTILIZATION REVIEW PROGRAM

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Pharmacy Services 855.577.6551
Behavioral Health 800.753.5456

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Land of Lincoln Health
P.O. Box 618357
Chicago, IL 60661-8357

DentalGuard Preferred
Select Network

NOTE: Vision & Dental Benefits are only available to dependents 18 years old and under.
Land of Lincoln Health
Sample Member ID Cards

UTILIZATION REVIEW PROGRAM

You must call for precertification prior to a scheduled admission or within 48 hours after an emergency admission.

Member Services: 844.674.3844
Pharmacy Services: 855.577.6551
Behavioral Health: 800.753.5456

Important Provider Information:
Provider Inquiries or to Verify Eligibility/Benefits/Claim Status: 844.674.3838

MAIL MEDICAL CLAIMS TO:
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P.O. Box 618357
Chicago, IL 60661-8357

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DentaGuard Preferred
Select Network

NOTE: Vision & Dental Benefits are only available to dependents 15 years old and under

This card is for identification ONLY. It is NOT a guarantee of eligibility.
1. Confirm Patient Insurance Status: 
   Check Member Information on the Land of Lincoln Health ID Card, Call number above or check 
   Provider Portal at LandofLincolnHealth.org.

2. Medical and Behavioral Health certifications are done by separate review companies. Please 
   refer to options listed above or patient ID card.

3. Precertification/Notification is required for certain services. There is a $500 benefit 
   reduction per episode of care applied to patient responsibility for each service not called in.

4. Access our provider portal and important documents at 
   LandofLincolnHealth.org

5. Referral Hotline for Emergency Behavioral Health Services, call 1-800-753-5456

6. Submit Claims within 90 days of service 
   Submit electronically using the EDI number #90096 (via Emdeon) or mail to:
   Land of Lincoln Claims 
   P.O. Box 618357 
   Chicago, IL 60661-8357

Claim status inquiry can be performed by accessing the provider portal or by calling 1-844-674-3838

- If you feel that a claim has been processed incorrectly or denied in error, please contact a claim specialist 
  for reconsideration of the claim at 844-674-3838.
- Once you have contacted a claim specialist for reconsideration and if you still are not satisfied with the 
  outcome of the claim, you may send in a formal written appeal request to:
  Land of Lincoln Health 
  222 S. Riverside Plaza, Suite 1900 
  Chicago, IL 60606, ATTN: Appeals
- If the issue is not resolved through the 1st written formal appeal process, you may submit a request for an 
  external review in writing to the same address above. Indicate request for external review.
- All appeals and reconsiderations may require copies of claims, EOB, and additional clinical information.
Land of Lincoln Health -2015 Services requiring Precertification/Notification

- **Inpatient Admissions & Services** - In facilities such as hospitals, skilled nursing facilities, rehabilitation facilities, behavioral health facilities and residential treatment facilities.
  - Emergency Admission (Notification Only – as soon as possible after admission but no longer than 2 Business days)

- **Maternity**
  - Maternity Admissions with additional precertification for stays longer than 48 hours for vaginal delivery and 96 hours for C-section delivery.
  - If newborn baby stays in the hospital longer than the mother, the newborn’s continuing hospital stay must be certified at the time the decision to extend the baby’s stay is made by the attending physician
  - Precertification required upon confirmation of pregnancy
  - Prenatal Care (Notification Only) for high risk or above routine care services. As soon as possible after the attending physician confirms pregnancy

- **Outpatient services**
  - All Outpatient Surgeries performed at independent or hospital surgical centers
  - In-office Invasive procedures with billed charges in excess of $500

- **Mental & Behavioral Health**
  - Intensive Outpatient or Partial Hospitalization for mental health and/or substance abuse

- **Radiology services**
  - Nuclear Cardiac
  - CT Scan (includes CTA)
  - MRI/MRS/MRA
  - PET Scan
  - Nuclear Scans
  - Radiation Therapy services provided at any location

- **Therapy Services**
  - Autism Spectrum Disorder
  - Physical Therapy
  - Cognitive/Occupational/Speech
  - Cardiac and Pulmonary Rehabilitation
  - Habilitative Services

- **Other Services**
  - Chiropractic Services (24 visits yearly)
  - Cosmetic (Reconstructive)
  - Bariatric Surgery
  - Durable Medical Equipment with billed charges in excess of $500
  - Home Health Care
  - Hospice Care (Inpatient and Outpatient)
  - Infertility Treatment
  - Prosthetics and Certain Orthotics
  - Renal Dialysis & ESRD
  - Skilled Nursing Care/Private Duty Nursing Services
  - Transplant Services

- **Infusion Therapy/Injectable Drugs**
  - Chemo Infusion Therapy
  - Non Chemo Infusion therapy and Injectable drugs with billed charges in excess of $1,000

- **Pharmaceutical**
  - Drugs administered in a provider’s office
    - Specialty Drugs with billed charges in excess of $1,000
    - Off-label use of drugs with billed charges in excess of $1,000
  - Drugs Purchased at Pharmacy
    - Drugs requiring precertification & purchased at a pharmacy will be coordinated through Catamaran not Valence. If you have questions, call 1-855-577-6551
    - Specialty Drugs and other drugs identified as needing preauthorization on the formulary list
    - Non-formulary drugs
    - Off-label use of drugs

*For Precertification, Notifications, Case Management and Disease Management call Valence Health at 1-844-674-3838*

Precertification and Notifications need to be called in 5 business days prior to services rendered or 2 business days following an emergent case. Failure to Pre-Certify will result in a $500 benefit reduction applied to patient responsibility for each episode of care not called in. Services listed for Precertification and Notification are not a guarantee of covered benefits and may vary by plan- please check eligibility and benefits for patients.