

THE HEALTH PLAN

BASIC OPEN ENROLLMENT OPTION (No RX Coverage)

**MEMBER HANDBOOK
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Any questions or problems, please call or write our Customer Service Department at:
St. Clairsville/Morgantown areas: 52160 National Rd. East, St. Clairsville, OH 43950, (740) 695-7902 or (888) 847-7902, TDD (740) 695-7919 or (800) 622-3925, website www.healthplan.org.
Nurse on Call and Utilization Review Staff -- 24 hrs. a day/seven days a week: (740) 695-3585 or (800) 624-6961. **Massillon area:** P.O. Box 4816, Massillon, OH 44648, (330) 837-6880 or (800) 426-9013, TDD (877) 236-2291, website www.healthplan.org. Nurse on Call and Utilization Review Staff--24 hrs. a day/seven days a week: (330) 837-6880 or (800) 426-9013. Hours are Monday-Friday, 8:30 a.m. - 5:00 p.m.

I. WELCOME TO THE HEALTH PLAN.

Thank you for selecting The Health Plan of the Upper Ohio Valley, Inc. (the Health Plan). The Health Plan (the Plan) is a Health Insuring Corporation (HIC) in Ohio and a Health Maintenance Organization (HMO) in West Virginia. The Plan is designed to meet your health care needs by arranging for medical and hospital services for members through Plan (contracted) physicians, hospitals and other health care providers.

You and your covered family members have chosen a Primary Care Physician (PCP) from a list of physicians participating in the Plan. Your PCP should manage all your health care needs. If you need specialized care, your PCP will refer you to a Plan specialist. The list of Plan providers (including hospitals) may change from time to time.

Most, if not all of your health care needs, can and will be taken care of by local, Plan health care providers. You may require special treatment not available locally and you may be referred outside the local area. If so, this treatment will first come from non-local contracted "tertiary facilities" of the Plan. You may be referred to other health care facilities only if the tertiary facilities do not provide the medically necessary specialty services. Out-of-Plan referrals to a specialist or tertiary facility need to be made by your PCP or a referred specialty physician. Referrals must be preapproved by the Plan to be valid.

You should make appropriate use of the health care benefits available. You can help by practicing sound, preventive health measures and by following the instructions of your PCP.

IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS. IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

II. READ YOUR HANDBOOK CAREFULLY.

This Member Handbook is designed to help you understand the Plan's services. Read it carefully to better understand your coverage. Refer to the "Schedule of Benefits" for any out-of-pocket expenses.

The Health Plan is not an insurance company and does not agree to assume responsibility for all of the health care costs you may incur. The Plan does agree to arrange to provide all of the health care services that are included as covered benefits under the "Schedule of Benefits". By following the procedures outlined, you will help us to provide you with appropriate, cost effective health care. After reviewing this Handbook should you have any questions, please call us. We will be happy to assist you. Remember, this is your Plan for good health.

III. DEFINITIONS.

ADVERSE DETERMINATION means a decision by the Plan or its designee that an admission, availability of care, continued stay or other health care service covered under this Agreement has been reviewed. Based upon the information provided, the health care service does not meet the Plan's requirements for benefit payment. The service is therefore denied, reduced or terminated.

AGREEMENT means The Plan "Group Medical and Hospital Service Agreement" and other evidence of coverage. These include the Member Handbook, Enrollment Form and current Provider Directory.

AUTHORIZED PERSON means a parent, guardian or other person authorized to act on behalf of a member with respect to health care decisions.

BASIC HEALTH CARE SERVICES (see Schedule of Benefits) means the following services when medically necessary.

- Physician services.
- Inpatient services.
- Outpatient services.
- Emergency services.
- Biologically based mental illnesses.
- Urgent care services.
- Diagnostic laboratory.
- Diagnostic therapeutic radiological services.
- Preventive care services.

Basic services do not include supplemental services (i.e., vision, dental or prescription) or experimental services.

BIOLOGICALLY BASED MENTAL ILLNESSES means schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder, as these terms are defined in the most recent edition of the diagnostic and statistical manual of mental disorders published by the American Psychiatric Association.

CONCURRENT REVIEW means utilization review conducted during a patient's hospital stay or course of treatment.

CONGENITAL means existing and present at birth. It includes certain mental or physical traits, anomalies, malformations, diseases, etc. They may be either hereditary or due to an influence occurring during gestation up to the moment of birth. This does not include conditions that are developmental in nature (not at birth).

COORDINATION OF BENEFITS (COB) means when the subscriber, their spouse, and/or their covered dependents are eligible for benefits under more than one health benefits program.

COPAYMENT (COPAY) means the amount required, if any, to be paid by a member for the services outlined in the Schedule of Benefits.

COVERAGE means the medically necessary and appropriate health benefits coverage under this Agreement.

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CREDITABLE COVERAGE means coverage of an individual under any of the following.

- Group health plan.
- Health insurance coverage.
- Medicaid.
- Military health program.
- Indian Health Service or tribal health program.
- A state health benefits risk pool.
- S-CHIP program.
- A Veterans Administration health plan.
- A public health plan (domestic or foreign).
- Medicare.
- Peace Corps.
- Cobra.
- Or similar plan(s).

Prior coverage does not qualify if there was a break in coverage under a prior health plan that was longer than a 63-day period. *Generally*, plans must give credit for prior health coverage regardless of the specific benefits covered by the prior plan.

The Plan will provide to terminated members (or by request) a “Certificate of Creditable Coverage”.

DEPENDENT means any member of a subscriber’s immediate family who meets all applicable requirements of the Eligibility section of this Agreement and is enrolled hereunder.

DURABLE MEDICAL EQUIPMENT (DME)/SUPPLIES means any equipment that can withstand repeated use, and/or its supplies whether disposable or reusable, made to serve a medical purpose and is generally considered useless to a person who is not ill or injured.

Examples of DME are as follows.

- Decubitus equipment.
- Oxygen equipment.
- Hospital bed.
- Insulin pump.
- Wheelchair.

Examples of DME supplies are as follows.

- Oxygen.
- Nebulizer medications.
- Infusion set.
- Tubing.
- Urinary catheters.

EMERGENCY CARE means care provided in or by a hospital emergency facility, available seven days per week, 24 hours a day, to evaluate, treat and stabilize a medical condition.

When medically appropriate, includes emergency transportation and out- of-area emergency care.

EMERGENCY MEDICAL CONDITION means a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, 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 dysfunction of any bodily organ or part.

ENROLLMENT AREA means the geographical area encompassing the following counties.

Ohio:

- Ashland.
- Belmont.
- Carroll.
- Columbiana.
- Coshocton.
- Cuyahoga.
- Geauga.
- Guernsey.
- Harrison.
- Holmes.
- Jefferson.
- Knox.
- Lorain.
- Mahoning.
- Medina.
- Monroe.
- Muskingum.
- Noble.
- Portage.
- Richland.
- Stark.
- Summit.
- Trumbull.
- Tuscarawas.
- Washington.
- Wayne.

West Virginia:

- Barbour.
- Brooke.
- Calhoun.
- Doddridge.
- Gilmer.
- Hancock.
- Harrison.
- Lewis.
- Marion.
- Marshall.
- Monongalia.
- Ohio.
- Pleasants.
- Preston.
- Randolph.
- Ritchie.
- Taylor.
- Tucker.
- Tyler.
- Upshur.
- Webster.
- Wetzel.
- Wirt.
- Wood.

The Ohio Department of Insurance and/or the West Virginia Insurance Commissioner may approve additional counties from time to time.

FEDERALLY ELIGIBLE INDIVIDUAL means an individual is one for whom, as of the date coverage is sought, the aggregate of the periods of creditable coverage is 18 or more months and whose most recent prior creditable coverage was under a group health plan, governmental plan or church plan. This coverage must not have been terminated due to nonpayment of premium or fraud. Also, if continuation coverage was offered, the individual must have elected and exhausted the continuation coverage. This individual must not be eligible for coverage under a group plan, Medicare or Medicaid.

FIXED PERIODIC PREPAYMENT means the amount established for monthly premium payment, by or for the subscriber, in return for basic and supplemental health care services.

HEALTH PLAN PERSONNEL means the personnel employed directly by the Plan as an employee to assist in carrying out its obligations under this Agreement. They may include, but not limited to, a medical director, nurses, administrative and clerical staff and other various positions.

HOSPICE CARE means a method for caring for the terminally ill. Hospice care helps those persons continue their lives with as little disruption as possible. This type of care promotes supportive services such as home care and pain control rather than cure oriented services. Hospice care is limited to members that have a medical prognosis of six months, or less, life expectancy.

HOSPITAL means an institution that maintains a contract with the Plan for hospital services and is operated pursuant to law. It must be primarily engaged in providing, on an inpatient and/or outpatient basis, for the medical care and treatment of sick and injured persons. This is done through medical, diagnostic and major surgical facilities. These services must be provided on its grounds, under the supervision of a staff of physicians, with 24 hour a day nursing service.

The term "hospital" does not include a convalescent nursing home or any institution or part thereof, which is used principally as a convalescent facility, rest facility, nursing facility or facility for the aged.

HOSPITAL SERVICES (see Schedule of Benefits) means those services for registered patients which are as follows.

- (1) Services that customarily are provided by acute care hospitals that contract with the Plan.
- (2) Services that are prescribed, directed or authorized by a Plan physician and approved by the Plan.

True emergency care does not require preauthorization.

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LIFETIME MAXIMUM BENEFIT is a benefit that has a lifetime maximum associated with it regardless of the subscriber/member change in employer group (or non-group) eligibility. Any applicable service obtained while a Plan member will be provided *one time only per a member's lifetime*. This is not applied to any *basic* health care service.

MEDICAID PROGRAMS means state medical assistance programs established by Title XIX of the Social Security Act and all amendments thereto.

MEDICAL SERVICES (see Schedule of Benefits) means those professional services of physicians and other medical professionals. These include medical, surgical, diagnostic, therapeutic and preventive services. These services must be performed, prescribed or directed by the Primary, Secondary or Specialty Care physician(s) or other health care professionals.

MEDICALLY NECESSARY AND APPROPRIATE when used to describe services or supplies proposed or received means that the Plan or its designee has determined that the service or supply meets its criteria for medical necessity. These criteria are derived from recognized accredited national sources. Sources such as national medical specialty societies or widely representative groups of specialists (and sometimes from regional or local members of the medical community or academic faculties) convened for the purpose. They are subject to regular review and revision when appropriate. They are also validated by committees of physicians drawn from the Plan's panels of local and tertiary physicians. It is important to recognize that even though a physician may have recommended a service or supply it may sometimes not qualify as being medically necessary.

MEDICARE ACT means Title XVIII of the Social Security Act and all amendments thereto.

MEMBER means any subscriber or dependent as outlined in the "Eligibility" section of this Agreement and is enrolled in the Plan.

ORTHOTIC means a device meant to correct any defect in form or function of the body; for example, a brace (non-dental), support or splint.

OSTEOTOMY means a surgical procedure to cut through a bone.

OUTPATIENT HOSPITAL OBSERVATION BED means a level of care that allows a patient to remain in a suitable facility of the hospital for extension of emergent/urgent diagnosis and treatment. No admission to an acute care facility occurs.

PHYSICIAN OFFICE VISIT may include, but not limited to, specific medical services of physicians and/or assistants (including nurse practitioners and midwives) in an office setting.

(1) **PLAN PHYSICIAN** means any duly licensed doctor of medicine, osteopathy or podiatry who contracts with the IPA or directly/indirectly with the Plan to provide medical services to members.

(2) **PRIMARY CARE PHYSICIAN (PCP)** means a Plan physician who is the coordinator of care. This physician is primarily responsible for the care of a member on a continuing basis.

(3) **SECONDARY CARE PHYSICIAN (SCP)** means a Plan (sub-specialty) physician (as outlined in the Provider Directory) that provides specialty care to a member on a routine basis.

(4) **SPECIALTY PHYSICIAN** means a Plan physician who provides specialty care to members. They shall confer with a member's Primary or Secondary Care Physician on any proposed plans of specialty treatment. Referral to and approval by the Plan is required.

PLAN PROVIDER means physicians, hospitals, pharmacies and other health care providers who contract directly/indirectly with the Plan and are part of the Plan's Provider Network.

PROSPECTIVE REVIEW means utilization review that is conducted prior to an admission or a course of treatment.

PROSTHETIC AND PROSTHETIC SUPPLIES means an externally attached or surgically implanted artificial substitute, and/or its supplies whether disposable or reusable, for an absent/non-functioning body part; for example, an artificial limb and supplies such as ostomy bags.

RETROSPECTIVE REVIEW means review of medical necessity that is conducted by the Plan after health care services have been provided to a patient. Retrospective review does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

SCHEDULE OF BENEFITS means the list of health care benefits or coverage that entails all medical, hospital and other services under this Agreement. The benefits are attached to or may hereinafter be made a part of this Agreement.

SERVICE AREA means the geographical area the Plan serves. It encompasses Ohio and West Virginia counties as follows.

Ohio:

- Ashland.
- Belmont.
- Carroll.
- Columbiana.
- Coshocton.
- Cuyahoga.
- Geauga.
- Guernsey.
- Harrison.
- Holmes.
- Jefferson.
- Knox.
- Lorain.
- Mahoning.
- Medina.
- Monroe.
- Muskingum.
- Noble.
- Portage.
- Richland.
- Stark.
- Summit.
- Trumbull.
- Tuscarawas.
- Washington.
- Wayne.

West Virginia:

- Barbour.
- Brooke.
- Calhoun.
- Doddridge.
- Gilmer.
- Hancock.
- Harrison.
- Lewis.
- Marion.
- Marshall.
- Monongalia.
- Ohio.
- Pleasants.
- Preston.
- Randolph.
- Ritchie.
- Taylor.
- Tucker.
- Tyler.
- Upshur.
- Webster.
- Wetzell.
- Wirt.
- Wood.

The Ohio Department of Insurance and/or West Virginia Insurance Commissioner may approve additional counties from time to time.

SKILLED NURSING FACILITY means an inpatient facility that provides services to members requiring 24-hour a day skilled nursing care. This care is provided directly by or requires the supervision of registered professional nursing staff. It also may include other skilled rehabilitative services. The facility must also meet Medicare requirements.

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SPELL OF ILLNESS means a period/spell that begins the day the member is hospitalized. It ends after the member has been out of the hospital or other facility that primarily provides registered professional nursing or rehabilitation services for 60 consecutive days.

STANDING REFERRAL means an ongoing referral to a specialty physician that is medically necessary to continue specialty care over a short period of time. This care is to resolve a condition that is not life threatening, degenerative or disabling.

SUBROGATION means those instances when another person, corporation, insurance company or entity (collectively referred to as "other entity") may be responsible for medical/hospital and other covered services to a member because of sickness, injury, disease or disability caused by another person or entity.

SUBSCRIBER means a person who is an employee of an enrolled group who meets all applicable eligibility requirements of the Eligibility section of this Agreement. They must enroll hereunder and the fixed periodic prepayment must be received by the Plan.

TERTIARY FACILITY means a facility that the Plan has contracted with to provide specialty medical and hospital services that are not normally available through local Plan providers in the Plan Service Area.

URGENT CARE 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.

UTILIZATION REVIEW means a process used to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy or efficiency of, health care services, procedures or settings. Areas of review may include ambulatory review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.

The pharmacist should contact the prescribing physician and suggest the formulary drug for treatment. If conversion to the formulary drug is authorized, the pharmacist will fill the prescription in the usual manner. Should the physician decide that the non-formulary drug is medically necessary, then the pharmacist or physician must contact the Plan's Pharmacy Benefit Manager (PBM) and the group number is 3602. An authorization request can be initiated by calling (800) 988-2262, seven days a week, 24 hours a day.

In cases of an emergency, when the prescribing physician and/or the PBM cannot be contacted, a 72-hour supply of the non-formulary medication can be filled if necessary. You will be responsible for the cost however, if you submit the receipt to the Plan, you will be reimbursed.

Note: Prescriptions prescribed for biologically based mental illnesses will be covered under the same terms and condition as other covered illnesses.

V. MEMBERS' RIGHTS AND RESPONSIBILITIES.

Member's Rights.

- 1. PLAN INFORMATION.** 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 our Customer Service Department.
- 2. DIGNITY.** 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.
- 3. CONFIDENTIALITY.** A member's medical history and enrollment file is held in the strictest confidence. Members have the right to privacy and confidentiality regarding their personal information. Members have a right to approve or refuse the release of personal information by the Plan except when required by law, regulation, this Agreement or to affect coverage under this Agreement.
- 4. CHOICE OF PRIMARY CARE PHYSICIAN.** The member's choice of a PCP enables them to participate in the management of their health care needs. Members are encouraged to establish a relationship with their PCP so that they can work together to maintain good health. A member may change physicians once per calendar month (depending on the availability of the chosen physician). With a proper referral, members have the right to see a Plan specialist(s).
- 5. FILE A GRIEVANCE.** Members have the right to express their comments, opinions or complaints about the Plan or the care provided. Members can pursue grievance and hearing procedures without reprisal from the Plan. Members have the right to have benefit denials reviewed by the appropriate medical professionals consistent with the Plan review procedures. See "Grievance Procedure/Appeal Process".
- 6. DECISION-MAKING.** Members may participate in decision-making about their health care, when possible and within guidelines, as outlined in this Agreement. 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 have the right to formulate Advance Directives.
- 7. COMMENTS AND OPINIONS.** Members have the right to have a meaningful voice in the organization. They may express their suggestions and comments regarding Plan coverage,

policies, Members' Rights and Responsibilities and operations. Members can submit their comments and opinions through the yearly Member Satisfaction Surveys, phone or by email at: info@healthplan.org or Internet Web Page at: www.healthplan.org (under "Member Services" – "Comments & Feedback"). Members may also place any comments or opinions in our "Member's Suggestion Box" located in the Plan lobby.

8. **MEDICAL RECORDS.** 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 our Customer Service Department.

9. **OBTAINING SERVICES.**

Emergency Care. Members have the right to a description of procedures to obtain emergency services. See "Emergency/Urgent Care".

Out-Of-Area Services. Members have the right to the procedures for obtaining out-of-area services. See "Obtaining Services".

OB/GYN Services. Women have the right to direct access to their OB/GYN. See "Obtaining Services".

Colorectal Cancer Exams. Members age 50 and over, or a symptomatic person under age 50, have the right to colon/rectal cancer screenings.

Diabetic Retinal Exam. Members with diabetes have the right to direct access to a Plan optometrist or ophthalmologist of their choice, without preauthorization by the Plan, for an annual diabetic retinal exam. See "Diabetic Coverage".

Member's Responsibilities.

To allow you to get the most from your membership, please share in the responsibilities by doing the following.

1. Choose a PCP for each person listed on your Plan ID card. The member has a responsibility to maintain a relationship with their PCP so he/she can act as the coordinator for your health care needs.
2. Identify yourself as a Health Plan member to avoid unnecessary errors. Always carry your ID card and never permit anyone else to use it.
3. Read 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 Plan for assistance, if necessary.
4. Notify the Plan of any changes in the following.

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- Name, address, phone number.
 - Number of dependents (marriage, divorce, newborn, etc.).
 - Loss of ID card.
 - Selection of PCP.
5. Be on time for appointments. Call the physician's office promptly if you cannot keep an appointment.
 6. Provide necessary information to the providers rendering care.
 7. 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.
 8. If you receive emergency care outside the Service Area, contact the Plan within 48 hours or as soon as possible.
 9. You must contact your selected PCP (or SCP or OB/GYN if applicable) **before** seeking any specialty physician/service.
 10. You must provide the Plan with all relevant, correct information and pay the Plan any money owed according to Coordination of Benefits or Subrogation policies.
 11. Make required copays under the "Schedule of Benefits".
 12. Be courteous and respectful of Plan employees, providers and their staff.

Privacy of Protected Health Information.

The Plan supplies each new subscriber with a copy of the Plan's Privacy Practices in the initial enrollment packet, and each year thereafter upon renewal. Members may also obtain a copy by calling the Plan or visiting our website.

Each subscriber will be notified, in writing, 60 days in advance of any revisions to the Plan's Privacy Practices.

The Plan will only use and disclose the minimum amount of necessary protected health information without authorization when required for: payment, operations, treatment or as required or permitted by law. To disclose protected information for purposes other than described, the Plan will request a signed authorization from the member.

Plan members have the right to inspect or obtain copies of their medical records and offer corrections to these records in accordance with applicable federal and state laws. Access within the Plan to protected health information whether oral, written, electronic, or for the use of measurement data, is limited to personnel on a "need-to-know" or "need-to-access" basis. The Plan has policies and procedures in place to ensure employees adhere to privacy/security requirements.

The Plan will not disclose information to employers that directly or indirectly identifies an employee or their dependents.

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VI. OBTAINING SERVICES.

A. Selecting a Primary Care Physician (PCP).

Plan members must select a Primary Care Physician (PCP) from the Plan's Provider Directory. Failure to select a PCP may result in **non-payment** of claims. Plan physicians are independent contracted physicians who work out of their own offices to manage your health care needs.

Each covered member of your family may select their own PCP. For example, you may select a single PCP for you and your entire family or each covered family member may select their own PCP. A PCP must be selected before claims can be processed for payment.

Whenever you need medical care, except for emergency care and some urgent care instances when a call is not practical, call or see your PCP **FIRST**. Your PCP will determine if you need any additional health care services. When appropriate, your PCP may arrange for additional services to other in-Plan providers. The Plan does not cover any services not provided or arranged for by your PCP **and approved by** the Plan.

It is important to establish a relationship with your PCP. If your PCP is new to you, arrange for an appointment at your earliest convenience. Having a physician who **knows you**, and that can coordinate all of your medical care, is the most productive use of your benefits. You should feel comfortable with your PCP and work together to maintain your health.

B. Selecting a Secondary Care Physician (SCP).

Certain members may have the need to list a SCP in addition to their PCP. The PCP will continue to provide all basic care and coordinate all *other* specialty care services. You may visit your selected SCP without a referral. Your PCP and SCP work together to coordinate your health care needs.

SCPs are listed in a separate section in the Plan Provider Directory.

C. Selecting an Obstetric-Gynecology (OB/GYN) Physician.

In addition to selecting a PCP, female members may also select an OB/GYN physician. You may visit your selected OB/GYN physician without a referral.

OB/GYNs are listed in a separate section in the Plan Provider Directory.

D. Physicians and other Providers are Independent Contractors.

All physicians and providers used by the Plan are **independent** contractors with the Plan. They are **NOT employees or agents** of the Plan.

All Plan providers shall seek payment for covered services solely from the Plan and not from Plan members, except for copays. Members shall be responsible for any and all non-covered services

Any questions or problems, please call or write our Customer Service Department at:
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Nurse on Call and Utilization Review Staff -- 24 hrs. a day/seven days a week: (740) 695-3585 or (800) 624-6961. **Massillon area:** P.O. Box 4816, Massillon, OH 44648, (330) 837-6880 or (800) 426-9013, TDD (877) 236-2291, website www.healthplan.org. Nurse on Call and Utilization Review Staff--24 hrs. a day/seven days a week: (330) 837-6880 or (800) 426-9013. Hours are Monday-Friday, 8:30 a.m. - 5:00 p.m.

E. Changing your Physician.

You may change your Plan physician **once per calendar month** by calling the Plan. If the physician you select is not accepting new patients, we cannot process your request. We will require you to select a new PCP if your PCP, for any reason, no longer contracts with the Plan. If a member fails to elect a new PCP within 30 days of the notice, the Plan will automatically assign a PCP. **Only the subscriber, or person with legal authority to act on behalf of a member, may be permitted to add/change a PCP, SCP or OB/GYN.**

F. Appointments.

If your Schedule of Benefits lists office visit copays, you are responsible for making the copay at the time of each office visit.

- Appointments with your Physician(s).
Calling your physician's office well in advance for appointments enables all concerned to better use the time available. **Never hesitate** to call your physician in an emergency situation. If you cannot keep a scheduled appointment, please contact your physician's office.
- Appointments with a Specialist (In-Plan Referrals).
Your PCP is your first contact for your health care needs. You must receive a referral for all specialty care services or visits *except* those with your SCP or OB/GYN. If your PCP feels that you need additional services, you may be referred to a Plan specialist or other health care provider. You must consult your PCP **BEFORE** receiving any other care. Your PCP will notify the Plan of the referral to a Plan specialist in advance of your appointment. Your referral may be limited to the services and/or number of visits listed on the referral approved by the Plan.
- Out-of-Plan/Out-of-Area Referrals.
Usually, you can receive medically appropriate care from your PCP or a Plan specialist. However, a member may require specialty care or services not available through our in-Plan network of providers. His/Her physician may submit an out-of-Plan referral to one of the Plan tertiary providers. **This referral is subject to review and approval by the Plan. Referrals to non-Plan providers will not be authorized if the Plan determines services can be provided in-Plan or by a Plan tertiary provider.** If the Plan determines that Plan providers are unable to provide a service, the Plan will arrange for services to a non-contracting provider. These services, consistent with the terms of this Agreement, will be provided at no additional cost to the member. Out-of-area referrals to both Plan and non-Plan providers must be **preapproved** by the Plan. Referrals **will not** be approved after the fact.

The Plan may enter into contractual arrangements with out-of-Plan/out-of-area providers for the purpose of facilitating certain out-of-network services which may not be available through the contracted in-Plan and tertiary care network. Such arrangements do not make these providers Plan Providers for other referrals.

- Standing Referrals.
Standing referrals facilitate ongoing specialist care. The PCP, in consultation with a specialist, identifies the need to continue specialty care.

A treatment plan is developed by both physicians and the member. The Plan of care, along with the number of visits, is subject to review and approval by the Plan. The specialist shall provide the PCP with regular reports on the care that the member is receiving. To extend the number of visits beyond the initial referral, the PCP must provide the Plan updated reports and treatment plans. In order for

the Plan to approve additional visit, this information must support medical necessity and appropriateness.

- Specialist Coordination of Health Care Services (for life threatening, degenerative or disabling diseases).

Specialist coordination of health care services facilitates ongoing specialist care. The PCP, in consultation with a specialist, identifies the need for specialty care. This care, over an extended period of time, is for a chronic condition. This condition is life threatening, degenerative or disabling and the PCP must initiate the specialist coordination referral.

A treatment plan is developed by both physicians and the member. The plan of care is subject to review and approval by the Plan. Upon approval of the specialist coordination referral, the specialist is authorized to provide and refer the health care services in the manner of the PCP. The specialist shall provide the PCP with regular reports on the care provided to the member. For the specialist to continue to coordinate care, the PCP is required to request from the Plan, an extension of the specialist coordination referral every six months. The PCP must provide the Plan with updated reports and treatment plans to support medical appropriateness.

For additional information on how to obtain services, call our Customer Service Department.

G. How to Obtain Care after Normal Office Hours.

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, St. Clairsville/Morgantown areas: (740) 695-3585, (800) 624-6961, Massillon area: (330) 837-6880 or (800) 426-9013. You will be put in contact with a "Plan Nurse on Call" for direction on what to do.

H. Termination of Provider Contracts.

The Plan shall notify any affected members of the termination of a PCP or hospital. Notification to the member shall be as follows.

- By mail within 30 calendar days of a termination of a member's PCP.
- By mail within 30 days of a termination of a hospital to each subscriber.
- By quarterly written notice to all subscribers.

The Plan shall pay for all covered services rendered by the PCP or hospital between the date of termination and five business days after notification is mailed. The notification is sent to the subscriber's last known address.

Any questions or problems, please call or write our Customer Service Department at:
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Nurse on Call and Utilization Review Staff -- 24 hrs. a day/seven days a week: (740) 695-3585 or (800) 624-6961. **Massillon area:** P.O. Box 4816, Massillon, OH 44648, (330) 837-6880 or (800) 426-9013, TDD (877) 236-2291, website www.healthplan.org. Nurse on Call and Utilization Review Staff--24 hrs. a day/seven days a week: (330) 837-6880 or (800) 426-9013. Hours are Monday-Friday, 8:30 a.m. - 5:00 p.m.

I. Restrictions on Choice of Providers.

1. Members must obtain a referral authorization from their PCP prior to receiving health care services from any specialist, including ancillary providers.
2. Members requiring specialty care or services not available through the Plan's local in-Plan network may be able to utilize Plan tertiary providers. Both a referral from the member's physician and approval by the Plan are required. Please refer to Section 7, "Tertiary Providers" in the Provider Directory and "Obtaining Services", of this Agreement.
3. Members with supplemental vision benefits, through Vision Services Plan (VSP), are limited to ophthalmologists or optometrists included on the List of Panel Providers in the Service Area.
4. Members may change PCPs no more than once per calendar month.
5. Podiatrists performing procedures are limited by the Plan guidelines in accordance with experience, training, certification and does not include routine foot care.
6. Chiropractors are limited to certain services within the scope of their contract with the Plan.

VII. EMERGENCY/URGENT CARE.

A. Emergency Care.

EMERGENCY CARE is provided by a hospital emergency facility and includes emergency transportation, when medically appropriate. Emergency care is available seven 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 lay person, 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 dysfunction of any bodily organ or part.

Examples of an emergency are as follows.

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

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.

See the Provider Directory for Plan hospital emergency facilities.

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,

St. Clairsville/Morgantown areas: (740) 695-3585, (800) 624-6961, Massillon area: (330) 837-6880 or (800) 426-9013. 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.

The rules of thumb for emergencies are as follows.

1. Attempt to reach your PCP.
2. Call the Plan, St. Clairsville/Morgantown areas: (740) 695-3585, (800) 624-6961, Massillon area: (330) 837-6880 or (800) 426-9013.
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.

B. Out-of-Area Emergency Coverage.

If you are temporarily out of the Plan Service Area (the Service Area) or are transported out of the Service Area by medical personnel, and receive services for a medical emergency, 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. The Plan may have contractual arrangements for emergency type care (only) with certain facilities, which are not Plan providers. The Plan may require a transfer to an in-Plan hospital when deemed medically feasible by the Plan. If the emergency room requires you to pay for the services, pay the bill and ask for an itemized copy. Send the bill, along with the receipt, to The Plan Customer Services Department within one year of the service. You will be reimbursed less the copay providing services were consistent with the terms of this Agreement. Copay(s) will not be any more than if services were rendered by Plan providers.

Dependent college students (as well as any other member) who are out of the Service Area are covered only for defined emergency medical conditions. All other services or treatment must be received in the Service Area.

C. Use of a Non-Plan Hospital for Emergency Care in the Service Area.

Emergency care provided by a non-Plan hospital within the Service Area will be covered providing one of the following circumstances applies.

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 health.
2. A prudent lay person 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. See letter "A" of this section.
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.

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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.

The Plan may require a transfer to an in-Plan hospital when deemed medically feasible by the Plan.

D. Urgent Care Services.

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 will be covered as follows.

- 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.

See the Provider Directory for Plan urgent care facilities.

- Out-of-Area. Those *urgent* medical 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.

The Plan does not cover the following services outside the Service Area.

- Non-urgent, non-emergency care.
- Maintenance therapy for chronic or continuing conditions.
- Normal, full-term delivery or post-partum care of a baby.
- 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 treatment must be provided, or arranged for, by your PCP.
- Elective (or planned) care.

VIII. ELIGIBILITY.

Note:

Individuals electing to enroll/re-enroll with the Plan that have violated the Termination of Coverage section of this Agreement whereby the member is responsible for repayment for any claims incurred and paid by the Plan after the member's previous termination, may not be permitted enrollment/re-enrollment in the Plan until such claims have been repaid to the Plan.

A. Subscriber.

To enroll as a subscriber, a person must be an approved applicant via The Health Plan Open Enrollment Questionnaire, live in the Enrollment Area, ineligible for Medicare, COBRA, employer sponsored coverage or have employer sponsored coverage available at the time of open enrollment.

B. Dependents.

An eligible dependent must be included on a subscriber's coverage at the initial enrollment. The dependent must live in the Enrollment Area (exceptions to this are college/post high school trade school students attending out-of-area accredited schools or if a Qualified Medical Child Support Order (QMCSO) in effect) be ineligible for Medicare, COBRA, employer sponsored coverage, or have employer sponsored coverage available at the time of open enrollment.

When adding a newly acquired dependent, the Plan must receive a new enrollment form, with applicable premium, within 31 days of the date of event. If not, the dependent may be required to wait until the next annual open enrollment period.

Dependents may include the following.

- **Spouse.** Your legally married spouse may be included on your coverage. If the spouse has a different last name from the subscriber, legal documentation (i.e., copy of the marriage certificate) is required to confirm the marital relationship.

Divorced or common-law spouse is excluded from eligibility.

- **Dependent Children.** Dependent children may include unmarried children of the subscriber or subscriber's spouse, until the child's 25th birthday at which time eligibility ends. Dependent child status must meet the standards of the U.S. Internal Revenue Code. Specifically, the child receives over 50% of his/her total support from the parent(s) and the child has limited, if any, personal income. A dependent child must not be otherwise eligible for employer-sponsored coverage as a subscriber/employee.

The Plan shall not deny enrollment of a dependent child on the basis that any of the following applies.

1. The child was born out of wedlock.
2. The child is not claimed as a dependent on the federal tax return of the parent.
3. The child does not reside in the household of the parent.
4. The child does not reside in the Plan Enrollment Area (college/post high school trade students/QMCSO). These children are required to choose a PCP from a list of Plan physicians and receive all health care services (while/if in the Service Area) from *Plan providers* as outlined in this Agreement.

An eligible unmarried dependent child of the subscriber or their spouse may include the following.

- **Natural children** of the subscriber or subscriber's spouse. If the subscriber/spouse is not married to the natural mother/father legal proof is necessary to confirm the parental relationship.
- **Step children.** Legal documents are required (i.e., copy of the birth certificate or divorce papers) to establish the parental relationship.
- **Legally adopted children.** To include assumption and retention by a person of legal obligation for the total or partial support of a child in anticipation of adoption. Legal documents required. Coverage for adopted children is on the same basis as other dependents.
- **Legal guardianship/custody.** Legal proof of guardianship/custody as determined by the Plan is required. Guardianship/custody will not be accepted for eligibility unless both natural parents are physically or mentally handicapped to the point where they cannot take care of the child.

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The Plan does **not** provide coverage through guardianship or custody for the child of a dependent child of the subscriber/spouse. This would include the grandchildren or step-grandchildren of the subscriber. The only exception to this is if the subscriber/spouse legally adopts the child.

- **Qualified Medical Child Support Order**. Section 1751.59 (B) of the Ohio Revised Code states, a “Qualified Medical Child Support Order” (QMCSO) is any court judgment, decree or order that provides for child support related to health benefits with respect to the child of a group health plan participant or requires health benefit coverage of such child in such plan and is ordered under state domestic relations law. These children are not required to live within the Plan’s Enrollment Areas but are required to choose a PCP from a list of Plan physicians and receive all health care services (while/if in the Service Area) from Plan providers as outlined in this Agreement. Legal documents required (i.e., copy of court judgment).

- C. **Newborn Children**. A newborn is covered from the moment of birth and remains effective for a 31-day period. To continue coverage beyond the 31-day period, **the subscriber must submit a new enrollment form through the employer within 31 days from the date of birth.**

If necessary changes are not made, services beyond the 31-day period will not be covered.

- D. **Handicapped Children**. Enrollment of a dependent unmarried child shall terminate on the child’s 25th birthday. However, dependent-unmarried children who live with you and are both incapable of self-sustaining employment by reason of mental retardation or physical handicap (prior to attainment of his/her 19th birthday) and are solely dependent upon the subscriber for support and maintenance, are eligible regardless of age. Proof of such incapability and dependency, to be determined by the Plan, must be furnished to the Plan within 31 days from the child’s 25th birthday. Periodic updates may be required.

- E. **Married Dependent Children**. Married dependent children are **not** eligible for coverage. It is the subscriber’s/member’s responsibility to notify the employer immediately of the date of marriage. Coverage for your dependent will end on the date of marriage. If the Plan provides benefits under this Agreement, because of a failure to be notified of the dependent’s marriage, the Plan may refuse to pay for these benefits. If benefits were paid, the Plan may recover the amount paid from the member.

- F. **Divorce**. Coverage will end for a divorced spouse on the divorce date. It is the subscriber’s/employee’s responsibility to notify the employer immediately of such date. If the Plan provides benefits under this Agreement because of a failure to be notified, the Plan may refuse to pay for these benefits. If benefits were paid, the Plan may recover the amount paid from the member.

- G. **Change of Residence**. If a member moves, exceptions being; college/post high school trade school students attending out-of-area accredited schools or if a Qualified Medical Child Support Order (QMCSO) is in effect, and the new residence is within our Enrollment Area coverage will continue unchanged. Notify the Plan immediately of an address change. If the new residence is outside our Enrollment Area you are no longer eligible to be a member of the Plan. Your coverage must be canceled at the end of the month in which you became ineligible.

- G. **Death of Subscriber**. Dependents should contact the Plan for a determination of available benefits.

- I. **Eligibility Dates**. The following eligibility dates are applicable to members.

1. Any person who has met the eligibility requirements on the effective date of the contract shall become eligible on such date.
2. Any person who meets the eligibility requirements after the effective date of the contract shall become eligible on the first day of the calendar month following the date of eligibility.

3. A newborn is covered from the moment of birth and remains effective for a 31-day period. To continue coverage beyond the 31-day period, **the subscriber must submit a new enrollment form to the Plan within 31 days from the date of birth.**
4. When a court or administrative order is in affect regarding dependent children, coverage will become effective on the date of the court/administrative order.

Effective Dates of Coverage. Upon receipt by the Plan of a properly completed enrollment form and the initial premium, coverage for eligible subscribers/members will begin on the earlier of the following dates.

1. On the effective date of the Non-Group/Individual contract.
2. On the first day of the month following his/her eligibility date.
3. If a subscriber/dependent is confined to an inpatient hospital on the effective date of coverage, the health services related to this confinement will be covered under this Plan. Services must be deemed medically necessary and appropriate by the Plan.
4. A newborn is covered from the moment of birth and remains effective for a 31-day period. To continue coverage beyond the 31-day period, **the subscriber must submit a new enrollment form to the Plan within 31 days from the date of birth.**
5. When a court or administrative order is in affect regarding dependent children, coverage will become effective on the date of the court/administrative order.

FINAL DETERMINATION FOR ALL ELIGIBILITY AND COVERAGE WILL BE MADE BY THE PLAN.

The Plan has the sole and absolute discretion to construe and interpret the provisions of this Agreement. Included but not limited to, eligibility to become or remain a member under this Agreement, entitlement to covered services, all claims and/or benefit determinations and operating the Grievance Procedure/Appeal Process.

No person will be refused enrollment/re-enrollment based on health status, health care needs, age (excepting dependency requirements) and is *not* subject to genetic testing or any results therein.

IX. TERMINATION OF COVERAGE.

Member.

Coverage under the contract for a member will terminate immediately, with written notice, as indicated below.

1. Failure of the member to pay, or to have paid on the subscriber's/member's behalf, the required premium when due.*
2. The member commits fraud or forgery.

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3. The subscriber/member makes any material misrepresentation on the enrollment application or other Plan forms.
4. If the member allows an ineligible member to use their Plan ID card.
5. If a member resides outside of the Plan Enrollment Area for three continuous months. The only exceptions being college/post high school trade school students attending out-of-area accredited schools or if a Qualified Medical Child Support Order (QMCSO) is in effect.
6. If the member no longer meets the eligibility requirements outlined in this Agreement. (The Plan may conduct eligibility audits and request eligibility verification from the subscriber or member. Failure to comply with the request, within the time frame given, will be cause for termination. Members may be eligible for continuation of coverage in some cases.)

***Payments are due on the first of the month with a grace period until the tenth. A 10% administrative surcharge will be added to payments received and accepted after the tenth on or before the 20th. If the Plan does not receive payment by the 20th, members are subject to termination.**

All benefits will cease at 11:59 p.m. on the effective date of termination. After termination, neither the Plan nor Plan providers have any further liability or responsibility under this Agreement.

All terminated-eligible members will be given an option to convert to a non-group policy. See "Continuation of Coverage".

It is the responsibility of the member to notify the Plan if any member fails to continue to meet the eligibility requirements. If the Plan provides benefits under this Agreement because of a failure to be notified, the Plan may refuse to pay for these benefits. If benefits were paid, the Plan may recover the amount paid for services from the member.

The member may appeal any action pursuant to the Grievance Procedure/Appeal Process outlined in this Agreement.

Any person obligated for any part of a prepayment (premium) may cancel this Agreement within 72 hours after they have signed the enrollment form.

A member may terminate coverage if the member gives 30 days prior written notice to the Plan.

X. CONTINUATION OF COVERAGE.

As a member of the Plan you may have certain options to continue coverage. State and Federal laws require that employees and/or their dependents may have the right to continue their group health coverage in certain situations.

1. Continuation of Coverage in the event of Insolvency.

Although it is not a member of any Guaranty Fund, the Plan maintains insolvency insurance. In the event the Plan became insolvent, this insurance would provide health care coverage (including necessary inpatient care) to members until the expiration of their contract with the Plan. Plan providers will continue to render covered services to members as needed to complete medically necessary services commenced but not finished. However, the member is protected only to the extent of the hold harmless provision outlined in Plan provider contracts.

In the event of insolvency, the member may be financially responsible for health care services rendered by a provider that is not under contract with the Plan. This is whether or not the Plan authorized the use of the provider or facility.

For additional information, please call the Plan at (740) 695-3585 or (800) 624-6961.

2. The Plan Non-Group Basic Conversion Continuation Coverage.

Pursuant to Section 1751.17 of the Ohio Revised Code, if a member ceases to be eligible under the Non-Group Basic Conversion Coverage, as outlined in the Eligibility and Termination of Coverage Sections of this Agreement, the Plan will send a letter to affected members outlining their potential continuation of coverage option including monthly premium amounts and schedule of benefits. Eligible members may elect continuation coverage, without furnishing evidence of insurability, if deemed eligible to do so by the Plan and provided such notice is given to the Plan within 30 days from the date of the letter. The member may continue his/her membership in accordance with such rules and regulations governing the Non-Group Basic Conversion Agreement. The coverage thereunder, the initial payment, the form of such agreement, and all terms and conditions as the Plan may have in effect at the time of his/her application for continuation of coverage shall apply.

If a member is eligible for other health care coverage or entitled to Medicare, such member may not be eligible for the Non-Group Basic Conversion Continuation Coverage.

The Non-Group Basic Conversion Continuation Coverage may not provide the same copay plan. If you have any questions concerning continuation of coverage, please call the Plan.

WARNING: The member will be responsible for repayment for any claims incurred and paid by the Plan after member's date of termination, unless you elect to continue coverage as defined in the Continuation of Coverage section of this Agreement.

XI. UTILIZATION REVIEW.

The Plan has a utilization review process in place that is designed to review the medical appropriateness of health care services. The review system consists of three areas: 1.) Prospective Review, a review conducted prior to an admission or course of treatment, 2.) Concurrent Review, a view conducted during an admission or course of treatment and 3.) Retrospective Review, a review conducted after health care services have been provided. Examples of services reviewed are physical therapy, home health services, emergency services, out-of-plan care, surgeries, CT scans and MRIs.

Reviews are performed by registered nurses to evaluate whether the service(s) meets the Plan's clinical guidelines for medical appropriateness. In instances that do not meet the guidelines, the nurses are required to involve physician reviewers to conduct a more detailed analysis. After careful review of the available clinical information, the physician reviewer may approve or disapprove coverage for the service.

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Review and Notification Time Frames.

A. Concurrent Review.

Concurrent Reviews must be completed within one business day after the Plan has obtained all necessary information with notification as follows.

- 1.) In the case of a determination to certify an extended stay or additional health care services, the Plan shall notify the provider or health care facility rendering the service by phone or fax. This notice will be within one business day after making the certification.
- 2.) In the case of an adverse determination, the Plan shall notify the provider or health care facility rendering the service by phone within one business day after making the adverse determination. The Plan will provide written or electronic confirmation to the member and the provider or health care facility. This will occur within one business day after the phone notification.

B. Prospective Review.

Prospective Reviews must be completed within two business days after the Plan has obtained all necessary information with notification as follows.

- 1.) In the case of a determination to certify an admission, procedure or health care service, the Plan shall notify the provider or health care facility rendering the service by phone or fax. This notice will be within two business days after making the initial certification.
- 2.) In the case of an adverse determination, the Plan shall notify the provider or health care facility rendering the service by phone within two business days after making the adverse determination. The Plan will provide written or electronic confirmation of the phone notification to the member and the provider or health care facility. This will occur within one business day after making the phone notification.

C. Retrospective Review.

Retrospective Reviews must be completed within 30 business days after the Plan has received all necessary information.

- 1.) In the case of a certification, the Plan shall notify the member and the provider or health care facility providing the service in writing.
- 2.) In the case of an adverse determination, the Plan shall notify the member and the provider or health care facility rendering the service in writing. This will occur within five business days after making the adverse determination.

Should the Plan not comply with the above review and/or notification time frames or the review does not resolve the difference of opinion, the member, authorized person or the provider or health care facility (with consent of the member) may request an Internal Review. See "Grievance Procedure/Appeal Process".

If you have any questions regarding the need for preauthorization of any service or utilization review, call our Customer Service Department.

XII. CASE MANAGEMENT.

The Case Management program is a process of coordinating resources and creating flexible, quality, cost effective health care options to result in a quality-efficient delivery of health care services. This individualized program is performed by registered nurses that focus on members with a complex illness and/or injury.

XIII. COORDINATION OF BENEFITS.

The Coordination of Benefits (“COB”) provision applies when a person has health care coverage under more than one plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total allowable expense.

DEFINITIONS.

- A.** A Plan is any of the following that provides benefits or other services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
- (1) Plan includes: group and nongroup insurance contracts, health insuring corporation (“HIC”) or health maintenance organization (“HMO”) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
 - (2) Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described by law (in Ohio see Ohio Revised Code sections 3923.37 and 1751.56); school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each other parts is treated as a separate Plan.

- B.** This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
- C.** The order of benefit determination rules determine whether Health Plan is a primary plan or secondary plan when the person has health care coverage under more than one Plan. When Health Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan’s benefits. When Health Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total allowable expense.

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Nurse on Call and Utilization Review Staff -- 24 hrs. a day/seven days a week: (740) 695-3585 or (800) 624-6961. **Massillon area:** P.O. Box 4816, Massillon, OH 44648, (330) 837-6880 or (800) 426-9013, TDD (877) 236-2291, website www.healthplan.org. Nurse on Call and Utilization Review Staff--24 hrs. a day/seven days a week: (330) 837-6880 or (800) 426-9013. Hours are Monday-Friday, 8:30 a.m. - 5:00 p.m.

- D.** Allowable expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

The following are examples of expenses that are not allowable expenses.

- (1) The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
 - (2) If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similarly reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.
 - (3) If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
 - (4) If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all Plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.
 - (5) The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the Plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.
- E.** Closed panel plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.
- F.** Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES.

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows.

- A.** The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
- B.** (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

- (2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
- C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply.
- (1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the primary plan and the Plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that that Plan covering the person as an employee, member, policyholder, subscriber or retiree is the secondary plan and the other Plan is the primary plan.
- (2) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows.
- (a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
- the Plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
 - if both parents have the same birthday, the Plan that has covered the parent the longest is the primary plan.
 - However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.
- (b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married.
- (i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
- (ii) if a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits; or

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Nurse on Call and Utilization Review Staff -- 24 hrs. a day/seven days a week: (740) 695-3585 or (800) 624-6961. **Massillon area:** P.O. Box 4816, Massillon, OH 44648, (330) 837-6880 or (800) 426-9013, TDD (877) 236-2291, website www.healthplan.org. Nurse on Call and Utilization Review Staff--24 hrs. a day/seven days a week: (330) 837-6880 or (800) 426-9013. Hours are Monday-Friday, 8:30 a.m. - 5:00 p.m.

- (iii) if a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
 - (iv) if there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows.
 - The Plan covering the custodial parent;
 - the Plan covering the spouse of the custodial parent.
 - The Plan covering the non-custodial parent; and then
 - the Plan covering the spouse of the non-custodial parent.
 - (c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.
- (3) Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The Plan covering that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
- (4) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
- (5) Longer or shorter length of coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the primary plan and the Plan that covered the person the shorter period of time is the secondary plan.
- (6) If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, Health Plan will not pay more than it would have paid had it been the primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN.

- A.** When Health Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its Plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount by the primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

- B. If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that Plan and other closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under Health Plan and other Plans. The Health Plan may get the facts we need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under Health Plan and other Plans covering the person claiming benefits. Health Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under Health Plan must give Health Plan any facts we need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT.

A payment made under another Plan may include an amount that should have been paid under Health Plan. If it does, Health Plan may pay that amount to the organization that made a payment. That amount will then be treated as though it were a benefit paid under Health Plan. Health Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY.

If the amount of the payments made by Health Plan is more than we should have paid under this COB provision, Health Plan may recover the excess from one or more of the persons it has paid or for whom it was paid, or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

COORDINATION DISPUTES.

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us, see "Grievance Procedure/Appeal Process" or call 1-888-847-7902, (740) 695-7902, TDD 1-800-622-3925, (740) 695-7919 or visit our website at www.healthplan.org for a description of the appeal procedures. If you are still not satisfied you may call the State Insurance Department, in the state you reside, for instructions on filing a consumer complaint.

Ohio Department of Insurance
1-800-686-1526, or visit the Department's
website at <http://insurance.ohio.gov>.

West Virginia Insurance Commission
(304) 558-3386, 1-888-869-9842.

XIV. SUBROGATION.

SUBROGATION refers to those instances when another person, corporation, insurance company or any entity (collectively referred to as "other entity") may be responsible for medical/hospital and other covered services to a member because of sickness, injury, disease or disability caused by another person or

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entity. The Plan (or an intermediary of the Plan contracting with the Plan) will pay for these services to which the member is entitled under this Agreement. The Plan has the right to recover for services it pays directly or for services paid by an intermediary which contracts with the Plan. This includes filing suit in the member's name. The Plan will recover the amount paid for these services. In the instance of capitated services, it will recover utilizing the Plan's fee-for-service rates (as opposed to the capitation payments themselves). If paid by a Plan intermediary, their fee-for-service rates. The Plan shall not recover in subrogation or reimbursement, more than the amounts paid for services rendered to the member. By accepting payment for these services, the member assigns to the Plan all of his/her rights to recovery against the other entity to recover for these services.

The member is obligated to help the Plan in all possible ways including signing documents which may be needed for the Plan to enforce its rights. The member may not impair or damage these subrogation rights in any way.

If the member makes a claim or files suit against the other entity mentioned above, the Plan must be immediately notified in writing. If a member receives money from the other entity responsible for the sickness, injury, disease or disability of the member, the member must pay the Plan for services covered by the Plan in the manner described above. This payment to the Plan includes, but is not limited to settlement proceeds, whether or not the recovery by the member specifies that monies he/she is receiving include monies for medical/hospital services. In instances where a member or his/her attorney fails to notify the Plan of a potential subrogation claim, or fails to cooperate with subrogation or reimbursement, the Plan will be entitled to recover payment it made for medical/hospital services from any monies obtained by or awarded to the member. This is whether or not the recovery by the member specifies that monies he/she is receiving include monies for medical/hospital services. Subrogation, and/or reimbursement also applies to insurance coverage such as medical payments coverage, uninsured and/or under-insured motorist coverage. However, it would not include the medical payments coverage of the member's auto or property and casualty insurance for such amounts for medical services not covered by the Plan.

You may receive a questionnaire or phone call from the Plan (or from a company that the Plan has contracted with to recover subrogation claims). They may ask for information regarding medical claims that may have been related to an accident or injury. You are required to respond. Coverage for the subscriber and his/her dependents may be terminated if they, or their legal representative, refuse to cooperate or carry through in any manner with the requirements of the subrogation terms of this Agreement.

If you receive a questionnaire from the subrogation company, it means that they are attempting to decide if your claim may be the responsibility of another entity. These may include auto liability, homeowner's liability, no-fault medical coverage, product's liability, Workers' Compensation, etc. The questionnaire will have a toll-free phone number and an address should you need to contact them. If you need to contact them to discuss your accident or injury, and you have not received a questionnaire, contact our Funds Recovery Department for assistance.

A successful subrogation program helps the Plan keep the cost of health care lower for you. Your cooperation with the Plan or the Subrogation Company is appreciated. The Plan reserves the right to change the subrogation company at any time. If you have any questions, call our Funds Recovery Department at (740) 695-3585 or (800) 624-6961.

NOTICE: The Plan will not recover, in subrogation or reimbursement, more than the amount paid for services rendered to members.

In addition, the Plan will apply the legal doctrines of "made whole" and "common fund" on a case-by-case basis, to the extent required by law.

XV. GRIEVANCE PROCEDURE/APEAL PROCESS.

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. Your appeal rights are explained below.

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. The Grievance Coordinator can be contacted by calling St. Clairsville/Morgantown areas: (740) 695-3585, (800) 624-6961, TDD (740) 695-7919 or 1-800-622-3925. You may also write to or contact in person at: Plan Grievance Coordinator, 52160 National Rd. East, St. Clairsville, OH 43950. Fax (740) 695-5297 or email: info@healthplan.org, Massillon area: (330) 837-6880, (800) 426-9013, TDD (877) 230-2291, fax (330)-830-5634, email: info@healthplan.org write to or in person at 100 Lillian Gish Blvd., Massillon, OH 44648. Grievances will be processed in accordance with state laws.

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 physician involvement in the review process.

The following is a description of the Grievance Procedure process.

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.

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A. Informal Review.

The member (or authorized person or provider) may request the Plan to reconsider the issue for informal review. The informal appeal may be written or verbal (by phone or in person). It will be documented by the Plan. If the *adverse determination does not change*, the Plan employee assisting the member will advise them of the next step in the process. 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 within 30 calendar days of the request to reconsider.

B. Formal Review.

If the member (or authorized person or provider) continues to receive an adverse determination in the informal review (or wishes to go directly to a formal appeal), they may submit a written formal appeal (formal grievance) on the Plan’s grievance form. This must be filed within one year of the date of the occurrence leading to the grievance. A Plan member may meet with a Plan representative and/or the

Plan’s Appeals Committee to review the situation. If the Plan Appeals Committee continues an adverse determination, a physician (of the same or similar specialty who provides or treats the requested service) will also review the appeal if it involves medical appropriateness. If the physician finds the service is not medically necessary and appropriate, the Plan will continue not to authorize coverage for the service. If the physician finds that the service is medically necessary and appropriate, the Plan may cover the service. If the Plan does not cover the service, 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 notification (see Independent Review/External Review section). The formal grievance will be processed in a reasonable length of time, but not to exceed 15 calendar days for “preservice” requests and 30 calendar days for “postservice” requests. Any member grievance in which time is of the essence will be handled quickly so that the member may realize the full benefit of a decision made in his/her favor. The length of time would depend upon the specific situation, but will be reasonable in respect to the situation, and no more than 72 hours after the request is made. If the member (or authorized person or provider) does not receive a determination and notification of the internal review decision within 15 calendar days for “preservice” or 30 calendar days for “postservice”, or of the expedited review within 72 hours, this shall be deemed a denial. The member (or authorized person or provider) may be afforded an external review. Such request must be made, in writing, within 180 days after the non-determination (see Independent Review/External Review section).

Requests for external reviews for services denied not a covered benefit or an administrative complaint, can be made at any time (after the Plan’s formal review) to the State Insurance Department that has jurisdiction (see Non-authorization Because the Services are Determined by The Plan Not to be a Covered Benefit or Administrative Complaints).

C. Expedited Review.

Any member grievance, in which time is of the essence, will be handled quickly so that the member may realize the full benefit of a decision made in his/her favor. 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 (see Independent Review/External Review section).

The expedited review may be requested if the member’s provider certifies that, in the absence of immediate medical attention, the following could happen.

- The health of the member (or unborn child) could be in serious jeopardy.
- Serious impairment to bodily functions could occur.

- 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, cancelations or nonrenewal of a member's coverage; eligibility determinations; observance of a member's 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.

Ohio Department of Insurance
Consumer Services Division
50 W. Town St., 3rd Floor, Suite 300
Columbus, OH 43215-1067
(800) 686-1526
(614) 644-2673

West Virginia Insurance Commission
P.O. Box 50540
Charleston, WV 25305-0540
(888) 879-9842
(304) 558-3386

For example, the appropriate State Insurance Department will review the Plan's contract benefits and the service requested. If the Insurance Department determines the service is not a covered benefit, the Plan does not have to cover/pay for the service. If the Insurance Department determines the service is a covered benefit the Plan must cover/pay for the service or appeal such determination (however such appeal is available).

3. External Independent Review.

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. 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 IRO. The \$500 does not apply in cases of expedited reviews. The IRO will not be professionally or financially affiliated with the Plan.

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 request must be in writing and include a certification from the provider that the services will cost more than \$500.

The IRO will review the relevant member's medical records, Plan medical appropriateness criteria, Plan's clinical rationale and standards it used and other information required by law to make its determination. If the IRO finds that the service is medically necessary and appropriate, the Plan will pay for the service according to the terms of the contract. If the IRO finds that the service is not medically necessary and appropriate, the Plan does not have to cover/pay for the service.

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B. Non-authorization Because Services Deemed Experimental/Investigational by the Plan.

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.

If the member has a terminal illness, the member may also request an external review when services have not been approved for coverage because they are deemed experimental or investigative. To qualify for this review the member must meet *all* of the following criteria.

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 not 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.
 - Standard therapies have not been effective in improving the member’s condition.
 - Standard therapies are not medically appropriate for the member.
 - 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.

If the IRO finds the health care service is not experimental/investigational, the Plan will cover the service. If the IRO finds the service is experimental/investigational, the service will not be covered. The IRO will respond to the Plan and the Plan will advise the requesting party of the determination.

C. Instructions for Requesting an Independent Review/External Review.

This external independent review process is available for 3-A and B of this section but 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.

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.

- A description of the member’s condition.
- The principal reason(s) for the decision.
- An explanation of the clinical rationale for the decision.

D. Expedited Reviews.

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.

The expedited review may be requested if the member's provider certifies that, in the absence of immediate medical attention, the following could happen.

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

E. Complaints/Concerns on Quality of Care.

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.

XVI. NEW TECHNOLOGY.

The Plan tries to keep pace with change and ensure members have access to safe and effective care. The Plan continually reviews new trends in medical technology, procedures, pharmacological treatments and drugs. Scientific evidence, medical effectiveness and determinations from regulatory bodies are all components of the review of new technology. The Plan reviews this information to form the basis for coverage decisions in the future.

XVII. BENEFIT OR RULE CHANGES.

Benefit or rule changes must comply with Ohio HIC and West Virginia HMO Law minimum standards.

THE PLAN MISSION STATEMENT

"In its mission to provide a comprehensive delivery of healthcare 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."

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XVIII. SCHEDULE OF BENEFITS

These services are covered when they meet Health Plan guidelines, are provided or arranged for by a Plan Physician, deemed medically necessary and appropriate and approved by The Health Plan. Services must be deemed medically necessary and appropriate by the Plan. There may be specific limitations (see “Limitations & Exclusion”).

Benefit Description	Member Cost
<p>Deductible: is the amount each member/family is required to pay each contract year before payment of eligible services will be paid by the Plan. To reach the family total, you can count the expenses incurred by two or more family members. However, the deductible contributed towards that total by any one family member cannot be more than the amount of a single deductible. If one family member meets the single deductible amount and again needs to use benefits, the Plan will begin to pay for that person’s covered services even if the deductible for the entire family has not been met.</p> <ul style="list-style-type: none"> •For services that the deductible is waived, copays/coinsurance still apply; copays/coinsurance do not accumulate towards the deductible. •Once the deductible is met, copays/coinsurance still apply. •Deductible applies as noted 	<p>Single: \$1,000 Family: \$2,000</p>
Inpatient Hospital Services	
<ul style="list-style-type: none"> •Room and board: semi-private room, ICU/CCU, nursing care, maternity and birthing room (48 hrs. normal, 96 hrs. cesarean, if mother and physician determine that the hospital stay is to be shortened, 72 hrs. of follow-up care will be provided), nursery, operating room, therapy (oxygen and respiratory, physical, occupational and speech), laboratory, therapeutic and diagnostic x-ray, observation bed, other services and supplies •Out-of-Area Inpatient Hospitalization: defined emergency or <i>approved</i> referral to Plan tertiary facility 	<p>40% coinsurance, deductible applies</p>
<ul style="list-style-type: none"> •Physician visits and services 	<p>40% coinsurance, deductible applies</p>
<ul style="list-style-type: none"> •Rehabilitation 	<p>40% coinsurance, deductible applies</p>
<ul style="list-style-type: none"> •Skilled Nursing Facility: medically necessary and in lieu of hospitalization 	<p>Not covered</p>
Outpatient Services (physician’s office, hospital, home setting, other Plan or approved provider)	
<ul style="list-style-type: none"> •PCP office visits: to include child health supervision services (review of physical and emotional status, birth to age nine), physical exam (one per calendar year) and well child care 	<p>\$25 copay</p>
<ul style="list-style-type: none"> •Ob/gyn office visits: approved referral required (unless selected Ob/gyn) 	<p>\$25 copay</p>
<ul style="list-style-type: none"> •Other office visits: approved referral required (unless selected SCP) 	<p>\$40 copay</p>
<ul style="list-style-type: none"> •Chiropractic services 	<p>Not covered</p>
<ul style="list-style-type: none"> •Podiatry 	<p>Not covered</p>

Benefit Description	Member Cost
<ul style="list-style-type: none"> •Maternity care: pre and post-natal care/obstetrical services •Post delivery follow-up visits: 48 hrs. normal, 96 hrs. cesarean, if mother and physician determine that the hospital stay is to be shortened, 72 hrs. of follow-up care will be provided 	\$25 copay 40% coinsurance, deductible applies
<ul style="list-style-type: none"> •Preventive Care: injections, immunizations (pediatric/childhood, adolescent and adult); annual mammography, Pap smear, prostate and hearing screening 	\$25 copay PCP or Ob/gyn, \$40 copay other office visits
<ul style="list-style-type: none"> •Cardiac rehabilitation •Pulmonary rehabilitation 	Not covered Not covered
<ul style="list-style-type: none"> •Therapy (physical, occupational and speech) 	Not covered
<ul style="list-style-type: none"> •Laboratory, therapeutic, diagnostic and radiological services: to include ultrasound, MRI, MRA, CAT and PET scans 	40% coinsurance, deductible applies
<ul style="list-style-type: none"> •Radiation and chemotherapy 	40% coinsurance, deductible applies
<ul style="list-style-type: none"> •Outpatient surgery 	40% coinsurance, deductible applies
<ul style="list-style-type: none"> •Oral surgical limited services: accidental or injury 	40% coinsurance, deductible applies
<ul style="list-style-type: none"> •Emergency care: in-area or out-of-area 	\$110 copay, waived if admitted, see Inpatient Hospital
<ul style="list-style-type: none"> •Urgent care: in-area or out-of-area 	\$45 copay, waived if admitted, see Inpatient Hospital
<ul style="list-style-type: none"> •Other Services (physician's office, hospital, home setting, other Plan or approved provider) 	
<ul style="list-style-type: none"> •Ambulance service: emergency transportation (medically necessary only), scheduled transportation (will be reviewed for medical necessity and appropriateness) 	\$110 copay
<ul style="list-style-type: none"> •Ambulette service 	Not covered
<ul style="list-style-type: none"> •Audiology: audiological exam (one per contract year, only if referred by a PCP or ENT physician) 	\$40 copay
<ul style="list-style-type: none"> •Biofeedback therapy 	Not covered
<ul style="list-style-type: none"> •Diabetes pharmacological agents: (members covered under prescription drug rider will receive pharmacological agents through their prescription drug rider unless the benefits supplied through the rider are at a lesser level) •Diabetes supplies: glucometers, syringes, lancets, glucose test strips, alcohol swabs, carp-u-jet, urine ketone testing strips, urine microalbumin test and penlets, supplied through pharmacies, the Plan may require the use of 	40% coinsurance, deductible applies 40% coinsurance, deductible applies

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Benefit Description	Member Cost
<p>specific brands of glucometers to ensure consistency of training and education services.</p> <p>See Diabetic Coverage for additional information</p>	
<p>•Durable medical equipment (DME) and DME supplies: rental or purchase (whichever costs less) for temporary use not to exceed a six-month period, limited to Plan's basic allowance, approved referral may be required</p>	<p>40% coinsurance, deductible applies</p>
<p>•Family planning: infertility services, limited to basic health care</p>	<p>40% coinsurance, deductible applies</p>
<p>•Hearing aid</p>	<p>Not covered</p>
<p>•Home Health: medically necessary services for intermittent skilled care only in lieu of hospitalization (home health aide not covered)</p>	<p>Not covered</p>
<p>•Home IV therapy/infusion therapy</p>	<p>Not covered</p>
<p>•Hospice: medically necessary in lieu of hospitalization</p>	<p>Not covered</p>
<p>•Orthotics</p>	<p>Not covered</p>
<p>•Prosthetic and prosthetic supplies: for mastectomies only (coverage is included for a member receiving benefits in connection with a mastectomy who elects reconstruction for: a breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of the mastectomy including lymphedemas), limited to Plan's basic allowance, approved referral may be required</p>	<p>40% coinsurance, deductible applies</p>
<p>•Temporomandibular joint dysfunction (TMJ): non-experimental, medically necessary services, approved referral required</p>	<p>40% coinsurance, deductible applies</p>
<p>Mental Health/Substance Abuse Services (other mental and emotional disorders that do not qualify as biologically based will be covered at \$550 per member per calendar year, applicable copay or coinsurance and deductible will apply)</p>	
<p>•Inpatient biologically based mental health illnesses treatment: inpatient hospital days, intensive outpatient hospital visits, partial hospitalization visits or residential treatment programs. Treatment programs may be combined</p>	<p>40% coinsurance, deductible applies</p>
<p>•Outpatient biologically based mental health illnesses treatment: office visits, hospital outpatient department or licensed outpatient treatment facility</p>	<p>\$40 copay</p>
<p>Substance Abuse Services</p>	<p>Not covered</p>
<p>Prescription benefit (RX)</p>	<p>Not covered</p>

Benefit Description	Member Cost
Other Information	
•Percentage coinsurances are based on the amount paid, allowed or negotiated by Health Plan.	✓
•If services fall in more than one category, the higher copay shall be applicable (not to include any office visits).	✓
•When services are limited to a maximum number of days, treatments, visits etc., each must be medically necessary and appropriate to be covered.	✓
<p>•Copay/coinsurance is the amount required to be paid by a member for each visit/service outlined in the Schedule of Benefits. Once a single subscriber has paid \$5,000 out-of-pocket in a contract year, The Health Plan pays 100% of expenses for covered services. For a family contract, the annual limit is \$10,000 before coverage begins at 100%. Any one family member will not contribute more than \$5,000 in copays/coinsurances. Calculation of the single or family out-of-pocket maximum does not include the single and family deductible, copays or coinsurance for inpatient or outpatient mental health or substance abuse services, prescription drugs, hospice care, home health care, skilled nursing care or the voluntary and unauthorized use of a nonparticipating specialist or facility.</p> <p>Copays/coinsurances paid by a member on any single covered basic health care service during a contract year shall not exceed 40% of the average cost to the Plan to provide the service. Average cost to the Plan is that amount paid by the Plan for a particular service during the previous calendar year derived by dividing the total amount paid by the number of services provided. Total copays/coinsurances shall not exceed 200% of the average annual premium rate.</p>	✓

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DIABETIC COVERAGE.

Treatment and/or management for members with insulin or non-insulin dependent diabetes or diabetes during pregnancy shall be covered. These services must be medically necessary and prescribed by a Plan physician as follows.

• DIABETIC MEDICATIONS - (insulin and oral medications).

Insulin and oral medications will be provided by participating pharmacies and billed to the Plan through the Pharmacy Benefits Manager (PBM). The items are subject to a closed formulary for insulin and oral medications as indicated below.

FORMULARY AGENTS.

- Glyburide (generic only).
- Glipizide (generic only).
- Chlorpropamide (generic only).
- Metformin (generic only).
- Insulin (Novolin only).

NOTE: Non-formulary agents will be paid only if a specific medical indication exists whereby the listed formulary agents cannot be used. This requires advance approval by The Health Plan Pharmacy Director.

A 30-day supply will be dispensed monthly. The member will pay a 40% coinsurance for each 30-day supply.

• ANNUAL DIABETIC RETINAL EXAM (\$40 copay).

Members with diabetes have direct access to a Plan optometrist or ophthalmologist of their choice, without preauthorization by the Plan, for an annual diabetic retinal exam. If the exam reveals an abnormal condition, future treatment by the optometrist or ophthalmologist requires preauthorization by the Plan. Applicable copay will apply.

Other Items not listed. - Other items may be covered if medically appropriate. Any items not listed above will require preauthorization by the Plan and applicable copay will apply.

Items specifically not covered are as follows.

Devices and supplies to improve care of teeth/gums, Medic Alert bracelet/device, dietary supplements/over the counter sugar-free aids, foot care products-hygienic in nature, Count a Dose magnifiers, vaginal yeast products and/or moisturizers, laxatives, antacids, anti-diarrheals and insulin carrying devices.

• DIABETES SELF-MANAGEMENT EDUCATION SERVICES (40% coinsurance).

The Health Plan will cover services provided for the purpose of educating diabetic members on proper self-management and treatment of their diabetes including information on proper diets.

Coverage of educational services for self-management education is limited as follows.

1. Must be prescribed by the member's PCP, referred specialist or a Health Plan Case Management nurse.

2. Must be medically appropriate based upon a diagnosis of diabetes and/or a significant change in the member's symptoms surrounding the diabetes diagnosis and/or a change in medication or prescribed therapies.
3. Must be provided by a Plan certified diabetic educator. A list of can be obtained from the Plan.
4. The certified diabetic educator must provide the member with a plan of care and some method for measurement of personal outcomes.

The Plan will cover 16 visits (maximum of eight individuals and eight groups) per year. Additional educational services may be covered on an as needed basis supported by medical necessity.

• **LABORATORY TESTING SERVICES.**

Laboratory testing services are covered as outlined in the "Schedule of Benefits" section of this Agreement.

Lab tests must be ordered by the PCP or referred specialist and provided through a Plan lab and/or physician's office. The Health Plan and the American Diabetes Association recommend the tests listed below for the diagnosis, treatment and management of diabetes and its related conditions.

- Fasting blood glucose.
- Glycosylated hemoglobin (HbA1c) at least twice per year.
- Lipid profile at least annually.
- Microalbuminuria testing at least annually.

Other lab test will be covered provided they are medically necessary and appropriate and meet Plan guidelines.

• **PHYSICAL EXAMS.**

Physical exams are covered as outlined in the "Schedule of Benefits" section of this Agreement.

• **OTHER SERVICES.**

Other services related to the diagnosis, treatment and management of diabetes may be covered if medically necessary and appropriate. They must meet Plan guidelines and may require preauthorization by the Plan. Applicable copay will apply. Contact the Plan for additional information.

All services limited to a maximum number of days, treatments, visits, etc., each visit, treatment, etc., must be medically necessary and appropriate to be covered.

EXCLUSIONS.

The following are NOT covered or are specifically limited as stated.

1. All dental, dental related services or dental related services applied to TMJ.
2. Except as stated in the benefits outline, cosmetic surgery, breast augmentation and reduction surgery and all related supplies, unless medically necessary; penile implants and related services.

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3. Treatment of obesity, including diet substitutes and supplements.
4. Experimental or investigational procedures, supplies and drugs.
5. All services that are not medically necessary, except for required preventive services.
6. Examinations specifically for the purpose of obtaining employment or insurance or examination precedent to engaging in recreational activities unless obtained in the context of periodic exam.
7. Recreational, sexual or education therapy. **Speech therapy, physical therapy and occupational therapy are covered on an inpatient basis only.**
8. For foot care due to:
 - a. treatment of weak, strained or flat feet or instability or imbalance of the foot.
 - b. treatment of corn, calluses or the free edge of toenails, except when necessitated for peripheral vascular disease or other illness of similar medical seriousness.
9. Vision care benefits or orthoptics, vision training, low vision aids or any related type of service including eyeglasses and contact lenses.
10. Services rendered prior to your effective date of coverage or after your coverage terminates (unless stated otherwise regarding termination of coverage).
11. Services received from a member of the immediate family or rendered by a physician or another provider to himself/herself.
12. Services that are for any illness or injury occurring in the course of employment if whole or partial compensation is available under Workers' Compensation laws or laws of any governmental entity.
13. Any service for which the member has no legal obligation to pay in the absence of this or similar coverage.
14. Services and expenses related to all aspects of organ or tissue procurement rendered or incurred prior to the site of presentation to the donor, including all donor expenses.
15. Transportation and living expenses, except for emergency ambulance services and organ transplants performed outside of the Service Area.
16. Services received while incarcerated or in the custody of law enforcement officials when such is the financial responsibility of the applicable prison system.
17. Services of nonparticipating providers, except in an emergency or for out-of-area benefits or when authorized in advance in writing by Health Plan.
18. Services and treatment of mental retardation and other mental health services, except as otherwise provided.
19. Hearing aids and related services and supplies, except medical services required for diagnosis and treatment of diseases of, or injury to, the ears.
20. Except as stated in the benefits outline, reconstructive surgery, unless deemed medically necessary by a participating physician with the prior approval of Health Plan to restore normal physiological functioning.

21. Outpatient private duty nursing or private rooms for hospitalization.
22. Nonprescription drugs, infertility drugs, growth hormones, medications and contraceptive devices, birth control pills including, but not limited to, Norplant and similar products.
23. Personal comfort items (such as radio, television, telephone and guest meals); private rooms unless medically necessary during inpatient hospitalization.
24. Custodial or domiciliary care or convalescent care (skilled nursing care, hospice care or home health covered under the Standard Option only unless medically necessary and with prior approval by the Plan in lieu of hospitalization).
25. Out patient physical therapy and rehabilitation services.
26. Reversals of voluntary induced infertility, experimental infertility procedures and non-medically necessary procedures including, but not limited to, artificial insemination, in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT).
27. Procedures, services and supplies related to sex transformations.
28. Services on which claim is based from care which is received in a veteran, marine or other federal hospital.
29. Nonmedical ancillary services and long-term rehabilitative services for the treatment of alcoholism or drug abuse, including rehabilitation services in a specialized inpatient or residential facility.
30. Except as stated in the benefits outline, orthotic and prosthetic devices.
31. Autologous bone marrow transplant, in some instances.
32. Services of chiropractor, podiatrists and optometrists.
33. Blood or blood plasma.
34. Kidney dialysis and end stage renal disease treatment after Medicare assumes responsibility.
35. Elective abortions.
36. Experimental artificial organs and related procedures.
37. Elective pre-surgery testing on an inpatient basis without pre-certification of the Health Plan Medical Director.
38. Megavitamin therapy, psychosurgery and nutritional based therapy.
39. Salabrasion, chemosurgery or other such skin abrasion procedures to remove scars, tattoos or which are performed as treatment for acne.

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40. Services performed after Health Plan or a participating physician has advised the member that further services are not medically appropriate or not covered.

LIMITATIONS.

1. *Major solid organ transplants (heart, heart-lung, lung, liver and pancreas) must be received through the Ohio Transplant Consortium. The member must also receive pre-certification by the Health Plan Medical Director. Other covered transplants-bowel, kidney, cornea and bone marrow-are not involved with the Transplant Consortium and will be covered if meeting all pre-certification criteria by Health Plan.*
2. *A Health Plan participating provider must be used for services unless the required specialty is not under contract with Health Plan and use of the nonparticipating provider is pre-certified by Health Plan.*
3. *All services must be provided by or pre-certified by the member's PCP.*
4. *Rental or purchase (whichever costs less) of durable medical equipment for temporary use, not to exceed a six-month period.*

A. PLASTIC SURGERY (Covered **only for reasons stated below).**

Plastic surgery, which is a direct result from acute trauma of an accident (i.e., car accident), a congenital birth defect (i.e., cleft lip or palate) or a mastectomy, is covered as follows.

Conditions related to malposition of the bones of the jaw are **not** covered (i.e., orthognathic procedures).

Accident/ Congenital Birth Defect.

Payment will be made for hospital/medical services incurred in connection with these conditions for plastic surgery only for the following.

1. Such above condition occurred while a member of the Plan,
2. or it is deemed by the Plan through review of prior medical records, the member has an ongoing medical history of plastic surgical correction resulting from the above conditions.

Mastectomy/Breast Implants and Removal/Replacement of Implants.

Benefits for reconstructive surgery after a mastectomy will be covered under the same terms as other regular inpatient services by the Plan. These benefits include the following.

- Coverage for reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Coverage for prostheses and physical complications of all stages of the mastectomy, including lymphedemas.
- Coverage for surgery required as a result of an injury caused by the act of a person convicted of a crime involving family violence.

No payment is made for surgical operations for breast implants unless it is necessary for breast reconstruction with mastectomy related to breast cancer or cancer related indication or fibrocystic breast disease.

No payment is made for the removal/replacement of breast implants except for those inserted for reconstructive purposes related to mastectomy for breast cancer or cancer related indication or fibrocystic breast disease or those that have been deemed medically necessary, by the Plan, to remove/replace.

B. ORAL SURGICAL SERVICES LIMITED.

Oral surgical coverage is limited and will only be paid as stated below.

Conditions related to malposition of the bones of the jaw are **not** covered (i.e., orthognathic procedures).

Impacted wisdom teeth and full mouth extraction.

Impacted wisdom teeth, full mouth extraction and anesthesia are not covered. Hospitalization (days) will be paid provided the PCP certifies it is necessary to safeguard the life of the member. Anxiety is not considered cause for hospitalization. Approval by the Plan is required.

Odontogenic dentigerous cysts.

Cysts that form in the mouth and/or jaw area will be covered if they are medical (non-dental) in nature. Hospitalization (days) will be paid provided the PCP certifies it is necessary to safeguard the life of the member. Anxiety is not considered cause for hospitalization. Approval by the Plan is required.

Diseases of the gums, that are non-dental in nature and deemed medically necessary and appropriate, are covered. Approval by the Plan is required.

Accident/Injury.

Oral surgical and hospital services resulting directly from acute trauma of an accident (i.e., car accident) or injury are limited to the following.

- The accident or injury must have occurred while a member of the Plan.
- Services must have been initiated and rendered within six months of the accident.
- Oral surgical services are limited to repair of hard or soft tissues of the face **excluding** the direct repair of teeth.
- Must require the expertise of an oral surgeon, be medically necessary and approved by the Plan.

Injuries to the gums, that are non-dental in nature and deemed medically necessary and appropriate, are covered. Approval by the Plan is required.

Congenital Birth Defects.

Payment will be made for medically necessary oral surgery and/or hospital/medical services to correct congenital birth defects (not developmental) only for the following.

1. Such condition must have occurred while a member of the Plan,
2. or it is deemed by the Plan through review of prior medical records, that the member has an ongoing medical history of oral surgical correction resulting from a congenital birth defect (i.e., cleft lip or palate).

When services are limited to a maximum number of days, treatments, visits, etc., each visit, treatment, etc., must be medically necessary and appropriate to be covered.

The subscriber/member shall be financially obligated for any and all non-covered services.

Any questions or problems, please call or write our Customer Service Department at:
St. Clairsville/Morgantown areas: 52160 National Rd. East, St. Clairsville, OH 43950, (740) 695-7902 or (888) 847-7902, TDD (740) 695-7919 or (800) 622-3925, website www.healthplan.org.
Nurse on Call and Utilization Review Staff -- 24 hrs. a day/seven days a week: (740) 695-3585 or (800) 624-6961. **Massillon area:** P.O. Box 4816, Massillon, OH 44648, (330) 837-6880 or (800) 426-9013, TDD (877) 236-2291, website www.healthplan.org. Nurse on Call and Utilization Review Staff--24 hrs. a day/seven days a week: (330) 837-6880 or (800) 426-9013. Hours are Monday-Friday, 8:30 a.m. - 5:00 p.m.

Insurance Fraud Warning: “Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.”

Help Us Help You!

Help stop insurance fraud. Each incident uncovered and stopped saves you and every other policyholder money. That is as important to us as it is to you. Health care fraud usually takes the form of false or misleading claims for payment submitted to insurance carriers and health care plans. Local and toll-free “FRAUD” hotline phone numbers are now available. If at any time you may have concerns or questions about charges or payments made for you or an eligible dependent, feel free to call the Health Plan Fraud Hotline (740) 699-6111 or (877) 296-7283.

The Health Plan of the Upper Ohio Valley, Inc. (“The Health Plan”)

Basic and Standard Conversion/Open Enrollment

Patient Protection and Affordable Care Act of 2010

AMENDMENT

This Amendment amends your health benefit plan (Plan), and becomes a part of your Plan as of the effective date located on your Identification Cards (I.D. card) which are enclosed. Please place this Amendment with your Evidence of Coverage for future reference.

On the Effective Date of this **Amendment**, certain benefits, terms, conditions, limitations, and exclusions in your Plan will be amended to comply with the requirements of the federal health care reform legislation, the Patient Protection and Affordable Care Act of 2010.

Regardless of the terms and conditions of any other provisions of your Plan, this **Amendment** will control.

The following Definition is added to your Plan:

“**Essential Health Benefits**” is defined under federal law (PPACA) as including benefits in at least the following categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Your plan may contain some or all of these types of benefits prior to 2014 when they become mandatory. If your plan contains any of these benefits, there are certain requirements that may apply to those benefits, as provided in this **Amendment**.

Emergency Services

Your Plan covers Emergency Services for an Emergency Medical Condition treated in any hospital emergency department.

Lifetime Dollar Limits

The Essential Health Benefits that may be provided by your Plan are not subject to a lifetime dollar limit. Plan benefits that are not defined as Essential Health Benefits may have a lifetime dollar limit. If you have reached a lifetime dollar limit under your Plan before the federal regulation prohibiting lifetime dollar limits for Essential Health Benefits became effective, and you are still eligible under your Plan’s terms, and that Plan is still in effect, you will receive a notice that the lifetime dollar limit no longer applies and that you will have an opportunity to enroll or be reinstated under your Plan. If you are eligible for this enrollment opportunity, you will be treated as a special enrollee.

Annual Dollar Limits

Your Plan may have annual dollar limits on the claims the Plan will pay each year for Essential Health Benefits. Your Plan may include other benefits not defined as Essential Health Benefits, and those other benefits may have annual dollar limits. If your Plan has annual dollar limits on Essential Health Benefits they are subject to the following:

For a plan year beginning on or after September 23, 2010, but before September 23, 2011, the limit can be no less than \$750,000.

For a plan year beginning on or after September 23, 2011, but before September 23, 2012, the limit can be no less than \$1.25 million.

For a plan year beginning on or after September 23, 2012, but before December 31, 2013, the limit can be no less than \$2 million.

For a plan year beginning on or after January 1, 2014, there is no dollar limit for Essential Health Benefits under your Plan.

Rescission of Coverage

A rescission of your coverage means that the coverage may be legally voided all the way back to the day the Plan began to provide you with coverage, just as if you never had coverage under the Plan. Your coverage can only be rescinded if you (or a person seeking coverage on your behalf), performs an act, practice, or omission that constitutes fraud; or unless you (or a person seeking coverage on your behalf) makes an intentional misrepresentation of material fact, as prohibited by the terms of your Plan. Your coverage can also be rescinded due to such an act, practice, omission or intentional misrepresentation by your employer.

You will be provided with thirty (30) calendar days' advance notice before your coverage is rescinded. You have the right to request an internal appeal of a rescission of your coverage. Once the internal appeal process is exhausted, you have the additional right to request an independent external review.

Preventive Health Benefits

Under Ohio law, the following preventive health benefits are required to be provided in your Plan:

- Initial Mammography starting at age 35
- Annual screening for cervical cancer
- Child Health Supervision

Your Plan provides additional coverage for selected preventive services without a copayment, coinsurance or deductible **when these services are delivered by a network provider**. Depending upon your age, services may include:

- Screenings and tests for diseases
- Mental Health screenings, including substance abuse
- Healthy lifestyle counseling
- Vaccines and immunizations
- Pregnancy counseling and screenings
- Well baby and well child visits through age 21
- Periodic physical exams

Eligible services have been determined by recommendations and comprehensive guidelines of governmental scientific committees and organizations. You will be notified, at least sixty (60) days in advance, if any item or service is removed

from the list of eligible services. Eligible services will be updated annually to include any new recommendations or guidelines.

Please contact us at www.healthplan.org or **740-695-3585** or **1-800-624-6961**, if you have any questions or need to determine whether a service is eligible for coverage as a preventive service. For a comprehensive list of recommended preventive services, please visit www.healthcare.gov/center/regulations/prevention.html.

Dependent Coverage (for plans that make dependent coverage available)

This Plan will cover your married or unmarried child as defined in the Eligibility section in the enclosed Evidence of Coverage (Member Handbook) of this Plan until your child reaches age 26.

Ohio Residents: Your Plan will provide coverage, or offer you the opportunity to purchase coverage, for your unmarried natural child, stepchild, or adopted child until your child reaches age 28 if your child is (1) a resident of Ohio or a full-time student at an accredited public or private institution of higher education; and (2) not employed by an employer who offers any health benefit plan under which your child is eligible for coverage; and (3) not eligible for Medicaid or Medicare.

Internal Claims and Appeals and External Review Process

Members have the right to appeal decisions of the Plan. If you feel the Plan did not provide or limited benefits you should receive under the Plan or you have an administrative complaint, you may file an appeal. Your appeal rights are explained below.

The Plan has designated a “Grievance Coordinator” to assure that individual members and authorized persons and providers, have a meaningful voice in the Plan through an effective Grievance Procedure. The Grievance Coordinator can be contacted by calling: (740) 695-7902, (888) 847-7902, TDD (740) 695-7919, (800) 622-3925. You may also write to or contact in person at: The Health Plan, Grievance Coordinator, 52160 National Rd. East, St. Clairsville, OH 43950. Fax (740) 699-6163 or email: info@healthplan.org Grievances will be processed in accordance with state laws.

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

- Be prompt and responsive.
- Be flexible enough to manage both complicated and uncomplicated grievances without delay.
- Provide the ability to modify the Plan’s operations in ways that address problems from patterns of grievances.
- 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.

- Non-authorization, limitation or reduction of the coverage of healthcare services.
- Administrative complaints such as cancellation/non-renewal or rescission of coverage and eligibility determinations.

The Grievance Procedure will involve a Plan employee with problem solving authority in the Grievance Procedure. Medically related grievances will have physician involvement in the review process.

The member is entitled to receive, free of charge and upon request, reasonable access to, or a copy of, all relevant documents ruled upon to make the appeal decision.

The following is a description of the Grievance Procedure process.

A. Internal Review.

When a member receives an “adverse determination” he/she, or an authorized person, may request an Internal Review. For prospective or concurrent review determinations, a member’s provider or healthcare facility (rendering the service), with consent of the member (“authorized provider”), may also request the reviews. Members in urgent care situations and individuals receiving an ongoing course of treatment may be allowed to proceed with an external review at the same time as the internal appeals process.

CONTINUATION OF BENEFITS:

All written appeal decisions, to the requesting party, are in easily understood language and in the prevalent language spoken by the member, or in an alternate format for special needs of the visually impaired or those with limited reading proficiency.

Members have a right to receive continuation of benefits while their internal appeal review is pending. Members can make their request for continuation of benefits by contacting the Appeals Coordinator at: (740) 695-7902, (888) 847-7902, TDD (740) 695-7919, (800) 622-3925. You may also write to or contact in person at: The Health Plan, Appeals Coordinator, 52160 National Rd. East, St. Clairsville, OH 43950, Fax (740) 699-6163 or email: info@healthplan.org.

NOTE: Member's will be liable for the cost of continuation of benefits if the appeal review decision upholds the Plan's decision to deny the service/authorization.

CONTINUATION OF BENEFITS PROCESS:

The Plan will continue member’s benefits while an internal appeal review is pending when:

- The member files the appeal timely (timely filing means on or before the later of within ten days of the Plan mailing of the notice of the adverse decision or the intended effective date of The Health Plan’s proposed action);
- The member is appealing a decision to terminate, suspend, or reduce a previously authorized course of treatment;
- The services were ordered by an authorized provider;
- The original period covered by the original authorization has not expired; and
- The member requests extension of benefits.

Benefits shall be continued or reinstated until:

- The member withdraws the appeal;
- The member did not request the continuation of benefits within ten days from the date of the Plan's appeal notice to the member indicating the denial was upheld, or has requested an external review with continuation of benefits until an external review decision is reached; or
- The time period or service limits of a previously authorized service have been met.

If the resolution of the appeal reverses the decision of the Plan to deny, limit, or delay services that were not furnished, the Plan shall authorize or provide the disputed services promptly or as expeditiously as the member's health condition requires. If the resolution of the appeal reverses the decision of the Plan to deny authorization of services, and the member received the disputed services while the appeal was pending, the Plan must pay for those services in accordance with state policy and regulations.

The member (or authorized person or provider) may request the Plan to reconsider the issue. The appeal may be written or verbal (by phone or in person); and it will be documented by the Plan. If the *adverse determination does not change during the initial contact*, the Plan employee assisting the member will advise them of how to proceed with the **appeal** process. The review is a one step appeal process. For review of care or services not yet preformed-("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 within 30 calendar days of the request to reconsider. In situations involving an urgent care claim, the Plan will notify the member within 24 hours.

The appeal must be filed within one year of the date of the occurrence leading to the internal review. A Plan member may meet with a Plan representative and/or the Plan's Appeals Committee to review the situation. If the Plan Appeals Committee continues an adverse determination, a physician (of the same or similar specialty who provides or treats the requested service) will also review the appeal if it involves medical appropriateness. If the physician finds the service is not medically necessary and appropriate, the Plan will continue not to authorize coverage for the service. If the physician finds that the service is medically necessary and appropriate, the Plan may cover the service. If the Plan does not cover the service, 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 notification (see Independent Review/External Review section). The internal review will be processed in a reasonable length of time, but not to exceed 15 calendar days for "preservice" requests and 30 calendar days for "postservice" requests. Any member's appeal, in which time is of the essence, will be handled quickly so that the member may realize the full benefit of a decision made in his/her favor. The length of time would depend upon the specific situation, but will be reasonable in respect to the situation, and no more than 72 hours after the request is made. If the member (or authorized person or provider) does not receive a determination and notification of the internal review decision within 15 calendar days for "preservice" or 30 calendar days for "postservice", or of the expedited review within 72 hours, this shall be deemed a denial. The member (or authorized person or provider) may be afforded an external review. Such request must be made, in writing, within 180 days after the non-determination (see Independent Review/External Review section).

Requests for external reviews for services denied not a covered benefit or an administrative complaint, can be made at any time (after the Plan's internal review) to the State Insurance Department that has jurisdiction (see Non-authorization Because the Services are Determined by the Plan Not to be a Covered Benefit or Administrative Complaints).

Expedited Review.

Any member's appeal, in which time is of the essence, will be handled quickly so that the member may realize the full benefit of a decision made in his/her favor. 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 (see Independent Review/External Review section).

The expedited review may be requested if the member’s provider certifies that, in the absence of immediate medical attention, the following could happen.

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

B. 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 healthcare services; denials, cancellations/non-renewal or rescission of a member’s coverage; eligibility determinations; observance of a member’s rights as a patient and the quality of healthcare services).

The Plan may, after internal 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 may request a review from the State Insurance Department that has jurisdiction. This review to the State Insurance Department is available only after an internal review has been completed by the Plan.

Ohio Department of Insurance	West Virginia Insurance Commission
Consumer Services Division	P.O. Box 50540
50 W. Town St., 3 rd Floor, Suite 300	Charleston, WV 25305-0540
Columbus, OH 43215-1067	(888) 879-9842 or (304) 558-3386
(800) 686-1526 or (614) 644-2673	

For example, the appropriate State Insurance Department will review the Plan’s contract benefits and the service requested. If the Insurance Department determines the service is not a covered benefit, the Plan does not have to cover/pay for the service. If the Insurance Department determines the service is a covered benefit the Plan must cover/pay for the service or appeal such determination (however such appeal is available).

C. External Independent Review.

1. 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. The member or authorized person or provider may request an external review by an IRO. The IRO will not be professionally or financially affiliated with the Plan.

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 internal review process. This request must be in writing.

The IRO will review the relevant member's medical records, Plan medical appropriateness criteria, Plan's clinical rationale and standards it used and other information required by law to make its determination. If the IRO finds that the service is medically necessary and appropriate, the Plan will pay for the service according to the terms of the contract. If the IRO finds that the service is not medically necessary and appropriate, the Plan does not have to cover/pay for the service.

2. Non-authorization Because Services Deemed Experimental/Investigational by the Plan.

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 healthcare services, in the internal review, which would be covered if it were not considered by the Plan to be experimental/investigative.

If the member has a terminal illness, the member may also request an external review when services have not been approved for coverage because they are deemed experimental or investigative. To qualify for this review the member must meet *all* of the following criteria.

- The member has a terminal condition that according to the current diagnosis has a high probability of causing death within two years.
- The member or authorized person requests an external review not later than **180** days after receipt of notice of the result of the formal review.
- 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.
- 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.

If the IRO finds the healthcare service is not experimental/investigational, the Plan will cover the service. If the IRO finds the service is experimental/investigational, the service will not be covered. The IRO will respond to the Plan and the Plan will advise the requesting party of the determination.

Instructions for requesting an independent review/external review.

This external independent review process is available for 1 and 2 of this section but only after the member, authorized person or provider has exhausted the internal 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 internal 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.

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.

- A description of the member's condition.
- The principal reason(s) for the decision.
- An explanation of the clinical rationale for the decision.

Expedited Reviews.

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.

The expedited review may be requested if the member's provider certifies that, in the absence of immediate medical attention, the following could happen.

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

-D. Complaints/Concerns on Quality of Care.

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

Direct Access to Obstetricians and Gynecologists

You do not need prior authorization from us or any other person (including a primary care physician) to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact The Health Plan at www.healthplan.org or 740-695-3585, toll free 1-800-624-6961.

Selection of a Primary Care Provider


We generally require the designation of a primary care physician. You have the right to designate any primary care physician who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care physician.

Until you make this designation, The Health Plan designates one for you. For information on how to select a primary care physician and for a list of the participating primary care physicians, contact The Health Plan at www.healthplan.org or 740-695-3585, toll free 1-800-624-6961.

This **Amendment** takes effect on the effective date of the Plan to which it is attached **or the effective date listed on your new Identification Cards (I.D. card) which are enclosed.** This **Amendment** terminates concurrently with the Plan to which it is attached. It is subject to all the definitions, limitations, exclusions and conditions of the Plan except as stated.

IN WITNESS WHEREOF:

The Health Plan of the Upper Ohio Valley, Inc.



Philip Wright
President