TheHealthPlan

Chapter 4

Commercial Fully Insured and Self-Insured/ Administrative Services Only

Provider Manual

Commercial Health Maintenance Organization (HMO) Plans

Commercial health maintenance organization (HMO) plans are plans that are fully insured by a Health Insuring Corporation (HIC). Employer groups contract with THP to provide a health insurance benefit plan and pay a monthly premium to cover eligible employees. THP is responsible for providing the benefit package, administering all aspects of the plan and assuming the risk for paying for all covered services. These plans require a member to choose a primary care physician (PCP), and the member must be referred by their PCP and follow precertification guidelines for procedures, diagnostic testing, outpatient surgical procedures, and inpatient admissions. Members do not have out-of-network benefits unless authorized by the plan.

HMO benefit plans generally have copays for:

- Primary and specialty care physician office visits
- Emergency room services
- Urgent care
- Outpatient mental health
- Physical, occupational, and speech therapy
- Durable medical equipment
- Prescription drugs

Members may have a deductible and co-insurance associated with their benefit plan, as well as cost sharing for laboratory and x-rays, not associated with preventive services, depending on the plan.

Commercial Point-of-Service (POS) Plans

Commercial point-of-service (POS) plans are fully insured by a Health Insuring Corporation (HIC). Employer groups, with a minimum size of two employees, contract with THPTHP to provide a health insurance benefit plan and pay a monthly premium to cover eligible employees.

POS plans are designed to allow members the freedom to choose between having their health care managed or arranged by their PCP as an in-plan option or having their health care arranged as an out-of-plan option. The plan provides the benefit package giving the employer the option to choose from a variety of deductibles and copay plans. These plans require a member to choose a PCP, obtain a referral for specialty physician services, and follow precertification guidelines for procedures, diagnostic testing, outpatient surgical procedures, and inpatient admissions.

Members have out-of-plan option benefits and may choose to access services outside THP network at an increase in their out-of-pocket expense for deductibles, copays, and co-insurance amounts.

POS benefit plans generally have copays for:

- Primary and specialty care physician office visits
- Emergency room services
- Urgent care
- Outpatient mental health
- Physical, occupational, and speech therapy
- Durable medical equipment
- BioTech drugs

Additionally, members are responsible for deductibles and co-insurance amounts associated with their plan benefit.

Commercial Preferred Provider Organization (PPO) Plans

Commercial preferred provider organization (PPO) plans are fully insured by a Health Insuring Corporation (HIC). Members who are covered under the PPO plan generally are not required to select a primary care physician (PCP) or obtain a referral for specialty physician services. All prior authorization guidelines for procedures, diagnostic testing, outpatient surgical procedures, and inpatient admission apply. By utilizing THP's network, members receive a higher level of benefits. Members who utilize out-of-network providers or fail to preauthorize a service will have increased out-of-pocket expenses for deductibles, copays, and co-insurance amounts.

PPO benefit plans generally have copays for:

- Primary and specialty care physician office visits
- Emergency room services
- Urgent care
- Outpatient mental health benefits
- Physical, occupational, and speech therapy
- Durable medical equipment
- BioTech drugs

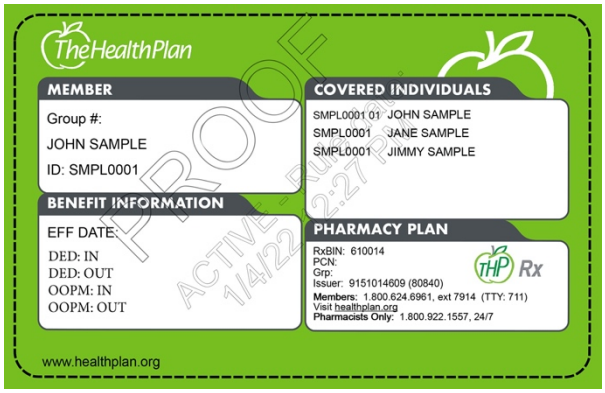
Additionally, members are responsible for deductibles and co-insurance amounts associated with their benefit plan.

Sample Commercial Member ID Cards

This card is issued to members enrolled in a Commercial (including Health Maintenance Organization [HMO], Preferred Provider Option [PPO] and Point of Service [POS]) plan. This includes WV State employees who are covered by the Public Employees Insurance Agency (PEIA) plan.

Commercial WV Sample ID Card

FRONT



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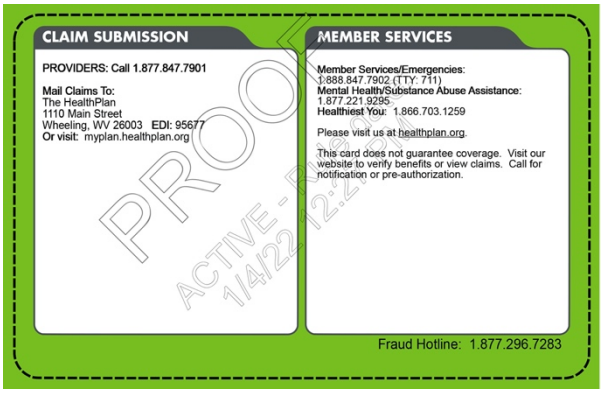

Commercial Ohio Sample ID Card

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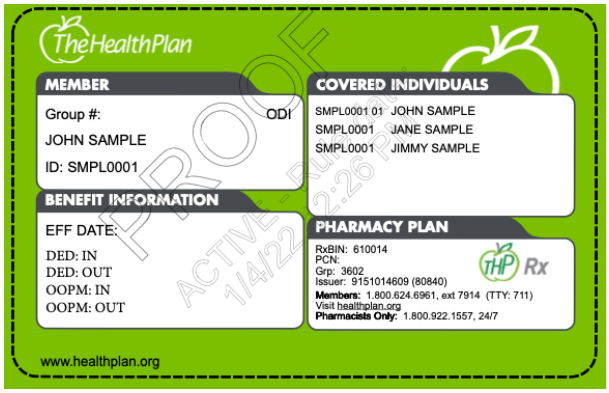

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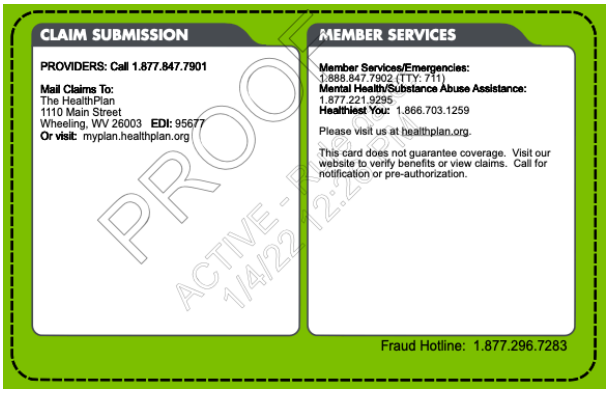

Self-Funded / Administrative Services Only (ASO) Employer Groups

Many employers choose to pay claims as they are incurred, rather than pay a prepaid monthly premium for their employee's medical benefits. THPTHP offers administrative services only (ASO) plans to assist these employers with administering their benefit plan. The plan offers them a contracted network of providers, utilization management services, medical management, prescription plans, customer service and claims processing. These plans are most often designed by the employer group and administered by THP. ASO plan benefits, copays, deductibles, and ID cards may vary from the standard insured plans offered by THP.

Sample Self-Funded/ASO ID Cards

This card is issued to members who are enrolled in a Self-Funded plan. The employer's name will differ on these cards (as shown on the front of the card).

Note: Services requiring referral/ prior authorization may differ by plan. Contact THP to confirm benefits.

Self-Funded/ASO Sample ID Card

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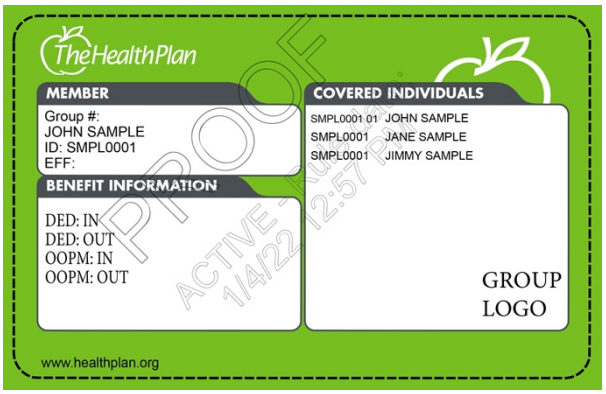

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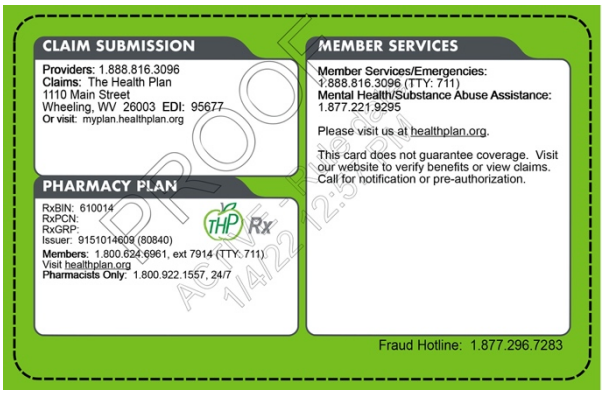

Self-Funded/ASO Reference Based Pricing (RBP) Sample ID Card

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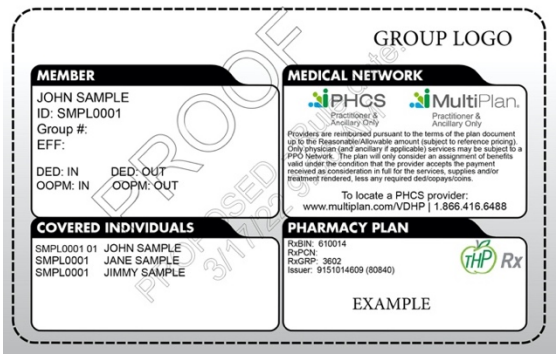

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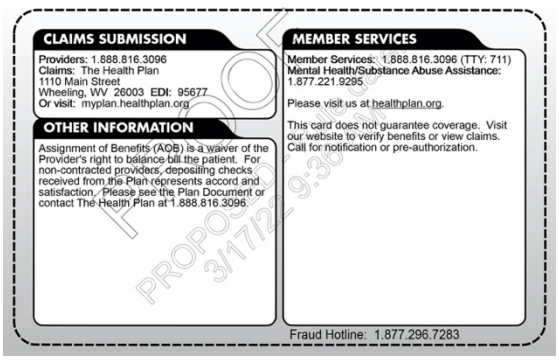

Vision Service Benefits

Members enrolled through THP Commercial programs may also have vision benefits. Superior Vision administers vision benefits for Commercial members. Please refer to resources available through Superior Vision for information on benefits and coverage under these vision plans.
THP offers benefit riders for vision benefits administered through Superior Vision for Commercial members. Providers must be participating with Superior Vision before offering covered vision services to members. Providers need to verify vision coverage through Superior Vision.

For WV Mountain Health Trust (MHT), vision service benefits, please refer to **Chapter 5** and for Medicare Advantage vision service benefits, please refer to **Chapter 6**.

Supervisor Vision is available at: Superior Vision (superiorvision.com) and 1.844.353.2900, Monday – Friday 8 a.m. to 9 p.m. EST

Members are entitled to vision benefits only under this separate vision service program.

Members may require ophthalmologic medical services in conjunction with a medical condition. These medical services must be offered through a contracted ophthalmologist or optometrist with THP. A referral from the primary care physician (PCP) may be required for the member to obtain medical services from an ophthalmologist or optometrist.

Vision Billing

In most situations, a vision screening (CPT 92015 Determination of Refractive State) is considered non-covered under a medical benefit plan but is often covered by a vision benefit plan. When there is the need to provide a vision screening as part of a medical exam, the following billing guidelines will assist you in obtaining appropriate reimbursement for the vision screening if there is a benefit that is available through THP's vision benefit vendors, provided you are a participating provider. Please note for Medicare members 92015 is a non-covered service when billed separately.
The visit is billed to THP on the appropriate CMS 1500 form with the following codes:

92002, 92004, 92012, or 92014	**Eye exam, new or established patient**
92015	**Determination of refractive state**

After THP has made payment for the exam and denied the refraction as non-covered, you can then submit the visit code and the 92015 – Determination of Refractive State – to THP's vision provider (as long as you are a contracted provider) for payment of the refraction.

Please include THP's payment voucher (with the page that shows the explanation of the denial codes) when submitting to Superior Vision for the remaining portion.

Superior Vision provider will coordinate benefits with THP and pay only the refraction, which is still due when a benefit is available to cover the refraction. If the member has a vision benefit through some other plan that is not associated with THP, you may also submit a claim for the refraction to that plan in the same manner and they will adjudicate the claim according to their plan guidelines.

- THP encourages our diabetic members to see an in-plan ophthalmologist or optometrist for an annual dilated retinal exam (excludes Self-Funded/ASO participants.) If a 92015-Determination of Refractive State is also completed during the visit, the *office copayment is waived.*

Once THP has made payment, please submit the visit code and the 92015-Determination of Refractive State to the appropriate vision plan, for payment of the refraction. Superior Vision will coordinate benefits with THP and pay only the amount which is still due.

THP's Members' Rights and Responsibilities Statement

Statement of Members' Rights

- Members have the right to receive information regarding the plan. This includes 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 rights and responsibilities as well as 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 THP's Customer Service Department at 1.888.847.7902.
- 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.
- All information concerning THP member's medical history and enrollment file is confidential. The member has a right to approve or refuse the release of personal information by THP except when the release is required by law. THP assures that all patient information is held in the strictest confidence. All staff must adhere to THP confidentiality policy revised and adopted in November 1993. This statement acknowledges the confidential nature of the review work, includes an agreement to honor that confidentiality, and documents the consequences of failing to do so.
- The member's personal choice of a primary care physician (PCP) enables the member to participate in the management of his/her total health care needs, including the right to refuse care from a specific practitioner. Members of THP are encouraged to establish a relationship with their chosen PCP so that they can work together to maintain good health. Members of THP may change physicians once per calendar month if so desired (depending upon the availability of the chosen physician).
- THP members have the right to express their comments, opinions or complaints about THP or the care provided and to file a grievance for an administrative or medical complaint and hearing procedures without reprisal from THP. Members also have the right to have coverage denials reviewed by the appropriate medical professionals consistent with THP review procedures. Both informal and formal steps are available to members to resolve all complaints/grievances.
- THP members may participate in decision-making about their health care when possible and within the plan guidelines. 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 also have the right to formulate advance directives.
- THP members have the right to have a meaningful voice in the organization by expressing their suggestions and comments regarding their health plan coverage, policies, members' rights and responsibilities, and operations. Member's comments and opinions are received by THP through yearly member satisfaction surveys, telephone calls from our members, by email to: information@healthplan.org or through our corporate website, healthplan.org. Member's comments/opinions are also received through various departments at THP.

- 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 THP Customer Service Department at 1.888.847.7902.

Statement of Members' Responsibilities

- A member must choose a PCP for each person listed on THP ID card. The member has a responsibility to maintain a relationship with a PCP, as the PCP will act as the coordinator for all their health care needs.
- A member must identify themself as a member of THP to avoid unnecessary errors; always carry their ID cards; and never permit anyone else to use their ID card.
- A member is asked, through outreach calls to new members, to read their member handbook and understand the benefits and procedures for receiving health care services. To assure maximum coverage, the member has a responsibility to follow the rules and to contact THP for assistance, if necessary.
- A member is required to notify THP of any changes in the following:
  1. Name, address, telephone number
  2. Number of dependents (marriage, divorce, newborns, etc.)
  3. Loss of an identification card
  4. Selection of a primary care physician
- Members are asked to be on time for appointments and to call the physician's office promptly if an appointment cannot be kept.
- Members must provide necessary information to the providers rendering care. Such information is necessary for the proper diagnosis and/or treatment of potential or existing conditions.
- Members must 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 the providers who deliver health care services.
- If members receive emergency care outside THP's service area, they are required to contact THP as soon as possible within 48 hours.
- Members must contact their PCP, secondary care physician, or OB/GYN **before** seeking any specialty physician/service.
- Members must provide THP with all relevant, correct information and pay THP any money owed according to coordination of benefits or subrogation policies.
- Members must make required copayments under the schedule of benefits.
- Members are asked to be courteous and respectful of THP employees, providers, and their THP member handbook is the primary source of information regarding THP member benefits. **THP member handbook is available upon request by the member.**

Member Copayments, Co-insurance & Deductibles

THP offers a variety of benefit plans requiring member responsibility for a portion of the cost of services. Member responsibility may take the form of copays for office visits or other medical services, co-insurance amounts, and deductibles. As groups re-enroll annually, the member copayment may change, depending upon the plan selected by the employer.

Copayments

Copays are a fixed amount, but may be a percentage of the allowed amount that is associated with a specific service such as an office visit, therapy visit, or diagnostic service and would be the member's responsibility. Members are expected to pay this amount at the time of service.
It is imperative that provider offices ask for the member's ID card at every visit. A sample of THP ID cards are shown on the product matrix located in **Chapter 2 – Product Information**.
Member copayments for physician office visits and certain other services may be found on THP's provider secure portal myplan.healthplan.org

Copays may not be waived; this is a provider's contract violation.

Copays should be collected at the time of service unless other arrangements have been made. Copays DO NOT apply to hospital inpatient physician visits, preventive services and/or prenatal office visits (after the initial visit), physician nursing home visits, or patient home visits when determined to be medically necessary by the plan. Members of specific employer groups may have a copay for specific outpatient procedures.

Collecting copayments when another insurance is primary

If you have questions regarding whether to collect an office copay, please contact THP Coordination of Benefits Department at 1.740.695.7903 or 1.800.624.6961, ext. 7903, or refer to the secure provider portal's 'Search Patients' tool at myplan.healthplan.org.

Co-insurance

Generally, co-insurance is an amount based upon the member being responsible for a percentage of the allowed amount for a covered service. A provider may request payment at the time of service; however, the provider must determine the member's specific benefit and apply any contract reimbursement terms to determine the amount of the co-insurance.

At no time should a provider collect more than the amount that is contractually obligated to be paid. The most accurate method to assure that the provider is collecting the correct amount may be to wait for the payment remittance) from THP showing the amount that is member responsibility. A copy of the remittance is also sent to the member letting them know the amount that is their responsibility.

Deductibles

Deductibles are an annual amount, defined by the member's benefit plan that members must satisfy before the plan pays for any services. A provider may expect payment from the member at the time of service if the member has not satisfied their annual deductible. Unless the member knows that they have not met their deductible, it is generally difficult to determine how much of the annual deductible has been met at a certain point in time.

Affordable Care Act and Member Responsibility

The Affordable Care Act (ACA) requires private insurers to cover certain preventive services without any patient cost-sharing. THP products affected by the ACA would be our commercial, HMO, PPO, POS, and self-funded employer groups.

Under the ACA, private health plans must provide coverage for a range of preventive services and **may not impose cost sharing (such as copayments, deductibles, or co-insurance)** on patients receiving these services. Please remember that annual well exams and other preventive services do not require a copay or co-insurance from the member, unless the employer group to which they belong is "grandfathered."

At no time should a provider collect more than the amount that is the member's responsibility as a copayment, coinsurance and/or deductible