

ADDENDUM TO THE PLAN OUTLINE

Individuals electing the Basic Option will have access to Mental Health Illnesses and Substance Abuse Treatment benefits as follows.

Office Visits: \$25/copay-deductible applies
Inpatient Services: 40% coinsurance payment-deductible applies

Individuals electing the Standard Option will have access to Mental Health Illnesses and Substance Abuse Treatment benefits as follows.

Office Visits: \$25/copay-deductible applies
Inpatient Services: 30% coinsurance payment-deductible applies

Temporomandibular Joint Dysfunction (“TMJ” otherwise known as “TMD”) is no longer be a covered benefit.



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	Basic Option	Standard Option
<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>	<p>Single: \$750 Family: \$1,500</p>
<p>Inpatient Hospital Services</p>		
<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> <p>40% coinsurance, deductible applies</p>	<p>30% coinsurance, deductible applies</p> <p>30% coinsurance, deductible applies</p>
<ul style="list-style-type: none"> •Physician visits and services 	<p>40% coinsurance, deductible applies</p>	<p>30% coinsurance, deductible applies</p>
<ul style="list-style-type: none"> •Rehabilitation 	<p>40% coinsurance, deductible applies</p>	<p>30% coinsurance, deductible applies</p>
<ul style="list-style-type: none"> •Skilled Nursing Facility: medically necessary and in lieu of hospitalization 	<p>Not covered</p>	<p>30% coinsurance, deductible applies</p>

Benefit Description	Basic Option	Standard Option
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 	\$25 copay	\$25 copay
<ul style="list-style-type: none"> •Ob/gyn office visits: approved referral required (unless selected Ob/gyn) 	\$25 copay	\$25 copay
<ul style="list-style-type: none"> •Other office visits: approved referral required (unless selected SCP) 	\$40 copay	\$40 copay
<ul style="list-style-type: none"> •Chiropractic services 	Not covered	Not covered
<ul style="list-style-type: none"> •Podiatry 	Not covered	Not covered
<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	\$25 copay 30% 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	\$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	Not covered Not covered
<ul style="list-style-type: none"> •Therapy (physical, occupational and speech) 	Not covered	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	30% coinsurance, deductible applies
<ul style="list-style-type: none"> •Radiation and chemotherapy 	40% coinsurance, deductible applies	30% coinsurance, deductible applies
<ul style="list-style-type: none"> •Outpatient surgery 	40% coinsurance, deductible applies	30% coinsurance, deductible applies
<ul style="list-style-type: none"> •Oral surgical limited services: accidental or injury 	40% coinsurance, deductible applies	30% 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	\$110 copay, waived if admitted, see Inpatient Hospital

Benefit Description	Basic Option	Standard Option
<ul style="list-style-type: none"> •Urgent care: in-area or out-of-area 	\$45 copay, waived if admitted, see Inpatient Hospital	\$45 copay, waived if admitted, see Inpatient Hospital
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	\$110 copay
<ul style="list-style-type: none"> •Ambulette service 	Not covered	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	\$40 copay
<ul style="list-style-type: none"> •Biofeedback therapy 	Not covered	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 <p>Note: The Plan may require the use of specific brands of glucometers to ensure consistency of training and education services</p>	40% coinsurance, deductible applies 40% coinsurance, deductible applies	30% coinsurance, deductible applies 30% coinsurance, deductible applies
<ul style="list-style-type: none"> •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 	40% coinsurance, deductible applies	30% coinsurance, deductible applies
<ul style="list-style-type: none"> •Family planning: infertility services, limited to basic health care 	40% coinsurance, deductible applies	30% coinsurance, deductible applies
<ul style="list-style-type: none"> •Hearing aid 	Not covered	Not covered
<ul style="list-style-type: none"> •Home Health: medically necessary services for intermittent skilled care only in lieu of hospitalization (home health aid not covered) 	Not covered	30% coinsurance, deductible applies
<ul style="list-style-type: none"> •Home IV therapy/infusion therapy 	Not covered	30% coinsurance, deductible applies
<ul style="list-style-type: none"> •Hospice: medically necessary in lieu of hospitalization 	Not covered	30% coinsurance, deductible applies

Benefit Description	Basic Option	Standard Option
• Orthotics	Not covered	Not covered
• 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	40% coinsurance, deductible applies	30% coinsurance, deductible applies
• Temporomandibular joint dysfunction (TMJ): non-experimental, medically necessary services, approved referral required	40% coinsurance, deductible applies	30% coinsurance, deductible applies
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)		
• 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	40% coinsurance, deductible applies	30% coinsurance, deductible applies
• Outpatient biologically based mental health illnesses treatment: office visits, hospital outpatient department or licensed outpatient treatment facility	\$40 copay	\$40 copay
• Inpatient substance abuse treatment: limited to five days per member per contract year, approved referral required	Not covered	30% coinsurance, deductible applies
• Outpatient substance abuse treatment: approved referral required	Not covered	30% coinsurance, deductible applies, limited to \$550 per member per contract year
Other Information		
Prescription benefit (RX)	Not covered	\$15/20% copay/coinsurance (see enclosed RX Benefits Brochure)
• To obtain mental health services, the member may contact the Plan at 1-877-221-9295.	✓	✓

Benefit Description	Basic Option	Standard Option
<ul style="list-style-type: none"> Percentage coinsurances are based on the amount paid, allowed or negotiated by Health Plan. 	✓	✓
<ul style="list-style-type: none"> If services fall in more than one category, the higher copay shall be applicable (not to include any office visits). 	✓	✓
<ul style="list-style-type: none"> When services are limited to a maximum number of days, treatments, visits etc., each must be medically necessary and appropriate to be covered. 	✓	✓
<ul style="list-style-type: none"> Copay/coinsurance is the amount required to be paid by a member for each visit/service outlined in the Benefits Schedule. 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%. 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>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. Total copays/coinsurances shall not exceed 200% of the average annual premium rate.</p>	✓	✓

LIMITATIONS

1. Major solid organ transplants (heart, heart-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.

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.

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

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

Insurance Fraud Warning: Pursuant to Ohio Revised Code Section 3999.21, "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."

72 Hour Cancellation Right: Any person obligated for any part of a pre-payment may cancel such agreement within 72 hours after he/she has signed an agreement or offered to enroll. Cancellation occurs when written notice of cancellation is given to The Health Plan. Notice of cancellation shall be considered given when the prospective subscriber mails a letter to The Health Plan.

UTILIZATION REVIEW.

The Health Plan has a utilization review process in place that is designed to review the medical appropriateness and location of proposed or received health care services. The review process consists of three areas: 1.) Prospective Review, a review conducted prior to an admission or course of treatment, 2.) Concurrent Review, a review 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.

Screening is first performed by registered nurses to evaluate whether the service and location of the service meet the Plan's criteria for medical appropriateness. For instances that do not meet review criteria, the nurses are required to involve physician reviewers. After careful review of available clinical information, the physician reviewer may authorize or not authorize the services based on medical necessity.

If you have any questions regarding utilization review, or the need for preauthorization of any service, please call The Health Plan at (740) 695-3585, 1-800-624-6961, TDD (740) 695-7919, 1-800-622-3925 or by e-mail: info@healthplan.org.

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.

PRIVACY OF PROTECTED HEALTH INFORMATION.

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

Any questions regarding protected health information, please contact the Plan by calling (740) 695-3585, 1-800-624-6961, TDD (740) 695-7919, 1-800-622-3925, email: info@healthplan.org.

Special Enrollment Periods under the Health Insurance Portability and Accountability Act (HIPAA)

HIPAA requires group health plans to offer two special 31-day enrollment periods for employees and dependents, who previously declined coverage to enroll, without waiting for the plan's next regular open enrollment.

1. **Loss of Group Coverage.** Plans must allow employees and dependents that lose other coverage to enroll if they have exhausted their COBRA coverage; they cease to be eligible for the other coverage or employer contributions for the other coverage cease, legal separation, divorce, death, termination of employment or reduction in hours.

The effective date of coverage will be the first of the following month upon Health Plan's receipt of the enrollment information.

2. **Change in Family Status.** Plans that offer dependent coverage must provide a special enrollment period when an employee gains dependents by reason of marriage, birth, adoption or placement for adoption.

The effective date of coverage will be the date of event.

In some instances, the enrollee will be required to provide The Health Plan with a "Certificate of Coverage".

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

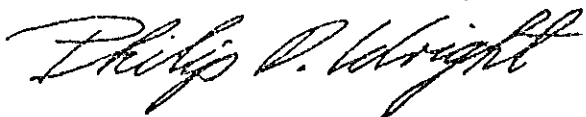
We generally require the designation of a primary care physician. You have the right to designate any primary care physician who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care physician.

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