MEMBERS' RIGHTS AND RESPONSIBILITIES STATEMENT

Statement of Members' Rights

Members have the right to receive information regarding The Health Plan's information such as a summary of our accreditation report and our 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 Network Provider (e.g., diplomas and board certifications). If a member needs assistance with any of the above, they may contact our Customer Services Department at 740.695.7902, 1.800.624.6961; TDD 740.695.7919 or 1.800.622.3925. Members can also contact us via our website at healthplan.org.

Members can expect to receive courteous and personal attention and to be treated with dignity. Health Plan employees, providers, and their staff will respect members' privacy.

All information concerning a Health Plan member's medical history and enrollment file is confidential. The member has a right to approve or refuse the release of personal information by The Health Plan except when the release is required by law. The Health Plan assures that all patient information is held in the strictest confidence. All Health Plan staff must adhere to The Health Plan's Confidentiality Policy adopted in November, 1996 and reviewed every three years unless warranted otherwise. This statement acknowledges the confidential nature of the review work, includes an agreement to honor that confidentiality, and documents the consequences of failing to do so.

The member's personal choice of a Primary Care Physician (PCP) enables the member to participate in the management of his/her total health care needs including the right to refuse care from a specific practitioner. Health Plan members are encouraged to establish a relationship with their chosen PCP so that they can work together to maintain good health. A Health Plan member may change physicians once per calendar month if so desired (depending upon the availability of the chosen physician).

Health Plan members have the right to express their comments, opinions or complaints about The Health Plan or the care provided and to file an appeal for an administrative or medical complaint and hearing procedures without the reprisal from The Health Plan. Members also have the right to have coverage denials reviewed by the appropriate medical professional consistent with our review procedures. Both informal and formal steps are available to Health Plan members to resolve all complaints/appeals.

Health Plan members may participate in decision-making about their health care when possible and within Health Plan guidelines. Members have the 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 Health Plan. Members also have the right to formulate Advance Directives.

Health Plan members have the right to have a meaningful voice in the organization by expressing their suggestions and comments regarding their Health Plan coverage, policies, Members' Rights and Responsibilities, and operations. Member's comments and opinions are received by The Health Plan through yearly member satisfaction surveys, phone calls from our members, and via our website at healthplan.org, under "Member Services". Comments and feedback can also be placed in our "Member's Suggestion Box" located in The Health Plan lobby. Member's comments and opinions are also received through various Health Plan Departments.

Members have the right to full disclosure, from their health care provider, of any information relating to

their medical conditions or treatment plan. Members have the right to examine and offer corrections to their own medical records, in accordance with applicable Federal and State law. The Health Plan will not release personal health information to an employer, or its designee, without a signed Health Plan Authorization Form by the member. For information on obtaining medical records, contact The Health Plan Customer Services Department at 740.695.7902, 1.888.847.7902; TDD 740.695.7919 or 1.800.622.3925.

Statement of Members' Responsibilities

Some members must choose a Primary Care Physician (PCP) for each person listed on The Health Plan I.D. card. The member has a responsibility to maintain a relationship with their PCP, as the PCP will act as the coordinator for all his/her health care needs.

A member must identify him/herself as a Health Plan member to avoid unnecessary errors; always carry their I.D. card; and never permit anyone else to use their I.D. card.

A member is asked, through "Outreach Calls" to new members, to read their Member Handbook and understand the benefits and procedures for receiving health care services. To assure maximum coverage, the member has a responsibility to follow the rules and to contact The Health Plan for assistance, if necessary.

A member is required to notify The Health Plan of any changes in the following:

- Names, address, phone number;
- Dependent information to include: marriage, divorce, newborn or other newly acquired dependents, ineligible dependents;
- Loss of I.D. card; and
- Selection of PCP.

Members are asked to be on time for appointments and to call the physician's office promptly if the appointment can't be kept.

Members must provide necessary information to the providers rendering care. Such information is necessary for the proper diagnosis and/or treatment of potential or existing conditions.

Understand your health problems and participate in developing mutually agreed upon treatment goals, to the highest degree possible, and follow those instructions and guidelines given by those providers who deliver health care services.

If members receive emergency care outside The Health Plan Network, they are required to contact The Health Plan within 48 hours or as soon as reasonably possible.

Members must contact their PCP, Secondary Care Physician (SCP,) or OB/GYN before seeking any specialty care services.

Members must provide The Health Plan with all relevant, correct information and pay The Health Plan any money owed according to Coordination of Benefits (COB) or Subrogation policies.

Members must make required deductible, copayments or coinsurance payments under the "Schedule of Benefits" in the Member Handbook.

Members are asked to be courteous and respectful of Health Plan employees, providers, and their staff.

PATIENT BILL OF RIGHTS

1. You have the right to a description of your rights and responsibilities, plan benefits, benefit limitations, premiums, and individual cost-sharing requirements.

2. You have the right to a description of The Health Plan's appeal and hearing procedures and the right to pursue appeal and hearing procedures without reprisal from The Health Plan.

3. You have the right to a description of the method in which you can obtain a list of The Health Plan provider network, including the names and credentials of all network providers, and the method by which you may choose providers within The Health Plan.

4. You have the right to choose an available participating Primary Care Physician (PCP) and with proper preauthorization, the right to a network specialist.

5. You have the right to privacy and confidentiality with regard to your personal information.

6. You have the right to full disclosure from your health care provider of any information relating to your medical condition or treatment plan and the ability to examine and offer corrections to your own medical records.

7. You have the right to be informed of Health Plan policies and any changes for which you will be responsible.

8. You have the right to a description of the procedures for obtaining out-of-network services.

9. You have the right to a description of the method by which you can obtain access to a summary of The Health Plan's accreditation report.

10. You have the right to have medical advice or options communicated to you without any limitations or restrictions being placed upon the provider or PCP by The Health Plan.

11. You have the right to have all coverage denials reviewed by appropriate medical professionals consistent with The Health Plan's review procedure.

12. You have the right to have coverage denials involving medical necessity or experimental treatments reviewed, after exhaustion of The Health Plan's internal appeal procedure, by appropriate medical professionals who are knowledgeable about the recommended or requested health care services, as part of an external review.

13. You have the right to emergency services without prior authorization if a prudent lay person acting reasonably would have believed that an emergency medical condition existed, and the right to a description of procedures to obtain emergency services.

14. A woman has the right to direct access, annually, to her OB/GYN for the purpose of a well woman examination without preauthorization from her PCP, and no woman shall be required to obtain preauthorization from her PCP as a condition to coverage of prenatal or obstetrical care.

15. A woman whose plan provides coverage for surgical services in an inpatient or outpatient setting has the right to reconstruction of the breast following mastectomy and reconstructive or cosmetic surgery required as a result of an injury caused by the act of person convicted of a crime involving family violence.

16. A woman whose plan provides coverage for laboratory or radiology services has a right to the following when performed for cancer screening or diagnostic purposes: 1) a baseline mammogram for women age 35 to 39, inclusive; 2) a mammogram for women age 40 to 49, inclusive, at least every two years; 3) a mammogram every year for women 50 and over; 4) a Pap smear at least annually for women age 18 and over.

17. A nonsymptomatic person over 50 years of age and a symptomatic person under 50 years of age have the right to colorectal cancer examinations and laboratory tests for colorectal cancer.

18. You have the right to rehabilitation services.

19. You have the right to child immunization services, which shall not be subject to payment of any deductible, copayment or coinsurance payment, per visit charge.

20. A diabetic whose health benefits policy includes eye care benefits, has the right to direct access of an optometrist or ophthalmologist of their choice from the network without preauthorization from their PCP for an annual diabetic retinal examination. When the diabetic retinal examination reveals the beginning stages of an abnormal condition, access of future examinations shall be subject to preauthorization from a PCP.