MEMBER HANDBOOK
I N D E X

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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 Health 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.

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

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 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.

THE HEALTH PLAN MISSION STATEMENT

"In its mission to provide a comprehensive delivery of healthcare services, the 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 Plan and its provider network."

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.

- **AFFILIATION PERIOD** means a period (not to exceed 90 days) which must expire before the health care coverage becomes effective.

- **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 List.

- **ALTERNATIVE HEALTH BENEFITS PLAN** means the health benefits plan(s) that the Group sets as an option(s) to the plan set forth in this Agreement.

- **APPROPRIATE PRIOR ARRANGEMENTS** means those special billing and eligibility arrangements, if any, agreed to by the Group (i.e., employer) and the Plan. These affect enrollment eligibility and effective dates of coverage (i.e., probationary periods, etc.)

- **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 and 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).

- **CONTRIBUTORY COVERAGE** means coverage for which the Group may set up required contributions to be made by the subscriber.

- **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. Copays 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. The total copays shall not exceed 200% of the average annual premium rate. This does not include copays for supplemental care services (i.e., prescriptions). Once the maximum amount is met, the Plan waives any additional copays for the remainder of the contract year.

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

- **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 layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following.

  • Serious jeopardy to the health of the individual (or an unborn child). • Serious impairment to bodily functions. • Serious dysfunction of any bodily organ or part.

- **ENROLLMENT AREA** means the geographical area encompassing the following counties.

  Ohio:

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

  West Virginia:

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

  The Ohio Department of Insurance and/or the West Virginia Insurance Commissioner may approve additional counties from time to time. Enrollment Area may also include any county that borders the approved counties, provided that the subscriber residing in a border county is employed in the Service Area.

- **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 coverage ended no more than 63 days before the date of application to the Health Plan. The person's most recent prior creditable coverage must also have been under a group health plan, governmental plan or church plan. This coverage must not have been terminated due to non-payment of premium or fraud. Also, if continuation coverage was offered, the person must have

elected and exhausted the continuation coverage. This person 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.

- **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.

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

  True emergency care does not require preauthorization.

- **LIFETIME BENEFITS MAXIMUM** is the maximum amount the Plan will pay for covered services per member. When such amount has been met, benefits will no longer be payable. This amount cannot transfer from one different employer to another but will carry over from one division of an employer to another or product line within the same employer.

  This is not applicable to any *basic* health care service under the jurisdiction of the Ohio Department of Insurance.

- **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 with a Plan member will be provided *one time only per a member's lifetime*.

  This is not applicable to any *basic* health care service under the jurisdiction of the Ohio Department of Insurance.

- **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.

- **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.

- **PLAN PHYSICIAN** means any duly licensed doctor of medicine, osteopathy or podiatry who contracts (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 List) 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.

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

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

  West Virginia:

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

- **SPECIAL ENROLLMENT PERIOD** (see Eligibility) means an enrollment period outside of the group's annual open enrollment period.

- **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.

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

IV. PLAN I.D. CARD.
Below is an ***example*** of the Plan member I.D. card.

ID: xxxxxxxxx **(1)** Eff : xx/xx/xx-xx/xx/xx **(9)** 01 xxx xxxx x **(2)** x **(10)** xx/xx/xx **(11**) 02 xxx xxxx x **(3)** 03 xxx xxxxx x PCP: $xx **(4)** SCP: $xx **(5)** ER: $xx **(6**) UC: $xx **(7)** DED: $xxx/$xxx **(8)**	**(12)** RxBin: 610014 Rx GROUP: 3602 Pharmacy Benefit ID xxxxxxxxx Name: 01 xxx xxxx x 02 xxx x 03 xxx x

(1) Identification number.
(2) Subscriber's name.
(3) Dependent's name(s).
(4) Primary Care Physician (PCP) office visit copay.
(5) Specialty Care Physician (SCP) office visit copay.
(6) Emergency room copay.
(7) Urgent care copay.
(8) Deductible amounts (individual/family).
(9) Effective & exit date of Group contract.
(10) Sex.
(11) Birth date.
(12) Pharmacy prescription information.

For all necessary emergency care outside the Plan Service Area, refer to the reverse side of your I.D. card. The Plan phone number and address are listed there.

BACK OF I.D. CARD.

NOTICE TO MEMBERS.

Please carry this card with you at all times. Present your card each time you receive benefits from a Plan contracted physician, pharmacy or other contracted health care provider. Except in defined emergencies, a Plan physician must arrange hospitalization and covered services must be obtained through a Plan provider. This card is the property of the Plan, 52160 National Rd. East, St. Clairsville, OH 43950 and is issued for identification purposes only. Authorized use of this card acknowledges receipt by the member of the Plan Member Handbook; agreement to all terms and conditions thereof.

IN CASE OF EMERGENCY.

Hospital/Medical Services, see Emergency/Urgent Care.

Mental Health/Substance Abuse Assistance call (877) 221-9295.

Prescription Services (*for members with prescription coverage*). Non-formulary prescriptions are prescriptions not on thru Plan's approved list of medications. All non-formulary prescriptions must be converted to a formulary prescription unless medical necessity is proven for the use of the non-formulary prescription. The following is the procedure for possible authorization of non-formulary prescriptions after normal business hours.

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 conditions 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 the Plan's 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 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 I.D. 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 I.D. 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.
   - Name, address, phone number.
   - Number of dependents (marriage, divorce, newborn, etc.).
   - Loss of I.D. 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.

Any questions regarding protected health information, please contact the Plan by calling:
St. Clairsville/Morgantown areas: (740) 695-3585, (800) 624-6961, TDD (740) 695-7919, (800) 622-3925, email: info@healthplan.org. Massillon area: (330) 837-6880, (800) 426-9013, TDD (877) 236-2291 or email: info@healthplan.org.

VI. OBTAINING SERVICES.

A. Selecting a Primary Care Physician ("PCP").

Plan members must select a Primary Care Physician ("PCP") from The Health Plan Provider List. 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 process 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 from 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 List.

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 List.

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 and/or deductibles. This is providing that the member has acted in accordance with this Agreement.

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 visits, 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.

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

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 (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.

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 "Tertiary Providers" in the Provider List 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 layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following.

- Serious jeopardy to the health of the individual (or an unborn child). - Serious impairment to bodily functions. - Serious dysfunction of any bodily organ or part.

Examples of an emergency are as follows.

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

Emergency room visits are subject to review and non-emergent services will **not** be paid by the Plan. *True emergency services* are covered without regard to preauthorization.

See the Provider List 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 I.D. 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 our Customer Service 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.

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

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.
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 List 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 (unless otherwise provided in the Group Agreement).

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.

The Plan requires all non-active employees and/or their eligible dependents (i.e., retirees or individuals receiving disability benefits), or any member for whom Medicare would be primary, to elect and enroll in Medicare A and/or B when eligible to do so. Failure of said member to do so will result in a change of premium to the Group/subscriber.

A. Subscriber/Employee.

To enroll as a subscriber, a person must live in the Enrollment Area and a full-time employee of the Group. The person must also be entitled to participate in the hospital and medical benefits arranged by the Group or entitled to coverage under the Consolidated Omnibus Budget Reconciliation Act ("COBRA").

Each year before the Group contract anniversary date, the Plan is required to hold an open enrollment period. Eligible persons may enroll at this time. Only newly hired employees are eligible to enroll after the annual enrollment period during the contract year. New employees may enroll in the month they become eligible. The Plan must receive a properly completed enrollment form on or before such date.

B. Dependents.

An eligible dependent must be included on a subscriber's coverage at the initial Group enrollment or at the annual open enrollment period. ***Newly*** acquired dependents may enroll during the Group's contract year. Adding a newly acquired dependent requires a new enrollment form. The Plan must receive the enrollment form (submitted through the employer) within 31 days of the date of event. If not, this dependent may be required to wait until the annual open enrollment period.

Dependents may include the following.

- Spouse. Your legally married spouse may be included on your coverage. To enroll as a dependent spouse, the person must live in the Enrollment Area. 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 (legally separated/separate maintenance spouse if required by Group) 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 children 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") is in effect. 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.

  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 (or Legal Separation/Separate Maintenance if required by employer). 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.

H. Death of Subscriber. Dependents should contact the employer's personnel office 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 Group Contract shall become eligible on such date.
2. Any person who meets the eligibility requirements after the effective date of the Group 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 through the employer 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.

J. Effective Dates of Coverage. Subscribers enroll during the initial open enrollment period by completing a Plan enrollment form. Upon receipt by the Plan of a properly completed enrollment form, and subject to the Group's payment of the monthly premium, coverage for eligible subscribers/dependents will begin on the earlier of the following dates.

1. On the effective date of the Group Contract.
2. On one's eligibility date when a person submits an enrollment form for membership on or before such date.
3. On the first day of the month following his/her eligibility date.
4. On the first day of the month following the end date of the open enrollment period. The subscriber must have submitted an enrollment form during the open enrollment period.
5. If an employee/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.

6. 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.**
7. When a court or administrative order is in affect regarding dependent children, coverage will become effective on the date of the court/administrative order.

K. 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 date.

1. Loss of Group Coverage.

Plans must allow employees and dependents that lose other coverage to enroll if any of the following applies.

1. They have exhausted Cobra coverage.
2. They cease to be eligible for the other coverage.
3. Employer contributions for the other coverage cease.
4. Legal separation/separate maintenance.
5. Divorce.
6. Death.
7. Termination of employment.
8. Reduction in hours.

The effective date of coverage will be the first of the following month upon the 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 any of the following.

1. Marriage.
2. Birth.
3. Adoption.
4. Placement for adoption.

The effective date of coverage will be the date of event upon the Plan's receipt of the enrollment information.

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

L. Plan Administrator. Your employer is the plan administrator under this Agreement. The plan administrator is solely responsible for administering this Agreement for the Group Plan members. This would include (but not be limited to) applying the eligibility requirements and complying with any federal, state, local law or regulation which may apply to the Group under this Agreement.

The Plan is the Administrator for claims determination only.

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

VERIFICATION OF ELIGIBILITY OR BENEFITS IS NOT A GUARANTEE THAT SERVICES ARE PAYABLE.

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 (unless otherwise provided in the Group Agreement).

Member.

Coverage under the Agreement 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.
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 I.D. 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. Should the subscriber/member not respond in the time frame given, will be cause for termination. Members may be eligible for continuation of coverage in some cases.)

Group.

Coverage under the Agreement for a Group and their affected members will terminate immediately, with written notice (unless otherwise stated), for any of the following.

1. If the Group fails to pay premiums or contributions in accordance with the terms of the coverage or fails to pay premiums in a timely manner.
2. If the Group terminates the Group Medical and Hospital Service Agreement with proper notification.
3. If the Group performs an act or practice that constitutes fraud or makes intentional misrepresentations of material facts under the terms of the coverage.
4. If the Group fails to comply with material plan provisions relating to employer contribution or group participation rules.
5. If Plan ceases to do business in the employer market with required-proper notification (not less than 90 days) to all applicable parties.
6. If the Group no longer has eligible enrollees in the Enrollment Area.

Members who are confined to a hospital on the day their health coverage is to end shall not have coverage end until the *earliest* occurrence of any of the following.

1. The member's discharge from the hospital.
2. Determination by the member's attending physician that inpatient care is no longer medically indicated.
3. The member's reaching the limit for contractual benefits.
4. The member's other coverage becomes effective.

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

All benefits will cease at 11:59 p.m. on the effective date of termination, unless specified differently by the employer group and agreed to by the Plan. 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 (or Group) 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 or Group 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. The member should also notify their employer of this action.

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 Group Coverage upon Termination of Employment.

Divisions (A) and (B) of section 1751.53 of the Ohio Revised Code, allows eligible employees to continue their group coverage for themselves and any eligible dependents for six months after the date the group coverage would otherwise end.

Eligible employee means the following.

- The employee had continuous coverage during the entire three-month period preceding the employee's termination.
- The terminated employee is entitled to Unemployment Compensation.
- The terminated employee is not entitled to or become entitled to Medicare.
- The terminated employee is not, and does not become covered or eligible for group coverage under which the employee was not immediately covered prior to termination. A person eligible for continuation of coverage under division (A) of section 1751.53 and eligible for coverage under section 3923.123 of the Ohio Revised Code may elect either coverage, but not both.

It is the Ohio *employer's* responsibility to notify the employee of the right of continuation under this section.

Pursuant to section 33-16-3.(e) of the West Virginia Insurance Laws, all members in groups or classes eligible for insurance provided through an employee's group plan shall be permitted to pay the premiums at the same group rate and receive the same coverages for a period not to exceed 18 months. This is providing they are involuntarily laid off from work.

It is the West Virginia *employer's* responsibility to notify the employee of the right of continuation under this section.

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") applies only to employers with 20 or more employees. The employer is responsible for determining whether the employee is subject to COBRA; however in consent with the COBRA Law.

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

3. Under COBRA.

Subscriber/Employee. If you lose your health coverage due to a reduction in hours worked or the termination of your employment you and/or your dependents may be able to continue your coverage that was in effect at the time of the Qualifying Event. Your coverage may be continued for a period of 18 months from the date of the Qualifying Event.

This 18-month COBRA period may be extended to 29 months if any for Qualified Beneficiary (subscriber, spouse or dependent child) is deemed by the Social Security Administration (under Title XI or Title XVII) to have been disabled before the end of the first 60 days of COBRA continuation coverage. The employer must be informed of the Social Security Disability Determination before the expirations of the 18 months and within 60 days of the date the disabled Qualified Beneficiary receives it. If a subscriber's employment is terminated and one or more Qualified Beneficiaries is determined to be permanently disabled under Title II or XVI of the Social Security Act, coverage may be continued for the subscriber and/or dependents for a maximum period of 29 months. See your employer for more specific details.

Legal Spouse of Employee. If you are the covered spouse of an employee you have the right to continue your coverage for a period of 18 months from the date of the Qualifying Event if you lose your group health coverage for either of the following.

a) The termination of your spouse's employment.
b) A reduction in your spouse's hours of employment.

Coverage may be continued for a period of 36 months from the date of the first Qualifying Event if your

group health coverage ends for the following reasons or if one of the following occurs in the first 18-month period after termination of the employee's employment or reduction in hours.

a) The death of the employee.
b) The employee's Medicare entitlement.
c) A divorce or legal separation/separate maintenance.
d) The loss of eligibility as a dependent child.

Dependent Child of Employee or Employee's Spouse. If you are a covered, or newly acquired, dependent child of an employee or of the employee's spouse you have the right to continue coverage for a period of 18 months from the date of the Qualifying Event if your group health coverage ends for the following.

a) The termination of the parent's employment.
b) A reduction of the parent's hours of employment.

Coverage may continue for a period of 36 months from the date of the first Qualifying Event for the following or if one of the following occurs in the first 18-month period after termination of the employee's employment or reduction in hours.

a) The death of the employee/subscriber.
b) The divorce or legal separation/separate maintenance of parents.
c) The employee's Medicare entitlement.
d) The loss of your eligibility as a dependent child.

If an employee becomes entitled to Medicare benefits while still actively employed an then terminates or reduces his/her hours of employment within 18 months after becoming entitled to Medicare, coverage may continue for the employee's spouse and dependent child(ren) for a period of up to 36 months from the employee's Medicare entitlement date.

Employee/Employer Responsibility.

The employee or a family member has the responsibility to inform the employer or employer's health benefits administrator of a divorce, legal separation/separate maintenance, a child losing dependent eligibility status, Medicare entitlement or Social Security Disability Determination. The employer has the responsibility to notify the plan administrator (i.e., employer or other entity) of the employee's death, termination of employment, reduction in hours, Medicare entitlement, Social Security Disability Determination, divorce, legal separation/separate maintenance or a child losing dependent eligibility status.

When your plan administrator learns that one of these events has happened, he/she must let you know in writing that you have the right to continue your coverage.

You and/or your dependents will have 60 days to elect COBRA coverage. The election period is limited to 60 days from the following:

a) The date of notice
b) or loss of coverage date.

COBRA coverage must be effective on the day immediately following the date of the Qualifying Event. There can be no break in coverage.

If you and/or your dependents choose to continue coverage, your employer must give you coverage similar to that of similarly situated active employees.

You will be responsible for paying the cost of the coverage you receive. Also, there may be an additional administrative charge.

Your continuation of COBRA coverage may be cut short for any of the following.

- Your employer no longer provides group health coverage for any of its employees.
- You do not pay the required monthly payment for your coverage within the month due.
- You become an employee of another employer and are covered by the employer's group health plan.
- You become entitled to Medicare after you have elected COBRA continuation coverage.
- You divorce a covered employee, later remarry and your new spouse covers you under his/her group health plan.
- You no longer live within the Plan's Enrollment Area. The Plan will provide emergency care (only) out of the Service Area for no longer than three months. Coverage will be canceled on the last day of the third month.

At the end of the 18, 29 or 36 months of COBRA coverage, you may be eligible to enroll in one of the Plan's Conversion Direct Pay Plans

The Plan's obligation to provide continued COBRA coverage or other similar law ceases upon termination of this Agreement for any reason. It is the employer's responsibility to provide for continuation of coverage for employees whose rights under COBRA or any similar law, are beyond the termination of this Agreement.

The Plan's policy is: Although COBRA eligibles have independent election rights; it does not imply they have individual enrollment rights (i.e., if enrollment through the employer group is family coverage and electing COBRA as family, the COBRA enrollment will be family with the applicable premium charged).

Note: It is the responsibility of your employer to formulate and generate proper Qualifying Event notifications as recommended by the Department of Labor.

The Plan maintains the right to deny a COBRA Beneficiary's enrollment if the COBRA guidelines have not been properly followed by the employer, COBRA Administrator or Beneficiary as prescribed by the Department of Labor.

If the employer fails to notify the Plan of a COBRA Qualifying Event or fails to issue proper and timely notices to member as required by law, the employer agrees to indemnify and hold harmless the Plan against any and all claims, penalties, expenses or overpayments incurred by the Plan and resulting from the employer's failure to provide such notices.

If you have any questions about your COBRA rights as described herein, contact your company benefits administrator.

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

4. The Plan's Non-Group/Direct Pay Conversion Plans.

Section 1751.16 of the Ohio Revised Code allows for conversion if a member ceases to be eligible under group 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 non-group direct pay conversion rights. This mailing will include monthly premium amounts and schedule of benefits. The member may convert, 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 convert his/her membership according to such rules and regulations governing the Conversion/Direct-Pay 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 conversion shall apply.

If a member is eligible for other employer sponsored health care coverage; such member may not be eligible for a Direct Pay Conversion Plan.

The Direct Pay Conversion Plan may not provide the same copay plan you had through your employer group coverage.

5. Continuation of Coverage During Military Service.

The Uniformed Services Employment and Reemployment Rights Act ("USERRA") protects the rights of anyone absent from work due to uniformed services. The USERRA applies to all group health benefit plans.

Special rules apply to health benefits under the USERRA. First, employees (subscriber) must be given COBRA like rights under the USERRA with respect to health care benefits. This means the subscriber and eligible dependents can elect up to 24 months worth of coverage under the employer's health plan if, their coverage was in effect at the subscriber left employment for active duty.

An eligible dependent may extend the 24-month period of continuation of coverage to a 36-month period of continuation if any of the following occurs during the 24-month period.

a) The death of the subscriber.
b) The divorce or legal separation/separate maintenance of the subscriber and spouse.
c) The cessation of dependency of a child pursuant to the terms of the contract.

An eligible person must file a written election of continuation of coverage with their employer and pay the applicable premium. The employer must notify the subscriber of the right to continue coverage under USERRA. The subscriber's written election of coverage must be received by the employer no later than 60 days after the later of the date of the notice or the date coverage would otherwise terminate.

The subscriber's/member's right to continuation of coverage on extension ceases on the date on which any of the following occur.

a) The subscriber/member becomes covered by another group health plan that does not contain any exclusion or limitation of any preexisting condition of that eligible member. This does not include the Civilian Health and Medical Program of the Uniformed Services ("CHAMPUS").
b) The 24-month or applicable 36-month period of coverage is exhausted.
c) The subscriber fails to make timely payment of monthly premiums. Coverage ends on last day for which premiums were paid.

d) The subscriber is discharged from active duty but fails to apply for reemployment within the period required to preserve his/her rights under USERRA in which case coverage will end the later of 18 months after the subscriber left employment or the last day the subscriber could have applied for reemployment under USERRA.
e) The group contract is terminated and is replaced by similar coverage under another group health plan or arrangement.

Whether or not the subscriber and/or dependents elect to continue coverage during leave for duty in the uniformed services, if the subscriber returns to work for the employer upon release from active duty, the subscriber and all eligible dependents are entitled to reenroll in the Group's coverage without waiting periods or exclusions.

6. Health Insurance Portability and Accountability Act ("HIPAA").

Pursuant to section 1751.16 (B) (1) (b) of the Ohio Revised Code, and in conjunction with Federal HIPAA requirements, the Plan has available to certain "Federally Eligible Individuals" the Basic or Standard Portability Plan. The Plan does not impose any preexisting condition exclusions to those that are eligible. See "Federally Eligible Individual" in the Definition section and "Special Enrollment Periods under HIPAA" in the Eligibility section. If you meet the eligibility requirements and submit an application to the Plan within 63 days of your loss of coverage, you may enroll in the Plan's Basic or Standard Portability Plan. Benefits under the Basic or Standard Portability Plan may vary from your current group benefits.

The Plan will provide to terminated members (or by request) a "Certificate of Creditable Coverage". See "Creditable Coverage" in the Definitions section**.**

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.

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

Reviews 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.

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

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 a**l**lowable 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

(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 be 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 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 the Plan's Funds Recovery Department St. Clairsville/Morgantown areas: (740) 695-3585, (800) 624-6961, Massillon area: (330) 837-6880 or (800) 426-9013.

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. MEDICARE AND EMPLOYER GROUP HEALTH PLANS ("EGHP").

If an *active employee* and/or dependent(s) are covered by both the Plan (through their employer) and Medicare, the Plan is generally primary and Medicare secondary in the following situations.

Working Aged.

When *all* of the following criteria are met, Medicare will pay as secondary.

- The beneficiary is age 65 or older.
- The beneficiary is entitled to Part A (hospital insurance) of Medicare.
- The beneficiary is **either**:
  - actively employed and covered by an EGHP with 20 or more employees or
  - the spouse of an active employed person and is covered by EGHP with 20 or more employees regardless of the employee's age.

Employers with 20 or more employees must offer their employees and employees' spouses of any age the same coverage they offer to employees under age 65, which is, coverage that is primary to Medicare.

Employer groups, with less than 20 employees that have actively-employed Medicare beneficiaries or dependents with Medicare entitlement, are mandated by the Plan to enroll these individuals in one of our Medicare options. For more information on our Medicare options, please contact your Plan Marketing Representative St. Clairsville/Morgantown areas: (740) 695-3585, (800) 624-6961, Massillon area: (330) 837-6880 or (800) 426-9013.

End Stage Renal Disease ("ESRD").

When the following criteria are met, Medicare will pay as secondary **for a period of up to 30 months**.

- The beneficiary is entitled to Medicare solely due to ESRD and
- the beneficiary is covered by an EGHP of any size.

This provision applies to all beneficiaries entitled to Medicare due to ESRD and covered by an EGHP through their employer or their spouse's, child's or parent's employer. There is no minimum size for the EGHP under the ESRD.

Disability.

When *all* of the following criteria are met, Medicare will pay secondary.

- The beneficiary is under age 65.
- The beneficiary is entitled to Medicare due solely to a disability other than ESRD.
- The beneficiary is covered by a Large Group Health Plan ("LGHP") with 100 or more employees and is an active employee or a dependent of an active employer.

Medicare will pay primary benefits when the employee is not an active employee (i.e., the employee is receiving disability benefits from the employer).

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

Should a Medicare entitled individual decline the EGHP:

A. the employer plan cannot offer to pay for Medicare covered services, but
B. can offer coverage for health care services that are not covered by Medicare such as hearing aids or routine dental care.

NOTE: IF A MEDICARE ENTITLED INDIVIDUAL DECLINES COVERAGE UNDER THE EGHP, NOTICE MUST BE GIVEN TO MEDICARE.

Medicare uses IRS and Social Security information to learn whether Medicare beneficiaries or their spouses are working. Medicare will use this information to determine whether the EGHP is primary to Medicare and will contact the employer to confirm such information. Medicare will request reimbursement from the employer for any services they paid primary in error.

The employer is responsible for assuring that all members in the Group are enrolled properly in accordance with the Medicare rules for employer group health plans. If the employer or any subscriber or member of the Group fails to comply with such requirements, the employer shall reimburse, indemnify and hold harmless the Plan against any and all claims, penalties or expenses incurred by the Plan as a result of such failure.

XVI. GRIEVANCE PROCEDURE/APPEAL 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, (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) 236-2291, fax (330) 830-5634, email: info@healthplan.org or write to or in person at Plan Grievance Coordinator, 100 Lillian Gish Blvd., P.O. Box 4816 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.

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 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.

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).

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

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, cancellations or non-renewal 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
2100 Stella Court
Columbus, OH 43215-1067
(800) 686-1526 or (614) 644-2673

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

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.

4. 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.

XVII. 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.

XVIII. BENEFIT OR RULE CHANGES.

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