The HealthPlan
HEALTHPLAN.ORG

The right plan for YOU

BARNESVILLE
EXEMPTED
VILLAGE SCHOOLS

Customer Manual

The Health Plan 1110
Main Street
Wheeling, WV 26003
888.816.3096
800.624.6961
www.healthplan.org

Thank you for joining The Health Plan!

This packet contains samples of important documents that you will be receiving from The Health Plan regarding your Plan administration.

- Summary of Benefits and Coverage (SBC)
  Provided to you at the beginning of your plan year to make available to your employees.
- ID Card
  A sample of the ID card that members will receive to present to providers for service.
- Benefits at your Fingertips with Our Member Portal
  Instructions for members on how to create a login for the member portal where they can see claims, EOBs, etc.
- Employer Portal
  Instructions for the employer group on how to create a login.
- Financial Information
  A summary of the administrative monthly billing and funding.

Summary of Benefits and Coverage (SBC)

The right plan for you

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 888.816.3096. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1.888.816.3096 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$3,000 Single/$6,000 Family**	If you have other family members on the **plan**, each family member must meet their own individual deductible until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible**
Are there services covered before you meet your deductible?	Yes. Preventive care services, office visits, urgent and emergency care and prescriptions.	This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But a **copayment** or **coinsurance** may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	**$6,850 Single/$13,700 Family**	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own **out-of-pocket** limits until the overall family **out-of-pocket** limit has been met.
What is not included in the out-of-pocket limit?	Premiums, health care this plan doesn't cover and supplemental riders	Even though you pay these expenses, they don't count toward the **out-of-pocket** limit.
Will you pay less if you use a network provider?	Yes. Call 1-888-816-3096 or see www.healthplan.org.	This **plan** uses a **provider network**. You will pay less if you use a **provider** in the plan's **network**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the **provider's** charge and what your **plan** pays (**balance-billing**). Be aware your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services.
Do you need a referral to see a specialist?	Yes	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have a referral before you see the **specialist**.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay per visit	Not covered	Deductible waived
	Specialist visit	$15 copay per visit	Not covered	Deductible waived
	Preventive care/screening/ immunization	No charge	Not covered	Deductible waived. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Preauthorization required
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.healthplan.org	Generic drugs	$10 copay retail or $20 copay home delivery	Not covered	Deductible waived. Covers up to a 34-day supply retail, 90-day supply home delivery
	Preferred brand drugs	$20 copay retail or $40 copay home delivery	Not covered	Deductible waived, Covers up to 34-day supply retail, 90-day supply home delivery. Member responsible for cost difference between generic and non-preferred brand.
	Non-preferred brand drugs	$50 copay retail or $100 copay home delivery	Not covered	Deductible waived, Covers up to 34-day supply retail, 90-day supply home delivery. Member responsible for cost difference between generic and non-preferred brand.
	Specialty drugs	30% or $300 whichever is less	Not covered	Deductible waived. Covers up to 31-day supply retail or home delivery. Preauthorization required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Preauthorization is required
	Physician/surgeon fees	No charge	Not covered	Preauthorization I required
If you need immediate medical attention	Emergency room care	$150 copay per visit	Not covered	Copay is waived if admitted
	Emergency medical transportation	$25 copay per incident	$25 copay per incident	Non-emergency transport preauthorization required
	Urgent care	$35 copay per visit	Not covered	Deductible waived. Copay waived if admitted.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Preauthorization required unless emergent admission

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	No charge	Not covered	Preauthorization required unless emergent admission
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay per visit	Not covered	Deductible waived office visit only, other care may include tests and services described elsewhere in the SBC (i.e. diagnostic testing)
	Inpatient services	No charge	Not covered	Preauthorization required unless emergent admission
If you are pregnant	Office visits	$15 copay initial visit only	Not covered	Deductible waived office visit only, maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound or preventive services)
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	No charge	Not covered	None
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Preauthorization required. Limited to 100 visits per Benefit Year
	Rehabilitation services	$0 copay	Not covered	Preauthorization required.
	Habilitation services	$15 copay after deductible per visit for visits 1-20; Visits 21+ 50% after deductible..	Not covered	Preauthorization required
	Skilled nursing care	$25 copay after deductible	Not covered	Limited to 90 days per Benefit Year. Preauthorization required.
	Durable medical equipment	No charge	Not covered	Limited to Plans basic allowance. Preauthorization is required for equipment greater than $500.
	Hospice services	No charge	Not covered	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None, unless supplemental rider is purchased
	Children's glasses	Not covered	Not covered	None, unless supplemental rider is purchased
	Children's dental check-up	Not covered	Not covered	None, unless supplemental rider is purchased

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Private duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor's Employee Benefits Security Administration at 1.866.444.EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services at 1.877.267.2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: The Health Plan Appeals Coordinator at 1.888.816.3096 or the Department of Labor's Employee Benefits Security Administration at 1.866.444.EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1.855.577.7123.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1.855.577.7123.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1.855.577.7123.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1.855.577.7123.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at www.healthplan.org

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$3,000
Specialist *[cost sharing]*	$15
Hospital (facility) *[cost sharing]*	$0
Other *[cost sharing]*	$0

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$40
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$3,050**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3,000
Specialist *[cost sharing]*	$15
Hospital (facility) *[cost sharing]*	$0
Other *[cost sharing]*	$0

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$480
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,480**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$3,000
Specialist *[cost sharing]*	$15
Hospital (facility) *[cost sharing]*	$0
Other *[cost sharing]*	$0

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

The plan would be responsible for the other costs of these EXAMPLE covered services.

ID Card

The right plan for you

Self-Funded

The HealthPlan

MEMBER

Group #: 0180957201

SAMPLE, JOE

ID: H18000000

EFF: 07/01/2019

COVERED INDIVIDUALS

01 SAMPLE, JOE

www.healthplan.org

The HealthPlan

1217-TH 2FB9 SF:THP.FH.NOLOG-0180954501--THPRX-- M(TheHPWhite)D()V()

20190611T01 Sh: 0 Bin 2
J160 Env [1] CSets 1 of 1

Self-Funded

The HealthPlan

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Group #: 0180957201

SAMPLE, JOE

ID: H18000000

EFF: 07/01/2019

COVERED INDIVIDUALS

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www.healthplan.org

The HealthPlan

PROOF
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1217-TH 2FB9 SF:THP.FH.NOLOG-0180954501--THPRX-- M(TheHPWhite)D()V()

20190611T01 Sh: 0 Bin 2
J160 Env [1] CSets 1 of 1

20190611T01 Sh: 0 Bin 2
J160 Env [1] CSets 1 of 1

1217-TH 3154 SF:THP.FH.NOLOG-0180954501--THPRX-- M(TheHPWhite)D(0V0)

CLAIM SUBMISSION

Providers: 1.888.816.3096
Claims: The Health Plan
1110 Main Street
Wheeling, WV 26003 **EDI:** 95677

RxBIN: 610014
PCN:
Grp: 3602
Issuer: 9151014609 (80840)

Members:
1.800.624.6961, ext 7914 (TTY: 711)
Visit healthplan.org
Pharmacists Only:
1.800.922.1557, 24/7

MEMBERS

Member Services: 1.888.816.3096 (TTY: 711)
Mental Health/Substance Abuse Assistance:
1.877.221.9295

Please visit us at healthplan.org.

This card does not guarantee coverage. Visit our website to verify benefits or view claims. Call for notification or pre-authorization.

To locate a First Health provider when using out-of-network benefits:
www.myfirsthealth.com | 1.800.226.5116

For Providers Outside Primary Network

First Health
www.myfirsthealth.com

Fraud Hotline: 1.877.296.7283

20190611T01 Sh: 0 Bin 2
J160 Env [1] CSets 1 of 1

1217-TH 3154 SF:THP.FH.NOLOG-0180954501--THPRX-- M(TheHPWhite)D(0V0)

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Fraud Hotline: 1.877.296.7283

PROOF
ACTIVE - Run date: 6/11/19 3:41 PM

TheHealthPlan

we are your health care concierge

We are committed to providing you superior service in a way that is convenient for you. Access information you need 24/7. Easily manage your personal information through our member portal at **myplan.healthplan.org**. Create an account and securely access plan information.

- View and print your member ID card
- Check eligibility of you and your dependents
- View EOBS electronically*
- Check claim status
- Access and utilize personalized wellness tools
- View benefit documents*

Stay up-to-date with news and the latest information by liking us on **facebook.com/thehealthplan**.

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* If you prefer a paper copy, call Customer Service at **1.800.624.6961** or visit Communications Preferences under "My Account" tab and select paper option. Please refer to **healthplan.org** for information regarding member rights and responsibilities and to view the latest newsletters.

rev. 10/2018

Benefits at your Fingertips!

Access your plan information 24/7 by visiting The Health Plan's secure member website. Start by visiting myplan.healthplan.org and creating a new account. Once you log in, you can view EOBs, check claim statuses, view benefit documents, find a provider, access wellness tools and more! If you prefer paper copies of EOBs or benefit documents, you can change your communication preferences online or by calling us at 1.800.624.6961.

The right plan for you

The HealthPlan

Member Portal QuickStart Guide

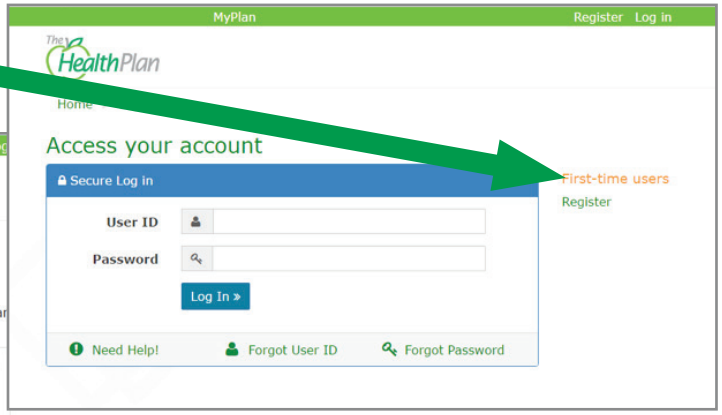
The Health Plan's member portal is convenient and easy to use.

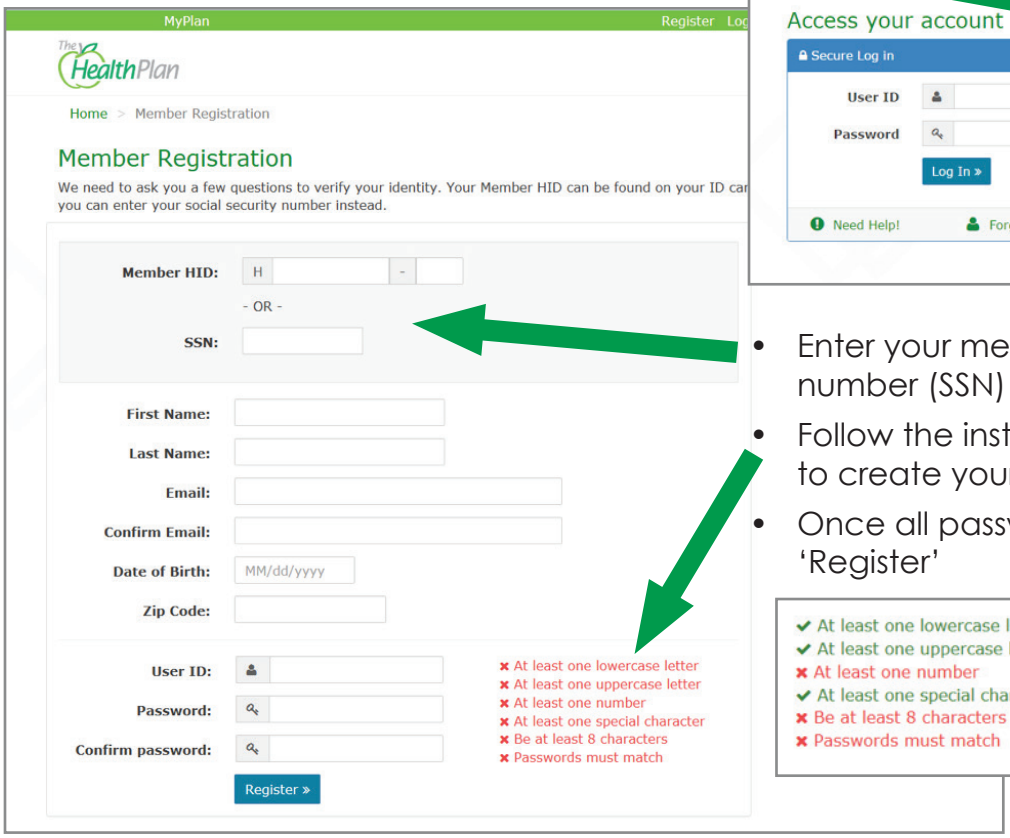
- Search for an EOB
- View current enrollment status, coverage type, and coverage start date
- Access deductible amounts and copays

HOW DO I GET ACCESS TO THIS PORTAL?

Select Member Sign In from **healthplan.org** or log on to **myplan.healthplan.org**

- **First-time users:** Click 'Register'





- Enter your member HID or social security number (SSN) to verify your identity
- Follow the instructions onscreen on how to create your password
- Once all password rules turn green, click 'Register'

Member Portal QuickStart Guide

NOW WHAT?

- You will receive a 'Thank You' screen with instructions on verifying your email
- Check your email for a noreply@healthplan.org message and follow directions on how to verify your email

CONGRATULATIONS!

- You can login and view your claims, coverage and benefit information

NEED HELP?

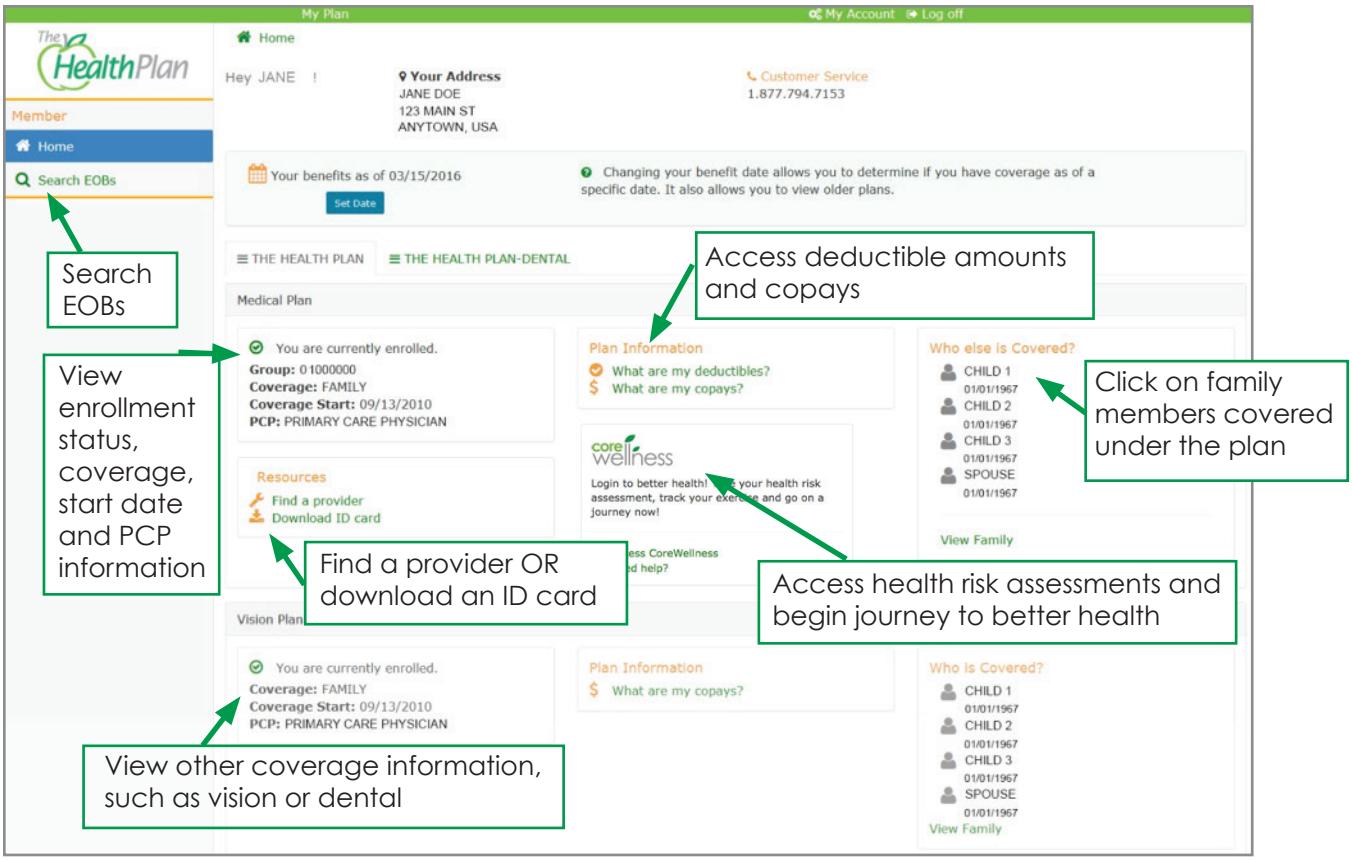
- After clicking 'Need Help,' click on one of the links for the help you need

FORGET YOUR USER ID or PASSWORD?

- It happens to the best of us. Click on 'Forgot User ID,' or 'Forgot Password,' follow prompts and enter your email address to recover

WHAT CAN I SEE?

- You can view your claims, benefit information, plan coverage, explanation of benefits (EOB) and CoreWellness. CoreWellness is our online wellness program where you can take a health risk assessment and participate in Journeys to better your health



Employer Portal

The right plan for you

The HealthPlan

Employer Portal QuickStart Guide

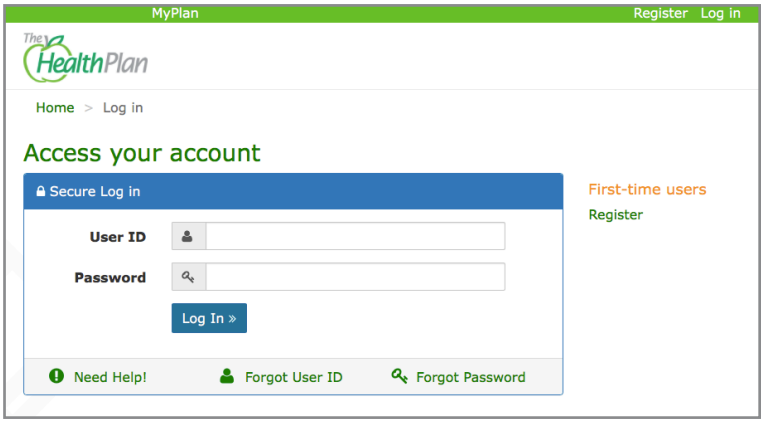
The Health Plan's Self-Funded employer portal is convenient and easy to use. Access the Self-Funded employer portal to:

- Search for an employee's EOB
- View current enrollment status, coverage type, and coverage start date
- Access employee deductible amounts and copays
- Edit and update a variety of employee and dependent information

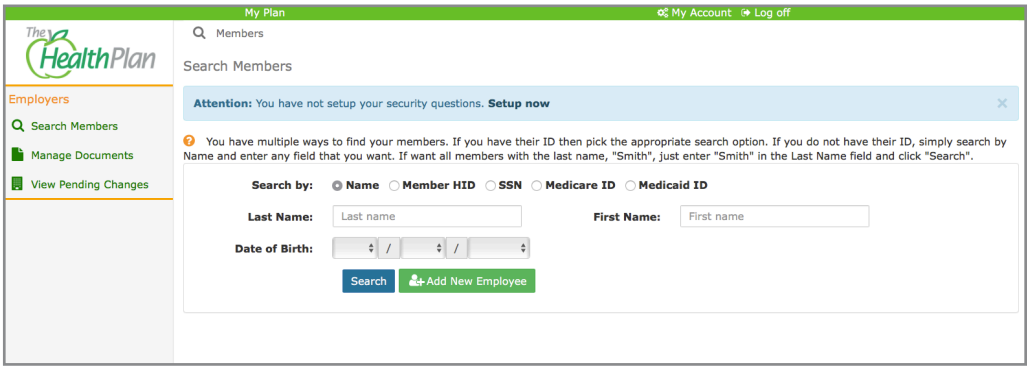
HOW DO I GET ACCESS TO THIS PORTAL?

Log on to **myplan.healthplan.org**

- **Do not register.** An account has already been created for you.
- First-time users will be asked to confirm their email address.
- Users will receive an email from noreply@healthplan.org. Please follow onscreen instructions to confirm your email address.
- It is important that you set up security questions for your account.

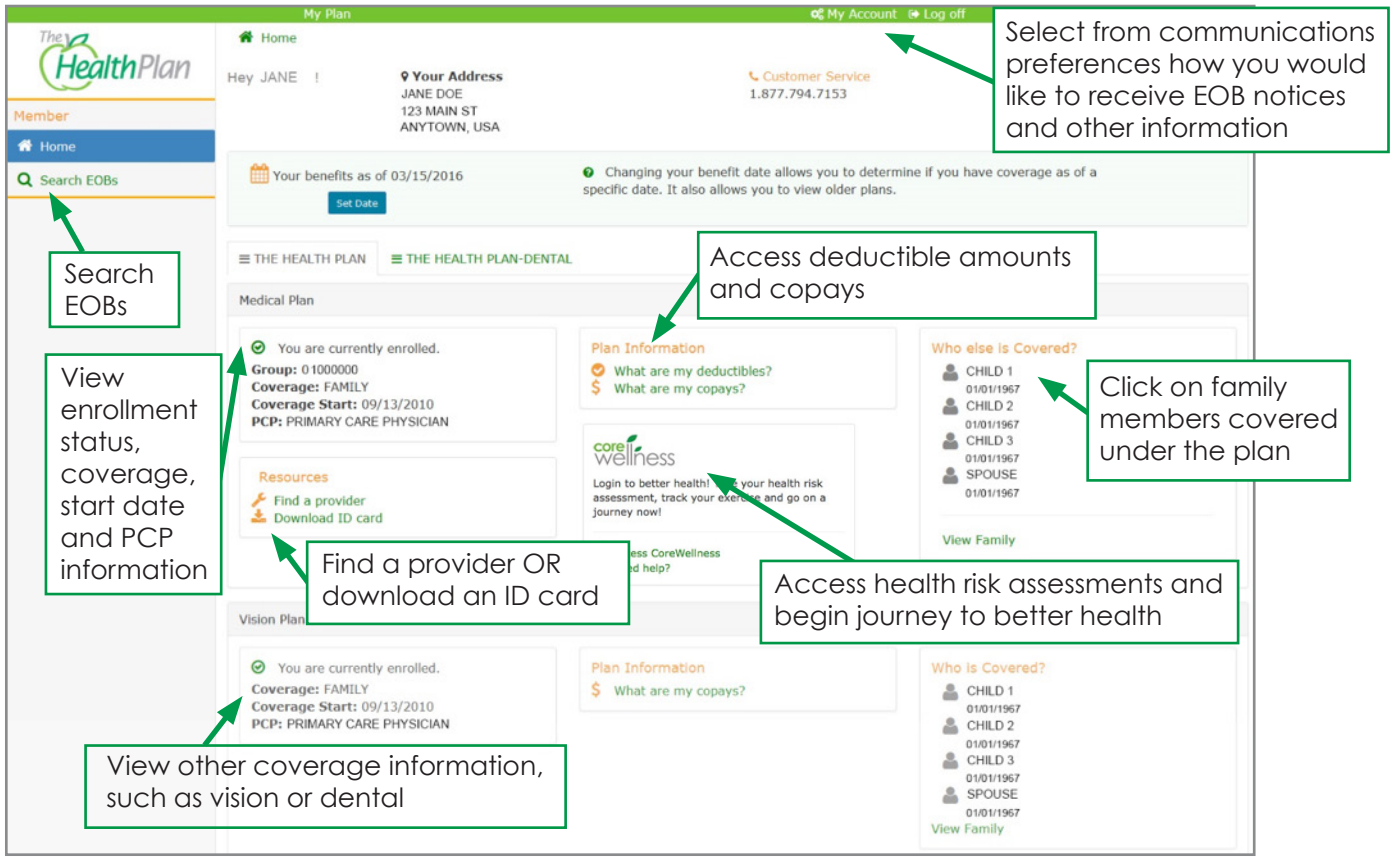


- From the **Home Page** you can search by name, HID number, DOB or SSN.

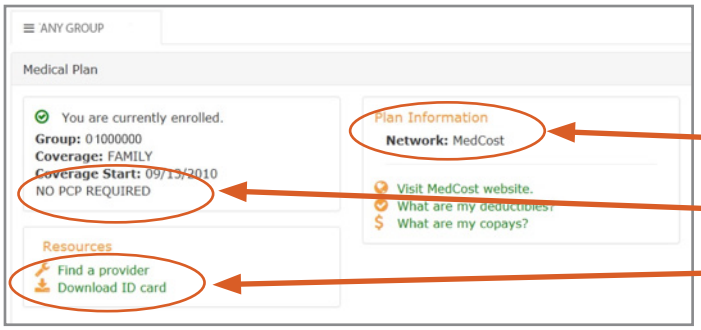


WHAT CAN EMPLOYEES SEE?

An employee can also see the following information.



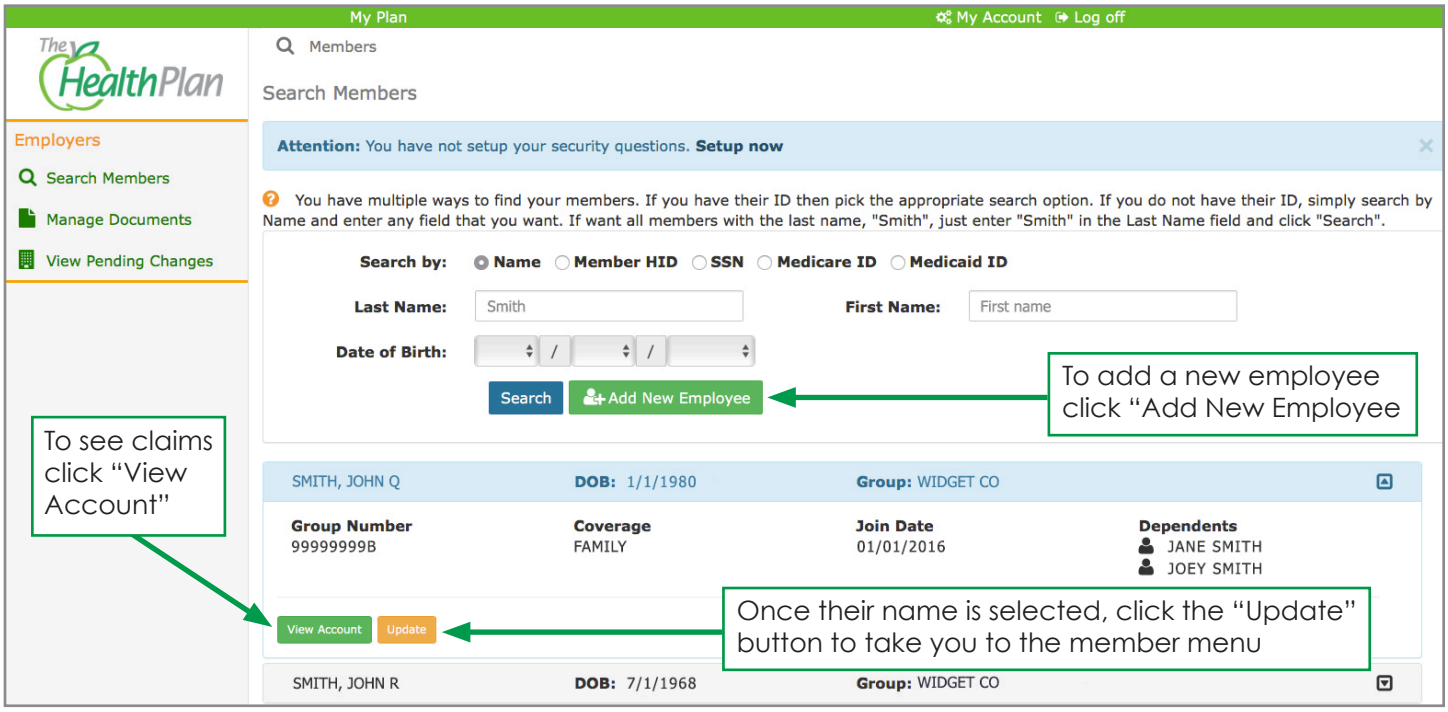
DEPENDING ON GROUP PLAN, SMALL CHANGES MAY OCCUR



HOW DO I MAKE CHANGES?

Perform a member search. Choose a specific member by clicking on their name.

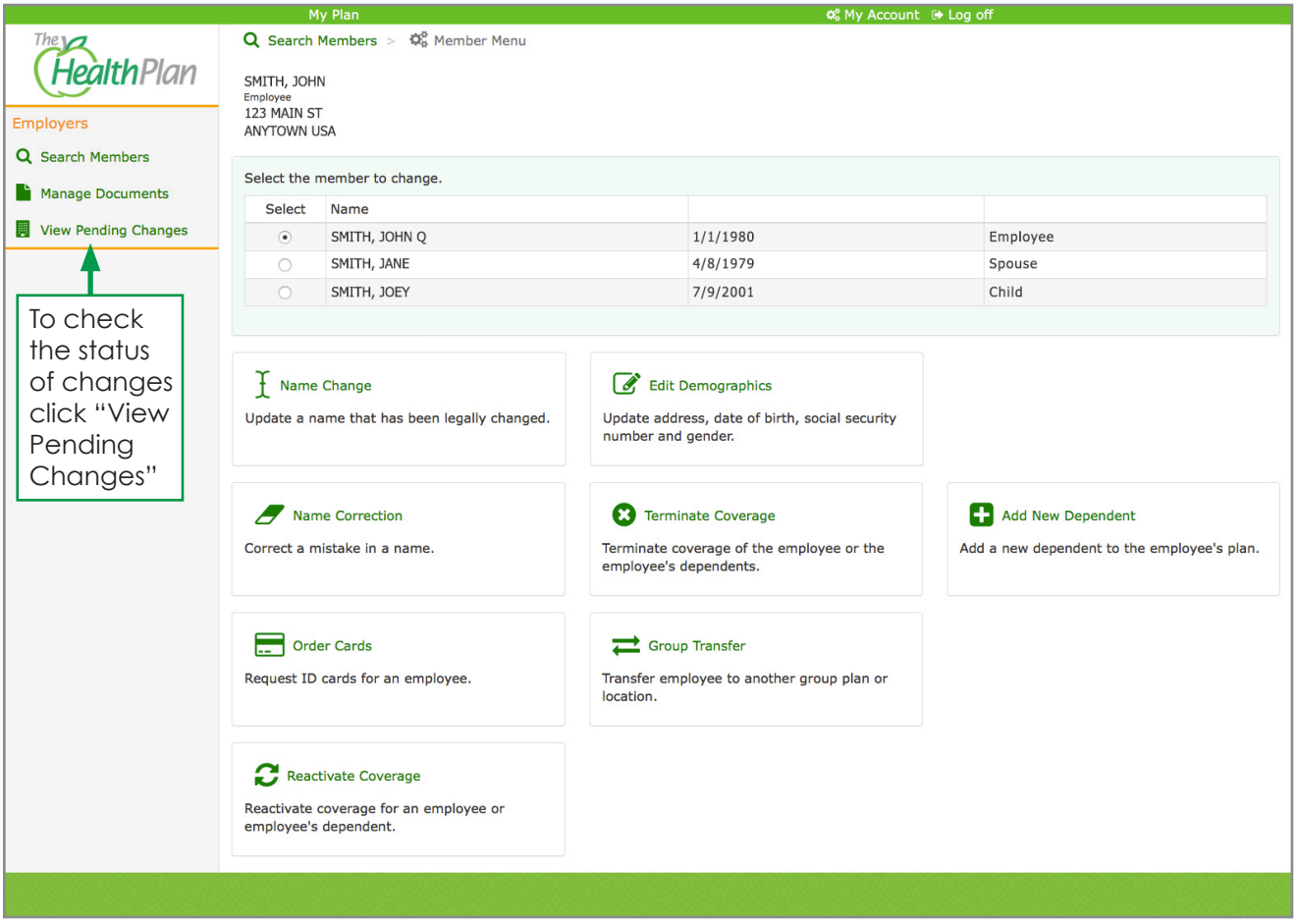
- A gold star icon ★ indicates the insured
- A person icon indicates a dependent



WHAT CHANGES CAN I MAKE?

For an active member:

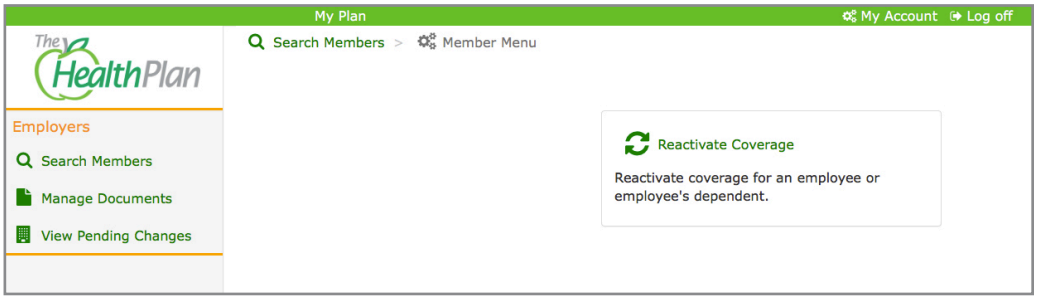
- Member-specific: change name, edit demographics, and correct name
- Family-specific: terminate coverage, add new dependent, order cards, transfer group, and re-activate coverage



By default, the subscriber of the plan is selected first.

To edit information for a dependent, you will need to specifically select them before you make a change.

For an Inactive member: You will be directed to "Reactivate Coverage" link where you can re-activate members that you have access to.



Network Providers

The right plan for you

For information regarding network providers, please visit our website, **healthplan.org/tpaservices**, and select your appropriate network provider from the list.

You can also contact our Customer Services Department for assistance at **1.888.816.3096**.

If you do not know the name of your plan, refer to your ID card. You ID card will indicate your plan so you can contact the customer service area most appropriate for your benefits.

NOTE: Providers are subject to change. Please check with your provider of choice to ensure he or she is currently participating with us and provides the service you require.

Financial Information

Administrative Monthly Billing:

The client's designated billing contact will receive an invoice from The Health Plan for monthly administrative fees. Client payments can be made three different ways; all of which were discussed and determined during the implementation process.

1. **Automated Payment Program:** *(preferred method)*
   THP will deduct your company's invoiced amount from the company's bank account on the 5th of each month. If the 5th is on a weekend or holiday, payment will be deducted on the following business day.
2. **Wire Transfer from the Client into The Health Plan's Operating Account**
3. **ACH from the Client into The Health Plan's Operating Account**

Funding Claims:

The Health Plan produces your check registers and will deliver those to you via secure email. All registers are provided in an Excel format. The check register provides a list that includes all checks being issued for claims payment to providers and/or your plan participants that are being released during the specified time period.

It is your responsibility to ensure funds are available in your designated bank account to cover the release of these checks. Upon receipt of signed approval form, checks will be released.

Funds can be sent to The Health Plan in one of three ways:

1. Pull into account *(THP initiated - preferred method)*
2. Push into Wire *(client initiated)*
3. Push into ACH *(client initiated)*