

The Health Plan



THP Insurance Co.

Here for You!



General Program Information

This document is intended merely as a general guide; members should refer to their individual handbook for specific details regarding plan benefits.

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Health Plan Contact Numbers

Main Switchboard

St. Clairsville 740.695.3585/1.800.624.6961
Massillon330.834.2200/1.877.236.2289

Customer Service--Providers

St. Clairsville740.695.7901
Massillon330.830.4370/1.888.830.4370

Customer Service—Members

St. Clairsville 740.695.7902/1.888.847.7902
Massillon330.837.6880/1.800.426.9013

Pre-Authorization Dept.

Massillon330.830.4370/1.888.830.4370

Pre-Authorization Help Line

St. Clairsville 1.800.753.2851
Massillon330.830.4370/1.888.830.4370

Referrals

St. Clairsville 740.695.7905/1.800.526.7511
Massillon330.830.4370/1.888.830.4370

Coordination of Benefits

St. Clairsville740.695.7903
Massillon330.834.2266

Enrollment Services

St. Clairsville740.695.3585

Pension

St. Clairsville 740.695.7906/1.866.581.8302

SecureCare/SecureChoice (Medicare) Members

St. Clairsville 740.695.7907/1.877.847.7907
Massillon330.834.2301/1.877.236.2296

Mountain Health Trust/ Mountain Health Choice Members (WV Medicaid)

St. Clairsville 740.695.7904/1.888.613.8385

Workers' Compensation

St. Clairsville 740.695.7678/1.888.847.7810

Outpatient and Elective Services

St. Clairsville 740.695.7905/1.800.526.7511
Massillon330.830.4370/1.888.830.4370

Customer Service Provider Relations

St. Clairsville 740.695.7901/1.800.624.6961
Massillon330.830.4370/1.888.830.4370

TDD (Hearing Impaired Only)

St. Clairsville 1.800.622.3925
Massillon 1.877.236.2291



Introduction

Respect for our members, respect for our providers, and respect for our clients.

At The Health Plan, our strong relationships with the communities we serve are driven by respect for the people who reside in our service areas.

The Health Plan developed the following mission statement to reflect our view of the role of our program.

“In its mission to provide a comprehensive delivery of health care services, The Health Plan strives to protect the patient’s right to obtain services in a cost efficient and quality system where patient dignity and satisfaction are enhanced by the services of The Health Plan and its provider network.”

Since 1979, The Health Plan has been pursuing this mission by helping our members stay healthier while helping employers provide high quality health coverage for their employees. Locally owned and operated, we can effectively serve the needs of the communities throughout our market area. With office locations in St. Clairsville, Ohio; Morgantown, West Virginia; and Massillon, Ohio, we provide a strong local community presence. We are readily available to our members and providers on a daily basis.

The Health Plan Member's Rights and Responsibilities Statement

Statement of Member's Rights	Statement of Member's Responsibilities
<ul style="list-style-type: none"> Members have the right to receive information regarding the Plan. Information such as a summary of the Plan's accreditation report and the Plan's services, policies, benefits, limitations, practitioners, and providers. Members have the right to information on member's rights and responsibilities and any charges they may be responsible for. Members have the right to obtain evidence of medical credentials of a Plan Provider, (i.e. diplomas and board certifications). If a member needs assistance with any of the above, they may contact the Plan's Customer Service Department at 1.888.847.7902 or 704.695.7902. Members can expect to receive courteous and personal attention and to be treated with dignity. Plan employees, providers, and their staff will respect members' privacy. All information concerning a Health Plan member's medical history and enrollment file is confidential. The member has a right to approve or refuse the release of personal information by The Health Plan except when the release is required by law. The Health Plan assures that all patient information is held in the strictest confidence. All Health Plan staff must adhere to the Health Plan Confidentiality Policy revised and adopted in November 1993. This statement acknowledges the confidential nature of the review work, includes an agreement to honor that confidentiality, and documents the consequences of failing to do so. The member's personal choice of a primary care physician enables the member to participate in the management of his/her total health care needs, including the right to refuse care from a specific practitioner. Health Plan members are encouraged to establish a relationship with their chosen PCP so that they can work together to maintain good health. A Health Plan member may change physicians once per calendar month if so desired (depending upon the availability of the chosen physician). 	<ul style="list-style-type: none"> A member must choose a Primary Care Physician ("PCP") for each person listed on the Health Plan ID card. The member has a responsibility to maintain a relationship with a PCP, as the PCP will act as the coordinator for all of his/her health care needs. A member must identify him/herself as a Health Plan member to avoid unnecessary errors; always carry their ID cards; and never permit anyone else to use their ID card. A member is asked, through "Outreach" calls to new members, to read their Member Handbook and understand the benefits and procedures for receiving health care services. To assure maximum coverage, the member has a responsibility to follow the rules and to contact The Health Plan for assistance, if necessary. A member is required to notify The Health Plan of any changes in the following: <ol style="list-style-type: none"> Name, Address, Telephone Number Number of Dependents (Marriage, Divorce, Newborns, etc.) Loss of an Identification Card. Selection of a Primary Care Physician. Members are asked to be on time for appointments and to call the physician's office promptly if appointment can't be kept. Members must provide necessary information to the providers rendering care. Such information is necessary for the proper diagnosis and/or treatment of potential or existing conditions. Understand your health problems and participate in developing mutually agreed upon treatment goals, to the degree possible, and follow those instructions and guidelines given by those providers who deliver health care services. If members receive emergency care outside The Health Plan's service area, they are required to contact The Health Plan as soon as possible within 48 hours.

The Health Plan Member's Rights and Responsibilities Statement (continued)

Statement of Member's Rights	Statement of Member's Responsibilities
<ul style="list-style-type: none"> • Health Plan members have the right to express their comments, opinions or complaints about The Health Plan or the care provided and to file a grievance for an administrative or medical complaint and hearing procedures without reprisal from The Health Plan. Members also have the right to have coverage denials reviewed by the appropriate medical professionals consistent with The Health Plan review procedures. Both informal and formal steps are available to Health Plan members to resolve all complaints/grievances. • Health Plan members are encouraged to participate in decision-making about their health care when possible and within the Plan guidelines. Members have a right to discuss with providers, without limitations or restrictions being placed upon the providers, appropriate or medically necessary treatment options for their condition(s) regardless of cost or benefit coverage. However, this does not expand coverage by the Plan. Members also have the right to formulate Advance Directives. • Health Plan members have the right to have a meaningful voice in the organization by expressing their suggestions & comments regarding their Health Plan coverage, policies, Member Rights & Responsibilities, and operations. Member's comments and opinions are received by The Health Plan through yearly member satisfaction surveys, telephone calls from our members, by e-mail to: information@healthplan.org, by the website: www.healthplan.org, and can also be placed in our "Member's Suggestion Box" located in The Health Plan lobby. Member's comments/opinions are also received through various Health Plan Departments. • Members have the right to full disclosure, from their health care provider, of any information relating to their medical condition or treatment plan. Members have the right to examine and offer corrections to their own medical records, in accordance with applicable federal and state laws. The Plan will not release personal health information to an employer, or its designee, without a signed Plan Authorization Form by the member. For information on obtaining medical records, contact The Health Plan Customer Service Department at 1.888.847.7902 or 740.695.7902. 	<ul style="list-style-type: none"> • Members must contact their Primary Care Physician, Secondary Care Physician or OB/GYN before seeking any specialty physician/service. • Members must provide The Health Plan with all relevant, correct information and pay The Health Plan any money owed according to coordination of benefits or subrogation policies. • Members must make required co-payments under the "Schedule of Benefits". • Members are asked to be courteous and respectful of Health Plan employees, providers, and their staff.

Your Community of Providers

Locating a Health Plan provider in your community is as easy as searching the web at www.healthplan.org or by calling Customer Service at **1.888.749.7902**. With over 6,100 providers located throughout Ohio and North Central West Virginia, Health Plan's network of Physicians, Hospitals and Extended Services is there to meet your healthcare needs.

In addition to providers based in your community, The Health Plan also provides a comprehensive network of specialized medical facilities including several world renowned academic medical centers. Your community providers along with The Health Plan Medical Management staff can help you coordinate your care and arrange for access to the specialized centers when needed.

Health Plan members can rest assured network providers are well credentialed according to National Committee of Quality Assurance (NCQA) guidelines. We go to great lengths to review the applications submitted by prospective providers and verify their credentials. New providers are reviewed and approved by our Medical Director, Credentialing Committee, which is a peer committee of plan participating physicians, and finally our Executive Management Team. Once a provider is on our plan, they are reevaluated every three years to ensure their credentials continue to meet our high standards.

Whether at home or when traveling outside our service area, if you feel you have a medical problem that must be treated immediately and access to your physician is limited, The Health Plan provides for Emergency Care. The Health Plan provides a nurse on call 24 hours a day seven (7) days a week who is there to assist in obtaining the needed care. If your situation is life threatening, please call 911 immediately and/or proceed to the nearest emergency room when possible. We'll work out the details later.

From finding a provider who specializes in a certain area or has office hours more conducive to your lifestyle to finding a provider who speaks a special language, Health Plan Customer Service Representatives are well trained to assist you with special needs that may occur from time to time. Please call **1.888.847.7902** and we'll do the rest.

Whether long or short-term, The Health Plan works with your Primary Care Physician as well as other providers to ensure that you have access to the appropriate specialty care necessary. We work with our provider network to ensure that they communicate regularly regarding your unique care needs. It is important that all of your regular providers have updated information on your on-going treatment needs. For this reason, we often work with the providers to ensure that reports and treatment plans are shared as appropriate.

Here for you . . . care for you . . . The Health Plan and our provider network are there for you!

Our provider relationships help to embrace **TWO** important concepts:

1

The personal physician. Members enrolled in our HMO and POS products are required to select a Primary Care Physician (PCP) who acts as your coordinator of care.

Members contact their PCP who can assist them in their care needs.

Although not required, PPO and other members are likewise encouraged to select a PCP for their care needs.

2

An established provider network. The Plan contracts with providers in order to obtain quality care at an affordable price. This enables us to contain premium increases to our membership and ensure that our members are cared for by a qualified group of health professionals.

Your Pharmacy Program

The Health Plan Pharmacy Program is **Regionally** focused with a **National Strength**

We are dedicated to delivering the personal attention, care and convenience you deserve.

Our program provides:

- Access to specially trained pharmacy technicians supported by our in-house staff of Pharmacists, Nurses, and Physicians.
- Technicians that are available 24 hours seven (7) days a week to provide benefit support and clinical assistance to you or your physician.
- Pharmacists who are available to discuss your medications and offer clinical guidance in areas of cost savings, drug interactions, and treatment options.
- A formulary (list of covered medications) that has been reviewed by local physicians and pharmacists to meet your needs for drug therapy.
- Clinical coverage review for medications that need prior authorization by staff pharmacists and physicians that focus on individual patient needs.
- Telephonic coverage review for prior authorizations. Over 95% of authorizations are completed in 48 hours or less.
- National coverage of your prescriptions to over 52,000 pharmacies in the United States.

We offer mail service pharmacy services through our partner Medco Health Solutions. Medco provides up to a 90 day supply of medications delivered to your home. Access to Medco is provided by www.medco.com. In most cases physicians can fax your prescriptions directly to Medco from their office to reduce the wait time in receiving your prescription.

Specialty Pharmacy

In addition to your regular pharmacy needs, we provide a Specialty Pharmacy Program to focus on the delivery and management of high cost pharmaceutical products that are generally, but not exclusively, biotechnological in nature. Due to the unique requirements associated with dispensing and administration of these medications and the covered services and reimbursement, Specialty Pharmacy can fall under either a Medical or Pharmacy benefit; therefore, reviews are required on a case-by-case basis.

to preauthorize
Specialty Pharmacy,
call:

1.800.624.6961, ext. 7914

Preauthorization is required for the following:

- Depo Lupron
- Colony Stimulating Drugs— Neupogen, Neulasta, Procrit,
- Epogen, Aranesp, Neumega
- Hep C Drugs – Pegasys, Co-Pegasys
- MS Drugs – Avonex, Betaseron, Copaxone, Rebif
- RA Drugs – Enbrel, Humira, Raptiva
- Viscous Supplementation - Synvisc, Hyalagan, Supartz
- Others – Forteo, Boniva injection, Byetta

Your Medical Management

The Health Plan Medical Management Department is available to ensure that the healthcare needs of each and every member are met in a prompt and efficient manner. The Health Plan Medical Staff consists of Physician Medical Directors, Registered Nurses, Pharmacists, and Social Workers with vast experience in primary, specialty, and behavioral health care. Our Health Plan nurses are available 24 hours a day, seven (7) days a week to assist with care needs including after-hours emergencies.

Services available to our members include the following:

Disease Management Services

Our Disease Management Programs provide resources to help manage chronic diseases such as diabetes, chronic heart failure, and chronic obstructive pulmonary disease. In addition, there is support to families experiencing a high risk pregnancy. Health Plan Disease Management Nurses team up with our physician to provide members with the needed support.

The Health Plan's Disease Management and Health Promotion Programs are developed to proactively identify populations with, or at risk for, chronic medical conditions. We currently manage members with diabetes, chronic heart failure, and chronic obstructive pulmonary disease. Our disease management programs support the practitioner-patient relationship and plan of care, emphasize the prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies. The Health Plan's pregnant members are also monitored with the intent to identify those at high risk for premature delivery. Our programs continuously evaluate clinical, humanistic, and economic outcomes with the goal of improving overall health status.

Chronic Obstructive Pulmonary Disease Program

This program is designed to modify risk factors associated with COPD as well as slow the progression of the disease by promoting treatment plan compliance through education, counseling, and support. Members with COPD require long-term, continual health care to maintain functional status and to help eliminate disease complications.

Congestive Heart Failure Program

This program is designed to modify cardiovascular risk factors and slow disease progression by promoting treatment plan compliance through education, counseling and support.

Diabetes Program

This program is designed to modify risk factors associated with diabetes as well as slow the progression of microvascular and macrovascular complications by promoting treatment plan compliance through education, counseling, and support. Members with diabetes require long-term, continual health care to maintain appropriate glycemic control and to decrease the risk of long term complications.

Prenatal Care Program

This program is designed to improve pregnancy outcomes and, hopefully, reduce neonatal hospitalizations associated with pre-term birth and other complications of pregnancy by providing prenatal education, promoting safe health behaviors, and enhancing the management of maternity care for women identified at high risk for premature labor and delivery.

The Disease Management Staff can be reached at **740.699.6110** or **1.800.624.6961, ext. 6110**. You can also find on the web at **www.healthplan.org** (Members > Member Services)

Your Medical Management (continued)

Case Management Program

The Health Plan Case Management Nurses assist members and their families with the most devastating health crises and illnesses by coordinating care with specialists at tertiary centers and continuing through rehabilitation and home health.

Registered nurses perform the case management function. They coordinate care and resources, provide alternatives to hospital care, facilitate care across the continuum and prevent duplication and fragmentation of health care services. They manage individual patients normally on a long-term basis who are identified to be at high risk due to catastrophic illness or injury.

Care Management and Social Services

Care Management Nurses and Licensed Social Workers are on staff at The Health Plan to assist in coordinating care and resources for our members with long-term or on-going health needs related to illness or injury. They coordinate and authorize services such as home care, specialty care and equipment needs. As nurses and social workers assist with your needs, they focus on promotion of health education, and member empowerment through self-maintenance. Members are identified by information provided from medical review activities, by referrals from family members or physicians, health risk assessments, and surveys.

The Utilization Management Program

The Utilization Management Program oversees the provision of appropriate health care services to its members, while addressing the effectiveness and quality of the care. The goal of utilization management is to promote the access of medically appropriate care in a timely, effective and efficient manner across the network through case/ care management, pre-authorization/referrals, admission/concurrent review and disease management programs.

Pre-authorization is performed to confirm eligibility, benefits, and medical appropriateness of services. The process is initiated by the member's Primary Care Physician or referring participating specialist with the assistance of the Medical Department Nurses.

Some services that require pre-authorization include, but may not be limited to (please refer to your handbook for specifics):

- Admissions to a hospital, skilled nursing or rehabilitation facility
- Admissions to a mental health facility
- All out-of-plan and tertiary care
- CT/ MRI/ MRA and PET scans
- Chiropractic care
- Home Health Services and Hospice Care
- Speech therapy
- Wheelchairs, Orthotics, and other Durable Medical Equipment

Evaluation of the medical appropriateness of the service is based on clinical information submitted by the provider and/or physician. Nationally recognized clinical criteria are utilized to perform reviews for medical appropriateness allowing for consideration of the needs of the individual member, their circumstances, medical history and availability of care and services within The Health Plan network. Input is sought in the review of criteria from physicians in the community who serve as members of our Medical Advisory Committees. In cases where specific clinical expertise is needed to perform a particularly specialized review, experts outside The Health Plan may be used.

Your Medical Management (continued)

The Health Plan makes determination decisions in a timely manner to best meet the needs of the member and to accommodate the clinical urgency of the situation.

- Non urgent pre-service decisions are made within two working days after receipt of the information.
- Urgent pre-service decisions are made within the day of receipt of request.
- Emergent pre-service decisions are made within one hour.

Communication is the key to completing prior authorizations, concurrent reviews and care/case management processes. You and your physician have the right to appeal in the event that services are not authorized. The Health Plan has written policies and procedures in place for registering and responding to pre-service, post-service, expedited appeals and appeals to an independent review entity. The process is member and physician friendly. Health care professionals with appropriate expertise participate in review of all appeals.

The Health Plan does not provide any financial incentive to practitioners and/or other individuals for denials of coverage or care.

An **APPEAL** may be initiated the following ways:

Members write or call Customer Service:

St. Clairsville	740.695.7902 or 1.888.847.7902
Massillon	330.837.6880 or 1.800.426.9013

Providers write or call Customer Service:

St. Clairsville	740.695.7901
Massillon	330.830.4370 or 1.888.830.4370

SecureCare Members must submit an appeal in writing only:

Written appeals may be mailed to:

APPEALS	or	APPEALS
THE HEALTH PLAN		THE HEALTH PLAN
52160 NATIONAL ROAD EAST		PO BOX 4816
ST CLAIRSVILLE OH 43950		MASSILLON OH 44648

We care about the care you receive!

Assessment of the quality of medical and behavioral health care is essential in today's health care delivery system. In the managed care setting, it is particularly important that quality issues receive appropriate emphasis. The Health Plan is committed to assuring that our enrollees, customers, and employers receive quality medical care and service, including behavioral health and substance abuse management, throughout our participating provider network.

Quality of care emerges most effectively from an internal commitment of providers to ongoing self-assessment and quality improvement. However, an internal commitment is not sufficient; there is a need to monitor general levels of quality, to identify areas in which improvement is needed, and to use appropriate means of affecting change when indicated.

The Health Plan recognizes that preventive services are a key to wellness and encourages members and providers to adhere to the Preventive Service Guidelines that are distributed annually. The HEDIS® reports are generated each spring and provide information regarding the areas where progress has been made as well as the areas where additional or a change in interventions are indicated.

The Health Plan also recognizes that patient safety has become an important factor in healthcare. At the forefront of safety is continuity and coordination of care between providers and settings of care. The Health Plan's Quality Management Program has been designed and operationalized to monitor and evaluate the degree to which health care services, operational processes, and customer service compare to expected outcomes and identify opportunities and strategies for improvements.

Goals & Objectives

The Health Plan Quality Management program goals and objectives are to:

- Establish standards and processes for measuring, evaluating, and improving the quality of care and services provided to members and customers. Performance monitors will include but may not be limited to the following areas:
 - Quality of clinical care including behavioral health and substance abuse management
 - Service quality and process improvement
 - Provider credentialing and recredentialing
- Employ a multi-disciplinary approach to identify areas where improvement is needed and implement and monitor corrective action plans
- Demonstrate improvements in the health delivery system as a result of quality improvement initiatives
- Demonstrate improvement in the quality of medical care and services provided to members as a result of quality improvement initiatives
- Demonstrate compliance with external Quality Improvement regulators and programs

Your Health & Wellness

Benefits and programs encourage everyone to stay healthy by seeking preventive care and medical treatment at the onset of illness. Wellness programs focus to promote healthy lifestyles and minimize health problems, enhancing the quality of our enrollees' life.

Members are encouraged to take advantage of the wealth of information and services offered at The Health Plan that will enhance well-being. We offer a way for you to sign up for Screening Test Reminders. Just one of many aide for you to remember your regular screening tests. You will be encouraged to sign up for email reminders.

Below is more of a taste of such information that may be obtained on The Health Plan website. Check out www.healthplan.org often for updates!

Web Access Points

- **Monthly Wellness Information:** Each month features short educational and informative pieces with links to various websites on specific topics.
- **Health Risk Assessments:** Online Health Risk Assessment tests from HealthStatus that give you customized health reports and self management tools. Sign up today to get started!
- **Disease Management Program:** Disease Management and Health Promotion programs are multi-disciplinary and continuum-based systems developed to proactively identify populations with, or at risk for, chronic medical conditions.
- **Preventive Health Guidelines:** The Preventive Health Guidelines help to ensure you obtain the recommended preventative services in the time frames indicated. Be sure to review these and stay on top of your healthcare.
- **Are You Pregnant?** Pregnant Health Plan members with concerns or questions about their pregnancy can enroll in the Pregnancy Program by accessing the Pregnancy Enrollment Form. A Health Plan nurse will call you. A link to March of Dimes information is accessible to assist members.
- **Advance Directives - Planning your care:** Resources to assist you and your family plan your medical care, including information on preparing a Living Will and Medical Power of Attorney.
- **Additional Links and Resources:** You as a member are directed to a number of website links that help with your health and wellbeing.

Community Based Services

Community Health Fairs
Watch for notice of Health Fairs sponsored by The Health Plan that may take place in your community. Plan to attend and obtain information on various health and wellness topics.

Flu Shot Clinics

Annually, The Health Plan provides clinics in some of our local communities to assist our members in obtaining needed flu shots. Be sure to watch for information on available clinics in your area.

Smoking Cessation Classes

Whether through programs offered by The Health Plan at one of our regional offices or through programs offered by our affiliated providers and hospitals, The Health Plan supports your efforts to quit smoking.

Vaccines & IMMUNIZATIONS

Vaccines have contributed to a significant reduction in many childhood diseases, such as diphtheria, polio, measles, mumps, and whooping cough. It is now rare for an American child to experience the devastating effects of any of these illnesses. Infant deaths due to these childhood diseases have nearly disappeared in the United States. But the germs that cause these vaccine-preventable diseases and death still exist, and can be passed on to people who are not protected by vaccines. Getting immunized is a life-long, life protecting job. Each Health Plan member is encouraged to make sure that you and your children have all the vaccinations needed to live a healthy life.

As part of our commitment to member wellness, we offer free flu and pneumonia vaccines to every member. A doctor's prescription is only needed for the pneumonia vaccine. Visit www.healthplan.org for dates and locations.

For more information and to download childhood/adult immunizations schedules please visit:
www.cdc.gov/vaccines/events/niam/default.htm

..... Preventive Health Care

Keeping you healthy is a primary goal of the Quality Improvement Department. The Preventive Health Guidelines are recommendations to keep you healthy to live a longer and happier life. Do not wait until you get sick; make an appointment to see your doctor when you are healthy for a complete physical.

Discuss with your doctor your current health status and appropriate preventive health measures specific to meet your needs. The preventive health guideline recommendations are based on recognized national resources. May we encourage you to take a moment and review The Health Plan's Preventive Health Guidelines for a complete list of recommendations—it is your life, please live it well!

To view current preventive guidelines, please visit:
www.healthplan.org (Members > Health & Wellness > Wellness Resources)

Wellness & Education

Exciting things have been happening on The Health Plan Member website. In an effort to educate our members and encourage you to have preventive healthcare and screenings, we have dedicated a portion of our website to wellness. Each month a specific topic, such as education, prevention, and screenings are addressed with links to credible websites that provide more information on the topic.

Our website also provides a tool to help you perform your own health risk assessment. This interactive tool is designed to help you and your physician determine your health risk for certain preventable diseases, key habits you can change to live healthier, and appropriate screenings you should have. You can also calculate your BMI (body mass index) and level of fitness using one of our many self management tools.

To access this information visit:
www.healthplan.org (Members > Health & Wellness)

Your Behavioral Health Services

The goal of the Behavioral Health Unit (BHU) is to ensure the highest quality of care for our members. To that end, we will work directly with providers and members to coordinate care and make known available resources within the provider and the community networks. Our Case Managers and Referral Coordinators are available to assist you and your providers in obtaining and locating needed services.

The BHU will work directly with other departments at The Health Plan to address behavioral health related concerns. This will incorporate behavioral components with disease management, primary care, specialty care, and behavioral providers.

24-Hour Phone Number

1.877.221.9295

For any Behavioral Health need

New Technology Review for You

As part of our commitment to assuring you and your family receive appropriate, quality healthcare services, The Health Plan Transplant and New Technology Committee (T&T Committee) evaluates new medical technologies and the new application of existing technologies including medical procedures, drugs, devices, and transplants to determine medical efficacy, safety, and appropriateness of treatment. We utilize various resources for our review including Medicare and Medicaid policies, FDA releases and current medical literature. Relevant appropriate medical specialists are asked to provide input when particular expertise is needed.

The Transplant and New Technology Committee is responsible for the development of Coverage and Review Guidelines to assist in determinations of medical appropriateness based on current supporting documentation available at the time of the review or request of a particular technology or service. Resources utilized in the committee review process may include:

- Centers for Medicare and Medicaid Services (CMS) coverage policies (National and Local)
- Winifred S. Hayes, Inc. independent technology assessments
- Federal and state regulatory agency guidelines and mandates
- Clinical outcome studies and data in peer-reviewed published medical literature
- Positions of nationally recognized health professional societies and colleges
- Managed Care organizations
- Technology and research agencies
- Opinions of physicians and practitioners in relevant clinical areas

Periodically, and upon request, the Committee will revisit and revise previously rendered review guidelines to establish if changes or updates are needed based on updated information on the technology, procedure, or service. The T&T Committee will notify practitioners of all technologies reviewed in The Health Plan Provider Newsletter and its determinations regarding coverage.

Please contact The Health Plan Medical Department for information regarding indications/inclusions, contraindications/exclusions, and limitations of coverage, as well as, preauthorization requirements that may apply to specific technologies, therapeutic approaches and services.

Coordinating Your Benefit Plans (COB)

Coordination of Benefits (COB) is intended to avoid claim payment delays and duplication of benefits when a person is covered by two or more Plans providing benefits or services for medical treatment. Coordination of Benefits is designed to eliminate the opportunity for a person to profit from an illness as a result of duplicate group health care coverage. By allowing two or more insurance carriers to work together, the insurance companies can ensure that claims are divided fairly and can avoid paying the same medical bills twice.

Claims for members with other insurance should be submitted to the Primary Carrier first for payment. The Primary Plan (the Plan that pays benefits first) always pays the same benefits it would pay in the absence of any duplicate coverage. The Secondary Plan (the Plan that pays benefits second) pays the difference of their allowable amount and whatever the Primary Plan paid. The Health Plan will work with your provider to ensure that you receive the maximum allowable benefit under your plans.

Order of Benefit Determination Rules

- Employee:** The Plan covering the person as an employee pays benefits first. (If the patient is our subscriber (the person who works directly for the Employer), The Health Plan is primary).
- Spouse:** The Plan covering that person as a dependent pays benefits second. (If the patient is the spouse of our subscriber, The Health Plan is secondary to the spouse's insurance).
- Dependent Children:** The Plan covering the parent whose birthday falls earlier in the year is determined before those of the Plan of the parent whose birthday falls later in that year. The term "birthday" refers only to the month and day of birth during the calendar year. (If both parents have the same birthday, the benefits of the Plan that covered the parent the longest is the Primary Plan).

More specific rules may apply for special circumstances.

**You may contact The Health Plan
COB Department at:**

St. Clairsville: 740.695.7903

Massillon: 330.834.2266

Understanding Your Benefits & Claims Payment

Understanding how your health insurance company reviews and pays your claims may seem like a complicated and confusing process. You may have an Indemnity or Preferred Provider Plan (PPO) that pays medical bills after they are incurred or you may be covered under one of the many varieties of Health Maintenance Organization (HMO) plans that may require a primary care physician to direct your care. It's tempting to ignore the whole claims payment process and assume that the Plan and doctors are communicating and handling everything satisfactorily.

Health insurance is not maintenance free and does require some monitoring on your part to ensure that billing and claims processing is handled appropriately. Just as you take an active role in your healthcare and treatment as a patient, you must also be aware of how your medical care is authorized and funded. You don't have to become an insurance expert to be able to oversee how your insurance company is processing the medical bills you are incurring. You do need, however, to obtain a copy of your coverage and to understand it. Become familiar with your benefit documents and keep them handy as you need to review information pertinent to your coverage and claims payments.

Areas to Locate in Your Plan Book

- **Schedule of Benefits** – is often found at the front of the plan description. It is the part that explains what the insurance company pays and what you as a patient pays. It lists the deductibles, the percentage that the insurance company funds and the co-pay that you are expected to pay at each doctor's visit.
- **Covered Benefits** – is a listing of what is covered.
- **Exclusions and Limitations** – lists the items that the plan will not cover, such as experimental treatment or cosmetic surgery. It also lists the services that will be covered but may have special limits, such as therapy, skilled nursing care, rehab or treatment for conditions that existed when your coverage started.
- **Claims Procedures** – explains how to file a claim. The important section here is how to appeal denials. You may want to read this section through, as there are usually some important time limits and other key information to consider.

For HMO plans, most of the claims work is done between your doctor and the HMO. It may require authorizing treatment before it is given. Learn about your medical condition. Know what alternatives to treatment are available. Ask if you will be notified if a denial occurs and work with your physician to explore alternatives or how you can participate in an appeal process.

Understanding Your Benefits & Claims Payment *(continued)*

Explanation of Benefits (EOB)

You will receive an Explanation of Benefits (EOB) whenever a claim is processed that assesses a member's financial responsibility beyond the stated co-pay amount. Review each EOB carefully. Check to see if everything was allowed in full, even if only a percentage was paid. If not, call your insurance company and ask for an explanation. There will be a toll-free phone number noted on the EOB. Don't be bashful about asking for more clarification. Take notes as to whom you talk to and what they say. Contact your physician if you disagree with the services the insurance company was charged for. Most billing is communicated between doctor and the insurance company in codes, and one misplaced digit can make a substantial difference in the medical care paid for or allowed. It is important to catch those small errors early, and you, as the claimant, are the best person to do it.

This process may take some time and effort on your part to understand how the process works and how you can affect it, but it will be well worth it.

Payments that may be your responsibility

The Health Plan offers a variety of benefit plans that require the member to be responsible for a portion of the cost of services. Member responsibility may take the form of co-pays for office visits or other medical services, coinsurance amounts and deductibles. As groups re-enroll annually, the member co-payment may change, depending upon the plan selected by the employer.

Office Visit Co-Pay / Medical Co-Pay: Generally, co-pays are a fixed amount, but may be a percentage of the allowed amount that is associated with a specific service such as an office visit, therapy visit, or diagnostic service and would be member responsibility. You are expected to pay this amount at the time the service is rendered.

Coinsurance: Generally, coinsurance is an amount based upon the member being responsible for a percentage of the allowed amount for a covered service. A provider may request payment at the time of service. However, the provider must take care to determine the member's specific benefit and apply any contract reimbursement terms to determine the amount of the coinsurance. At no time should a provider collect more than the amount that is contractually obligated to pay. The Health Plan will provide you with an Explanation of Benefits (EOB) showing the amount that you owe.

Deductibles: Deductibles are an annual amount as defined by the member's benefit plan that members must satisfy before the plan pays for any services. A provider may expect payment from the member at the time of service, if the member has not satisfied their annual deductible. The Health Plan will provide you with an Explanation of Benefits (EOB) showing the amount that you owe.

Your Emergency Care

Your health is important to us and when there is an emergency, prompt action on your part is extremely urgent. Please keep in mind the following information to guide you in an emergent situation and visit your Plan Member Handbook for the Emergency/Urgent Care section.

Emergency Care is provided by a hospital emergency facility and includes emergency transportation, when medically appropriate. Emergency care is available seven (7) days a week, 24 hours a day to evaluate, treat and stabilize a medical condition. This condition manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Serious jeopardy to the health of the individual (or an unborn child).
2. Serious impairment to bodily functions.
3. Serious dysfunctions of any bodily organ or part.

Examples of an emergency are as follows:

- Acute abdominal or chest pain
- Seizures
- Broken bones
- Severe burns or lacerations
- Convulsions
- Symptoms of a heart attack
- Excessive bleeding
- Unconsciousness
- Poisoning

Emergency room visits are subject to review and non-emergent services will not be paid by the Plan. True emergency services are covered without regard to preauthorization. Plan hospital emergency facilities are listed in your Provider Directory.

WHAT TO DO IN AN EMERGENCY

- **First, when practical, CALL YOUR PCP DAY OR NIGHT. He/she can direct you to the appropriate care and can assure proper follow-up to that care.**
- **If your PCP cannot be reached, call the Plan's 24-hour/seven days a week emergency number: 740.695.3585 or 800.624.6961. You will be put in contact with a "Plan Nurse on Call" for direction on what to do.**

When a phone call is impractical or impossible, go directly to the nearest in-plan emergency room, if possible. Identify yourself as a Plan member. Contact your PCP. By informing your physician of the situation, your care can be better coordinated.

EMERGENCY RULES OF THUMB

1. Attempt to reach your PCP.
2. Call the Plan: **740.695.3585** or **800.624.6961**.
3. Go directly to an in-plan emergency room and contact your PCP within 48 hours of the visit.
4. Call 911 if available in your area.

Your Emergency Care (continued)

Out-of-Area Emergency Care is used if you are temporarily out of the Plan Service Area or are transported out of the Service Area by medical personnel, and receive services for a medical emergency. Please refer to your Plan Manual for further information as to what your Plan will cover.

- Always present your Plan ID card for payment.
- If you are hospitalized, the Plan should be notified within 48 hours or as soon as reasonably possible.
- If you are required to pay upfront, always get an itemized copy of the bill attached to your payment receipt to send to your Plan Insurance Company's Customer Service.

Non-Plan Hospital Emergency Care in Service Area may be covered providing certain circumstances and then the Plan may require a transfer to an in-Plan hospital when deemed medically feasible by the Plan. Please refer to your Plan Member Handbook for further information.

1. Due to circumstances beyond the member's control, the member was unable to use a Plan emergency facility without serious threat to life or death.
2. A prudent layperson with an average knowledge of health and medicine would have reasonably believed that, under the circumstance, the time required to travel to a Plan emergency facility could result in one or more adverse health conditions.
3. A person authorized by the Plan refers a member to an emergency facility and does not specify a Plan emergency facility.
4. An ambulance takes the member to a non-Plan emergency facility and was not directed to do so by the member.
5. The Member is unconscious.
6. A natural disaster obstructs the use of a Plan emergency facility.
7. The status of an emergency facility changed from Plan to non-Plan during a contract year and no good faith effort was made by the Plan to inform members of the change.

Urgent Care Services means health care services that are appropriately provided for an unforeseen medical condition that would require medical attention without delay. This medical condition does not pose a threat to the life, limb or permanent health of the injured or ill person. Urgent Care services are usually covered as below. Please refer to your Plan Member Handbook for further information for what is covered and your Provider Directory for Plan urgent care facilities.

- **In-Plan.** Those urgent medical services that the member's PCP cannot promptly address first will be covered when provided only by a Plan Urgent Care Facility.
- **Out-of-Area.** Those urgent services incurred by a member who is temporarily out of the Service Area, requiring prompt medical attention that may be provided by a physician's office or Urgent Care Center.

Some services are not covered outside the Service Area:

- Non-urgent, non-emergency care
- Maintenance therapy for chronic/continuing conditions
- Normal, full-term delivery or post-partum care of a baby
- Elective (or planned) care
- Preventive care, such as routine physical examinations
- Follow-up care after emergency and urgent care treatment (i.e. removal of stitches). Emergency or urgent care follow-up must be provided or arranged for by your PCP.

Your Issues With Us

Members have the right to appeal decisions of the Plan. If you feel the Plan did not provide, or limited benefits you believe you should receive under the Plan, you may file an appeal. The Plan has designated a “Grievance Coordinator” to assure that individual members, employer groups, and authorized persons and providers have a meaningful voice in the Plan through an effective Grievance Procedure. Your grievance/appeal will be processed in accordance with state laws.

Contacting the Grievance Coordinator

- **Call:**
740.695.3585 or **1.800.624.6961**
Hearing Impaired: **740.695.7919** or **1.800.622.3925**
- **Write:** (mail, email, fax, or in person)
Plan Grievance Coordinator
52160 National Road East
St. Clairsville, OH 43950
F: 740.695.5297
email: info@healthplan.org

The Grievance Procedure/Appeal Process is designed to do the following:

1. Be prompt and responsive.
2. Be flexible enough to manage both complicated and uncomplicated grievances without delay.
3. Provide the ability to modify the Plan’s operations in ways that address problems from patterns of grievances.
4. Provide a feedback mechanism from both members and providers, meant to improve the Plan’s operations.

These objectives will guide the Plan in resolving complaints/concerns and/or grievances. These include but are not limited to the following:

1. Non-authorization, limitation or reduction of the coverage of health care services.
2. Administrative complaints such as cancellation/non-renewal of coverage and eligibility determinations. Employer groups may utilize appeals also.

Each level of the Grievance procedure will involve a Plan employee with problem-solving authority in each step of the Grievance procedure. Medically related grievances will have a physician/pharmacist/nurse involvement in the review process.

Your Issues With Us (continued)

The following is an outline of the Grievance Procedure process. Please refer to your Plan Member Handbook for complete process instructions.

- 1. Internal Review.** When a member receives an “adverse determination” he/she, or an authorized person, may request the following reviews. For prospective or concurrent review determinations, a member’s provider or health care facility (rendering the service), with consent of the member (“authorized provider”), may also request the reviews.

Informal Review. This may be written or verbal (by phone or in person). For review of care or services not yet performed (“preservice”), the Plan must make its decision within 15 calendar days of the request to reconsider. For review of care or services already received (“postservice”), the Plan must make its decision with 30 calendar days of the request to reconsider.

Formal Review. If you continue to receive an adverse determination in the informal review (or you wish to go directly to a formal appeal), you must submit a written formal appeal/grievance using the Plan’s grievance form and filed within one year of the date of the occurrence leading to the grievance.

Expedited Review. Any member grievance, in which time is of the essence, will be handled quickly. The decision is made within 72 hours of the request. If the member (or authorized person or provider) does not receive notification within 72 hours, this is deemed a denial and the member may be afforded an independent external review by an independent review organization (IRO). Such request must be made, in writing within 180 days after the notification. The expedited review may be requested if the member’s provider certifies that, in the absence of immediate medical attention, the following could happen:

- i. The health of the member (or unborn child) could be in serious jeopardy.
- ii. Serious impairment to bodily functions could occur.
- iii. Serious dysfunction of any body organ or part could occur.

- 2. Non-authorization because the services are determined by the Plan not to be a covered benefit or administrative complaints** (including but not limited to: matters relating to the provisions of the Plan’s contracts, claims regarding the scope of coverage for health care services; denials, cancellations or non-renewal of a member’s coverage; eligibility determinations; observance of a members rights as a patient and the quality of health care services).

The Plan may, after formal review, not authorize coverage of a service because the Plan deems the service is not a covered benefit or reverse an administrative decision the Plan has deemed appropriate. In these cases the member, authorized person or provider, or employer group (when applicable) may request a review from the State Insurance Department that has jurisdiction. This review to the State Insurance Department is available only after a formal review has been completed by the Plan. The Plan must abide by the State decision.

The State Insurance Departments are:

Ohio Department of Insurance
Consumer Services Division
2100 Stella Court
Columbus, OH 43215-1067
1.800.686.1526
614.644.2673

West Virginia Insurance Commission
P.O. Box 50540
Charleston, WV 25305-0540
1.888.879.9842
304.558.3386

Your Issues With Us (continued)

3. External Independent Review. The following outlines various external independent reviews. Please refer to the Plan Member Handbook for complete information.

A. Non-authorization because services are not medically necessary and appropriate. The Plan may not authorize coverage of a service because it deems the service is not medically necessary and appropriate.

- i. If the service and related expenses will cost you more than \$500 if it is not covered by the Plan, the member or authorized person or provider may request an external review by an Independent Review Organization (IRO). The \$500 does not apply in cases of expedited reviews. The IRO will not be professionally or financially affiliated with the Plan.
- ii. The request for review must be made within 180 days of date of letter notifying the member's, authorized person's or provider's request was not granted in the formal review process. This must be in writing and include a certification from the provider that the services will cost more than \$500. The Plan will abide by what was decided by the IRO.

B. Non-authorization because services deemed experimental/investigational by the Plan.

- i. Experimental or investigative drugs, devices, procedures or other therapies ("services") generally are not covered by the Plan. However, a member or authorized person or provider, may request an external review if the Plan does not authorize coverage for these types of health care services, in the formal review, which would be covered if it were not considered by the Plan to be experimental/investigative.
- ii. A member with a terminal illness may also request external reviews when services have not been approved for coverage because they are deemed experimental or investigative. All of the follow criteria must be met to qualify:
 1. The member has a terminal condition that according to the current diagnosis has a high probability of causing death within two years.
 2. The member or authorized person requests an external review no later than 180 days after receipt of notice of the result of the formal review.
 3. The member's physician certifies that one of the following situations applies to member's condition:
 - a. Standard therapies have not been effective in improving the member's condition.
 - b. Standard therapies are not medically appropriate for the member.
 - c. There is no standard therapy covered by the Plan that will benefit the member more than the therapy requested by either the member or their physician.
 4. The member's physician has recommended a drug, device, procedure or other therapy that he/she certifies in writing is likely to benefit the member more than standard therapies or the member's requested therapy has been found in preponderance of peer-reviewed published studies to be associated with effective clinical outcomes for the same condition.
- iii. The Plan will abide by the IRO decision. The IRO will respond to the Plan and the IRO will advise the requesting party of the determination.

Your Issues With Us (continued)

C. Requesting an Independent Review/External Review.

- i. This is only available for 3-A and B above and only after the member, authorized person or provider has exhausted the formal appeal offered by the Plan. The request for an external review must be made in writing within 180 days of receiving notice of the result of the Plan's formal review. The member, authorized person or provider is not required to pay for the review. The review is paid for by the Plan. The request for the external review must be sent to the Plan. The Plan will then forward it to the IRO.
- ii. The IRO must provide the member or authorized person (or authorized provider if applicable) and the Plan with a response within 30 calendar days of receipt of the review. The decision will include the following:
 1. A description of the member's condition
 2. The principal reason(s) for the decision
 3. An explanation of the clinical rationale for the decision

D. Expedited Reviews.

- i. Some reviews must be completed quickly because of the member's medical condition. In those cases the member, authorized person or provider (when applicable) may request an expedited-external review by phone, fax or e-mail. However, the member must follow up this request with a written confirmation within five days of the phone, fax or e-mail request. The IRO must provide the requesting party (or the Plan for experimental/investigational reviews) a response to an expedited review within seven calendar days of receipt of the request. This is providing the IRO needs no additional information.
- ii. The expedited review may be requested if the member's provider certifies that, in the absence of immediate medical attention, the following could happen:
 1. The health of the member (or unborn child) could be in serious jeopardy
 2. Serious impairment to bodily functions could occur.
 3. Serious dysfunction of any body organ or part could occur.

E. Complaints/Concerns on Quality of Care.

- i. The member may submit a written complaint relating to the quality of care (rendered by health care providers) to The Plan Quality Improvement Department, 52160 National Rd., East, St. Clairsville, OH 43950. The Quality Improvement Department will investigate the complaint and take appropriate action if necessary.

New Member Outreach Program

Service to you is what health insurance is all about. The Customer Service Department is ready to take your calls or personal visits to The Health Plan, help you in any way possible in the most efficient way possible, and promptly follow-up all work generated by member encounters. There are actually many departments that are ready to help service you as a member. The department names and their phone numbers are listed below. When in doubt about any insurance issue, please call Customer Service at any time during our business hours as below.

NEW MEMBER “OUTREACH” PROGRAM

The “Outreach” Program was developed in an effort to provide education and general information to all new members regarding their benefits, out-of-pocket expenses and Health Plan procedures in a proactive effort to eliminate errors which could result in “denied services”. At this time members are given an opportunity to ask any questions about their Health Plan services. An Outreach Representative will attempt to make the initial contact to a new member within 30 days from their effective date, but not later than 90 days.

If you are a new member that still has questions or an established member with the Health Plan and you would like to speak to an Outreach Representative regarding your coverage, please call Customer Service at St. Clairsville **1.888.847.7902** or Massillon **1.800.426.9013**.

Customer Service	St. Clairsville Office	Massillon Office
Hours of Operation	Monday through Friday 8am to 5pm	Monday through Friday 8am to 5pm
Main Switchboard	740.695.3585 1.800.624.6961	330.834.2200 1.877.236.2289
Customer Service (Providers)	740.695.7901	330.830.4370 1.888.830.4370
Customer Service (Members)	740.695.7902 1.888.847.7902	330.837.6880 1.800.426.9013
Referrals/Pre-Authorization	740.695.7905 1.800.526.7511	330.830.4370 1.888.830.4370
Coordination of Benefits	740.695.7903	330.834.2266
Enrollment Services	740.695.3585	
Pension	740.695.7906 1.866.581.8302	
SecureCare (Medicare) Members	740.695.7907 1.877.847.7907	330.834.2301 1.877.236.2296
SecureCare (Medicare) Members Prospective Members Only	740.695.7915 1.877.847.7907	330.834.2301 1.877.236.2290
Mountain Health Trust/ Mountain Health Choice (Medicaid) Members	740.695.7904 1.888.613.8385	
Workers' Compensation	740.695.7678 1.888.847.7810	
Case Management Program	740.695.7644 740.695.7643	
Outpatient/Elective Services	740.695.7905 1.800.526.7511	330.830.4370 1.888.830.4370
Pharmacy Services	1.800.624.6961, ext. 7914	1.800.624.6961, ext. 7914
TDD (for hearing impaired only)	1.800.622.3925	1.877.236.2291
FRAUD Hotline!	740.699.6111 1.877.296.7283	1.877.296.7283



St. Clairsville Office
52160 National Road East
St. Clairsville, OH 43950-9365
PH: 1.800.624.6961
Hearing Impaired: 1.800.622.3925
FAX: 740.695.5297
www.healthplan.org

HomeTown Office
100 Lillian Gish Boulevard
P.O. Box 4816
Massillon, OH 44648-4816
PH: 1.877.236.2289
Hearing Impaired: 1.877.236.2291
FAX: 330.837.6869
www.healthplan.org



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

We are required to provide this Notice to you by the Health Insurance Portability & Accountability Act (“HIPAA”).

PLEASE REVIEW IT CAREFULLY.

At The Health Plan, we are committed to safeguarding the privacy of your protected health information. “Protected health information” includes your individually identifiable information which relates to your past, present, or future health treatment or payment for health care services.

This notice describes our privacy practices, which includes how we may use, disclose, collect, handle, and protect our members’ protected health information. This Notice becomes effective August 1, 2005. This Notice also describes your rights with respect to the Protected Health Information and how you can exercise those rights.

We are required by law to:

- Maintain the privacy of your Protected Health Information;
- Provide you this notice of our legal duties and privacy practices with respect to your Protected Health Information; and
- Follow the terms of this notice.

We reserve the right to revise our privacy practices and the terms of this Notice. We reserve the right to make the revised or changed Notice effective for all protected health information that we maintain, including protected health information we created or received before we made the changes. Before we make a material change in our privacy practices, we will change this Notice and notify all affected members in writing, in advance of the change.

You may request a copy of our Notice by contacting us using the information listed at the end of this Notice.

The Health Plan will collect, use, and disclose your protected medical information to administer

your health benefits plans. This shall include making payment for service and other operations necessary to administer your benefits. We consider this information private and confidential and have policies and procedures in place to protect the information against unlawful use and disclosure.

This notice describes what types of information we collect and explains when and to whom we may disclose it. Our privacy practices apply to all of our past, present, and future customers.

HOW THE HEALTH PLAN MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION:

Much of the information maintained in The Health Plan record systems consists of private medical information of plan members. This information has been entrusted to us by the membership of the plan and the provider community. It is highly sensitive and requires thoughtful and attentive management by those who have access to it. **ALL** Health Plan staff are committed to protecting each member's right to privacy and safeguarding the medical information contained in the plan's record systems.

In performing daily functions, Health Plan employees shall seek to balance the need to access information to perform daily functions and ensure members appropriate and timely access to care with the need to protect the member's right to privacy.

- **For Payment:** We may use and disclose protected health information to pay for benefits under your health benefits coverage. For example: We may use your protected health information to pay claims from doctors, hospitals, pharmacies, and other services rendered to you that are covered by your health plan; to determine eligibility for benefits; to coordinate benefits with other insurance carriers, with respect to a particular claim; to obtain premiums; to examine medical necessity; to issue explanations of benefits to the person who subscribes to the health plan; or to assist you with your inquires or disputes.
- **For Health Care Operations:** We may also use and disclose protected health information for all activities of our healthcare operations. For example: Conducting quality assessment and improvement activities; case management and care coordination; conducting or arranging for medical review; legal and auditing services, including fraud and abuse detection and compliance programs; customer service; resolution of internal grievances; rating and underwriting; and to credential healthcare providers.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION TO OTHER ENTITIES:

We may use and disclose protected health information to:

- **Other Covered entities:** (health plans, healthcare clearinghouses, and health care providers) For example, we may disclose your protected health information to a healthcare provider when needed by the provider to render treatment to you; and we may disclose protected health information to another covered entity to conduct healthcare operations in the areas of quality assurance and improvement activities, an accreditation, licensing, or credentialing.
- **Business Associates:** Is a person or entity that performs certain types of functions on our behalf, or provides services (such as utilization management, subrogation, or pharmacy benefit management). Business associates that receive, create, maintain, use or disclose protected health information can do so only after we require the business associate to agree, in writing, to the contract terms designed to appropriately safeguard your protected health information.
- **Family and Friends Involved in Your Care:** With your approval, we may from time to

time disclose your personal health information to designated family, friends, and others who are involved in your care or in payment for your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation, and we determine that a limited disclosure may be in your best interest, we may share limited personal health information with such individuals without your approval. If you have designated a person to receive information regarding payment of the premium on your plan, we will inform that person when your premium has not been paid. We may also disclose limited personal health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

USES AND DISCLOSURES TO PLAN SPONSORS:

The plan sponsor is the party or entity that ultimately pays for all the coverage, benefit, or product. A sponsor can be an employer, union, government agency, association, or insurance agency.

We may disclose your protected health information to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan sponsor may contact us regarding a member's question, concern, issues regarding a claim, benefit, service, coverage, etc. We may also disclose summary health information about the enrollees in your group health plan to the plan sponsor to obtain premium bids for the health insurance coverage offered through your group health plan or to decide whether to modify, amend or terminate your group health plan.

USES AND DISCLOSURE OF PROTECTED HEALTH INFORMATION REQUIRED BY LAW:

We disclose protected health information when required by federal, state or local law including;

- **Public Health Activities:** For example, we may use or disclose your protected health information for the purpose of preventing or controlling disease such as reporting disease outbreaks. Additionally, we may provide protected health information to a governmental agency or regulator with health care oversight responsibilities.
- **Law Enforcement or Legal Proceedings:** We may disclose your protected health information in response to a request by a law enforcement official made through a court order, subpoena, warrant, summons, or similar process if it is necessary to locate or identify a suspect, fugitive, material witness, or missing person.
- **Inmates:**
If you are an inmate of a correctional institution, we may disclose your protected health information to the correctional institution or to a law enforcement official for:
 1. the institution to provide healthcare to you,
 2. your health and safety and the health and safety of others, or
 3. the safety and security of the correctional institution.
- **Coroners, Medical Examiners, Funeral Directors, and Organ Donations:** We may disclose protected health information to a coroner or medical examiner for purposes of identifying a deceased person; determining a cause of death; or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose, as authorized by law, information to funeral directors so they may carry out their duties. Additionally, we may disclose protected health information to organizations that handle organ, eye, or tissue donation and transplantation.

- **Research:** We may disclose protected health information for research studies that meet all privacy law requirements (such as research related to the prevention of disease or disability).
- **Abuse or Neglect:** We may disclose your protected health information to a government authority that is authorized by law to receive reports of abuse, neglect or domestic violence.
- **Workers' Compensation:** We may disclose protected health information to comply with Workers' Compensation laws and regulations related to Workers' Compensation.
- **To Prevent a Serious Threat to Health or Safety:** Your protected health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.
- **Government Functions:** Your protected health information may be disclosed for the use of specialized government functions, such as protection of public officials or reporting to various branches of the armed services.

OTHER USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION:

Other uses and disclosures of your protected health information not covered by this notice and permitted by the laws that apply to us will be made only with your written authorization or that of your legal representative. You may revoke that authorization, in writing, at anytime and this revocation will be effective for future uses and disclosures of protected health information. However, you should understand that we will not be able to take back any disclosures we have already made with your authorization.

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION WE MAINTAIN ABOUT YOU:

The following is a description of your rights with respect to your protected health information:

- **Right to Access:**

You have the right to inspect or get copies of the protected health information we maintain about you. However, you may not inspect or copy psychotherapy notes or information collected by us in connection with, or in reasonable anticipation of, any claim or legal proceedings. You must make a request in writing to obtain access to your protected health information

To inspect and/or copy your protected health information, you may obtain a form to request access by using the contact information listed at the end of this Notice. The first request within a 12 month period will be free. If you request access to your protected health information more than once in a 12 month period, we may charge you a reasonable cost based fee for responding to these additional requests. We will notify you upon receipt of your requests of the cost involved and you may choose to withdraw or modify your request at that time, before any costs are incurred.

We may deny your request to inspect and copy your protected health information in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. A licensed healthcare professional, designated by The Health Plan, will review your request and the denial. We will comply with the outcome of that review.

- **Right to A List of Disclosures:**

You have a right to request a list of certain disclosures of your protected health information that are for reasons other than treatment, payment, or healthcare operations. Please note that most disclosures of protected health information will be for purposes of payment or healthcare operations.

The List of Disclosures will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed and the purpose of the disclosure. To request this list, you must submit your request in writing. Your request must state the time period from which you want to receive a list of disclosures. The time period may not be longer than 6 years and may not include dates before April 1, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12 month period will be free. We may charge you for responding to any additional requests. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time, before any costs are incurred.

You may request a list of disclosures by contacting us by using the information listed at the end of this Notice.

- **Right to Request Confidential Communications:**

You have the right to request that we communicate with you in confidence about your protected health information in a certain way or at a certain location if you tell us that communication in another manner may endanger you. For example, you can ask that we only contact you at work or via your work email. You must make your request in writing and you must state the information could endanger you if it is not communicated in confidence by the alternative means or to an alternate location you want. You must specify how or where you wish to be contacted. We will accommodate your requests if it is reasonable and continues to permit us to collect premiums and pay claims under your health plan.

You may request confidential communications by contacting us using the information listed at the end of this Notice.

- **Right to Request a Restriction:**

You have the right to request a restriction on the protected health information we use or disclose about you for treatment, payment or healthcare operations, or that we disclose to someone who may be involved in your care or payment for your care like a family member or friend. We will consider your request, **but we are not required to agree to these additional restrictions.** If we do agree to it, we will comply with your request unless the information is needed to provide emergency treatment to you, is legally required, or which is necessary to administer our business.

You may request a restriction by contacting us using the information listed at the end of this Notice.

- **Right to Amend Your Protected Health Information:**

If you believe that your protected health information is incorrect or incomplete, you have the right to request that we amend your protected health information while it is kept by or for us. Your request must be in writing and it must explain why the information should be amended.

We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended.

You may request to amend your protected health information by contacting us using the information listed at the end of this Notice.

- **Right to File a Complaint:**

If you believe that your privacy rights have been violated, you may file a complaint with us using the contact information listed below. All complaints must be submitted in writing. You may also submit a written complaint to the U. S. Department of Health & Human Services. We will provide you with the address to file your complaint with the U. S. Department of Health & Human Services.

You will not be penalized in any way should you choose to file a complaint with us and/or the U.S. Department of Health & Human Services.

ADDITIONAL INFORMATION:

If you want additional information about our privacy policies or practices, or have questions or concerns, please contact us using the information listed below.

CONTACT INFORMATION:

	Local	Toll-Free
<u>Customer Service Dept. (Health Plan):</u>	(740) 695-7902	888-847-7902
<u>Customer Service Dept. (HomeTown):</u>	(330) 837-6880	800-426-9013

THE TERMS OF THIS **NOTICE OF PRIVACY PRACTICES** APPLY TO THE HEALTH PLAN AND ALL SUBSIDIARY ORGANIZATIONS WHICH INCLUDES: THE HEALTH PLAN OF THE UPPER OHIO VALLEY, INC., HOMETOWN HEALTH PLAN, HOMETOWN INSURANCE GROUP, HOMETOWN HEALTH NETWORK, HP AGENCY, INC, AND THP INSURANCE COMPANY, INC.

EACH ORGANIZATION LISTED WILL SHARE PERSONAL HEALTH INFORMATION OF MEMBERS/INSUREDS AS NECESSARY TO CARRY-OUT TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS AS PERMITTED BY LAW.

EFFECTIVE DATE

This Notice of Privacy Practices is effective August 1, 2005.

01/2003
04/2005
08/2005

Your Privacy on Our Website

The Health Plan wants you to know what we do with any information about you that we collect from our website.

Casual visitors to our website: The Health Plan collects the Internet domain name of your computer and IP address of the computer you use to visit www.healthplan.org. We also obtain the type and version of the web browser you use along with the date and time of each visit to each webpage you access. This is typically the same amount of information that most all websites collect from your computer. The Health Plan collects this information for the purposes of running summary reports for analyzing website traffic and bandwidth load analysis. For the casual visitor, no personally identifiable medical information is collected.

Visitors who submit electronic forms on our website: If you fill out any of the online forms on our site to request services such as changing address, requesting ID cards, changing your primary care physician, or sending us comments, this personally identifiable information will be kept confidential and will not be shared, given, or sold to any third parties unless those third parties are business partners of The Health Plan and whose services are required to provide service to you. This information you provide to us online will only be used to respond to any request for services and will be stored on secure computer systems that have technical and physical safeguards in place to protect your information.

By providing us with your email address in an online form, you are indicating that you wish to be contacted by us via return email. If you do not wish to be contacted by email, please indicate you would prefer a phone call or postal mail.

Cookies: Cookies are small pieces of temporary data exchange between a website and a user's computer which enable a "session" to be established between the two computers. The Health Plan does not use cookies to collect any personally identifiable information from you nor do we use cookies to maintain a "session" with your computer.

Limitations: This privacy statement does not apply to third-party external links from our website because those sites are out of Health Plan control.



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