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Owner	Alison Muklewicz: Director, Utilization Management
Area	Clinical Services - All
Lines Of Business	All Lines of Business

Levels of Care

Purpose:

To ensure well-managed patient care, including a system to assure referrals for Medically Necessary specialty, secondary, tertiary and out-of-network care. To define the levels of care related to plan documents, and to deliver the appropriate services to our members.

Policy:

Levels of care are divided into the categories of primary care, secondary care, tertiary care, and out-of-network care. Each level is related to the complexity of the medical cases being treated as well as the skills and specialties of the providers.

Procedure:

Established Network

The Health Plan contracts with providers and facilities (hospitals, surgery centers, rehabilitation hospitals etc.) to create an *in plan* network, so that our members may obtain quality care at an affordable price. All services that can be appropriately performed *in plan* must be obtained *in plan.* Services which are not available through this *in plan* network require prior authorization.

In Plan Care

Primary Care

The 'primary care' level includes the basic level of care between members and the The Health Plan Network. This includes, general practitioners, internal medicine practitioners, the family physician, nurse practitioners, or physician assistants. There are some primary care specialist as well, including OB-GYN's, geriatricians, and pediatricians. Primary care providers treat common diseases or injuries, basic curative care services, maternal and child health services, prevention of disease, provide immunizations and health education.

Members enrolled in our HMO and POS products are required to select a primary care physician (PCP), who act as the coordinator of care for the patient. Members per their plan design might have to contact their PCP prior to making appointments with participating secondary specialty providers.

Specialty Care/ Secondary Care

Secondary care specialist focus either on a specific system of the body or a specific disease or condition. When the members care cannot be delivered in the Primary Care setting the member will be referred to an in plan participating specialist to treat their condition. Examples: Endocrinologist, Oncologist, Nephrologist etc.

Tertiary Care

Tertiary care is defined as care of highly technical and specialized nature, provided in a medical center, usually one affiliated with a university, for patients with unusually severe, complex, or uncommon health problems. Examples of tertiary care include: transplants, perinatology, neonatology, trauma surgery, complex cancer cases. An in plan evaluation may be required prior to care being deemed appropriate at a higher level of care.

Tertiary care requires prior authorization. Prior authorization requests for tertiary care should be submitted from a participating in-network primary or secondary care provider following medical evaluation. Consideration of the member's medical needs and determination if their needs can be met with an in-network provider or facility is reviewed by a medical director. Tertiary care is approved only when services or providers required to meet a member's medical needs are not available within The Health Plan's local (primary or secondary care) network or if they cannot be safely provided in network due to complexity of care.

Out-of-Network Care

Out-of-network care is defined as care outside of The Health Plan's contracted network of in plan (primary, secondary or tertiary) providers and facilities. Out-of-network care requires prior authorization. Prior authorization requests for out-of-network care should be submitted from a participating in-network primary, secondary or tertiary care provider following medical evaluation. Consideration of the member's medical needs and determination if their needs can be met with an in-network provider or facility is reviewed by a medical director. Out-of-network care is approved only when services or providers required to meet a member's medical needs are not available within The Health Plan's network or cannot be

safely provided in network due to complexity of care.

WVCHIP Out-of-Network Care

The Health Plan must ensure that the cost to the enrollee is no greater than it would be if the services were furnished within the network.

Services must be covered as adequately and timely as if such services were provided within the network, and for as long as The Health Plan is unable to provide them.

To the extent possible, The Health Plan must encourage out-of-network providers to coordinate with them, with respect to payment.

For additional information on out-of-network single care agreements look to the Transition of Care.

All Revision Dates

7/29/2025, 4/26/2024, 11/3/2020, 8/21/2020, 3/14/2019

Approval Signatures

Step Description	Approver	Date
EMT	Mumtaz Ibrahim, MD: Chief Medical Officer	7/29/2025
MDOC	Robert Cross, MD: Medical Director	7/29/2025
	Heather Jones: VP Clinical Services	5/27/2025
	Alison Muklewicz: Director, Utilization Management	5/27/2025