



## We're happy that you're here.

Inside is everything you'll need to help get you started.

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#### **Customer Experience Team**

8 AM - 5 PM | Mon - Fri

866-945-2292

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# Welcome to the Healthcare Highways Health Plan!

## Everything we do is focused on you and your covered family members.

Welcome to the Healthcare Highways Health Plan, your individual and family health coverage. Your good health and wellbeing are what make us jump out of bed in the morning! We're so glad that you're going to be a member.

We are honored to be partnering with your employer to provide you with affordable, high-quality healthcare solutions. We currently cover more than 500,000 lives and find that members like you select our networks or health and pharmacy plans in order to have a more affordable choice, to have access to quality providers, and to enjoy our simple and convenient care experience.

We're here for you in whatever way works best for you.



#### **Member Portals**

Our member portals allow you to look up information on your own. You're in control.



#### **Customer Experience**

Our customer experience team is ready to answer any question you might have about your health plan. Contact us by calling 866-945-2292.



#### **Resource Center**

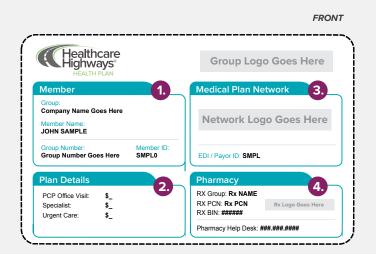
Your resources at HCHHealthPlan.com will provide you with everything you need in one easy spot.

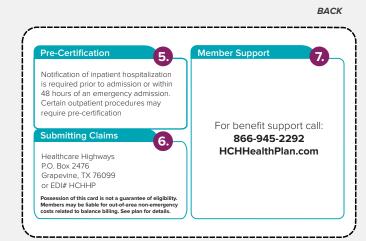
Quick Fact! On the next page you will find information to help you understand your member ID card.

Until then, know that we are paving the way for a smooth transition to your new year with Healthcare Highways Health Plan.

#### Your passport to care and coverage: understanding your member ID card

Looking at your ID card with all those unfamiliar terms and sections can be confusing. Our goal is to make you an expert on your member ID card so you're in control.





#### 1. Member

**Group:** This is the name of the group you're covered under (usually the name of the company where the primary member works).

**Group number:** This number is unique to the company. Everyone insured through the company will have the same group number.

**Member name:** Policyholder's name, typically the employee.

**Member ID:** This is your unique ID number. This allows health plan staff the ability to verify coverage and answer benefits and claims questions.

#### 2. Plan Details

The plan details section informs you of the amount you will be required to pay at the time of that specific service.

#### 3. Medical Plan Network

This section provides a logo that Indicates a seamless network where a patient can receive in-network care.

**EDI/Payer ID:** This code is used by providers to submit claims electronically.

#### 4. Pharmacy

**RX Group:** The name of your Pharmacy Benefit Manager (PBM).

**RX PCN:** PCN stands for processor control number. It's a number used to locate your pharmacy member profile under the PBM system.

**RX Bin:** This is the number pharmacies use to process your prescription drug claims.

**Pharmacy Help Desk:** Phone number to call for questions regarding pharmacy claims, benefits, and coverage.

#### 5. Pre-certification

Make note of this important notice.

#### **6. Submitting Claims**

This information is used by providers to submit claims manually.

#### 7. Member Support

Here, you'll find the phone number to call for questions regarding your health plan.

#### **Quick Fact!**

If you need assistance finding a local provider, accessing your information, or have a question, our Customer Experience Team is here to provide extra support 866-945-2292, 8 AM to 5 PM, Monday through Friday.



## Member Checklist.



#### Checklist.



#### Member Portal - Sign up.

Go to www.hchhealthplan.com and click on the member portal button. Login to access the member portal where you can find your claims history, view member ID cards, and more.



#### Find your healthcare provider.

Most preventive screenings and immunizations are covered by your health plan, so it's a good idea to call your primary care provider (PCP) and get your first checkup on the calendar.

If you need assistance finding a local provider, accessing your information, or have a question, our Customer Experience Team is here to provide extra support 866-945-2292, 8 AM to 5 PM, Monday through Friday.



#### Save money by staying in-network.

Check your member handbook for benefits details. Your Health Plan has options at time of need, however, your medical situation and your choice on where to seek care can impact what you may have to pay out-of-pocket or whether the provider is considered in-network or out of network.



#### Know your pharmacy benefits.

Login to the pharmacy portal by going to https://goodrx.hchrx.com/ and creating an account. Here, you can compare prescription drug prices, map your way to the nearest network pharmacy, and place refill requests for mail ordered medications.



#### Benefits at a Glance

Below is an overview of the services we offer to you as a health plan member\*.



#### **Care Coordination\***

As an employee benefit, a dedicated care coordination team is included to help you navigate and make the most of your healthcare services. The care coordination team provides you with personalized, one-on-one care coordination and navigation assistance to help eliminate barriers to your health care needs. Care coordination services include:

- Care decision support
- Quality and prevention
- Chronic disease support
- Complex care support

- Medication support
- Transition of care
- Behavioral Health
- Provider Selection Assistance

Please refer to **Care Coordination on pg. 17** under the Benefits section for more information.



#### **Preventive Services\***

Each health plan member has preventive services available at no cost. Please take full advantage of your preventive care benefits and other available wellness resources. Talk with your doctor about ways to improve your health. There is no better time than now to get started – and head off potential health problems before they begin.

Preventive services include, but are not limited to:

- Children and Adolescents: health counseling, well exams, immunizations, and screening tests
- Adults: Preventive exams, immunizations, and screening tests
- Women: well exams, screening tests, maternity-specific care

Please refer to **Preventive Services on pg. 19** under the Benefits section for more information.



#### Pharmacy\*

CerpassRx is an innovative Pharmacy Benefit Administrator that offers access to pharmacies in your local community and tools to assist you in managing and navigating your prescription benefit.

CerpassRx members are able to access our pharmacy benefit plan resources in a number of ways:

- Member Services Support Center
- Mobile App

Member Portal

Mail Delivery and Specialty Programs

Please refer to **Pharmacy Benefits on pg. 24** under the Pharmacy section for more information.



#### **Telemedicine\***

As a Healthcare Highways health plan member, you have a telehealth benefit giving you virtual care, anywhere at a price you can afford.

- Board-certified doctors
- Available 24/7/365

- PHONE or VIDEO consults
- E-prescriptions if appropriate

Please refer to **Telemedicine on pg. 18** under the Benefits section for more information.

<sup>\*</sup>Depending on your plan, you could have this benefit. See your summary plan description for more details or call the Customer Experience Team for any questions at 1-866-945-2292.



Seeking Care

#### The importance of having a primary care physician:

## Why it matters.



Chances are high that at some point in your life you'll have to see a doctor for a medical event. The primary care physician-to-patient (P2P) relationship lies at the heart of Healthcare Highways and as a valued health-plan member, we encourage you to establish a relationship with a primary care physician (PCP).

#### Having a PCP has many benefits for you, including:



#### **Better Care**

Having a primary care physician who knows your medical history results in more tailored care. Data from routine checkups can help your PCP formulate a snapshot of your health status and treat and/or diagnose illnesses more precisely. In addition, your PCP can coordinate care with specialists so that you get the most appropriate care, at the most appropriate time.



#### **Health Savings**

An established relationship with a PCP empowers you as a member to be proactive in managing your family's wellness journey, resulting in cost savings. In fact, studies show that having a PCP results in 33% less healthcare costs compared to people without a PCP. Additionally, in the event of a non-life threatening condition, having a PCP makes it more likely that you'll go there for care instead of an emergency room or urgent care, which can be more costly.



#### **Time Savings**

Having an established PCP enables your doctor to address health care concerns more quickly and effectively, given that they are familiar and knowledgeable with your medical history.

We're here for your health plan needs. To find an in-network provider, use our online Find a Medical Provider tool on www.HCHHealthPlan.com or call the Customer Experience Team at 1-866-945-2292 for any questions, 8 am to 5 pm Monday through Friday.



i https://www.aafp.org/medical-school-residency/choosing-fm/value-scope.html

## What's the difference?

We're glad you're a member and are here to help you navigate the healthcare landscape. Make informed decisions when choosing care and maximize your health plan benefits by being familiar with your plan.

To begin, you've probably heard the term network before. In the context of your health plan, a network refers to the hospitals, clinics, and doctors that a plan has contracted with to provide medical care to its members.

Providers can fall into one of two categories: in-network providers or out-of-network providers.



#### in-network providers

**In-network** providers are those that have contracted with your health plan and agreed upon the rates the provider will be paid. You receive the highest level of coverage (least out-of-pocket costs) when you receive in-network care from providers in your health plan network.



#### out-of-network providers

On the other hand, **out-of-network** providers refer to providers with which your health plan has not negotiated a discounted rate. If you get care from an out-of-network provider, you may have to pay the entire bill yourself or just a portion. Your portion of out-of-network charges should be indicated in your benefit summary guide.



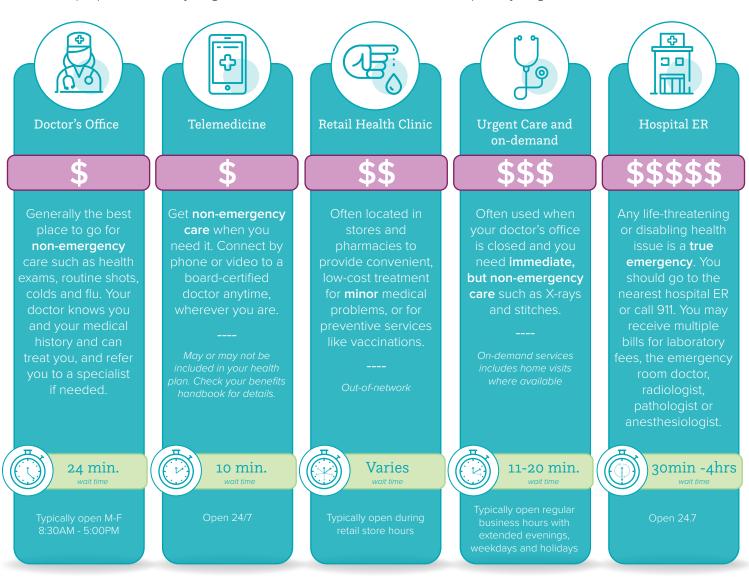
#### in-network vs. out-of-network: what's the difference?

The biggest difference between the two is **cost**—staying in-network will save you money. Another difference is how much your plan helps with the cost of care when you see an out-of-network provider.



## Get care when you need it.

It's important to know where to go when you need medical care. Knowing your options and deciding where to go can make a big difference in how much you pay and how long you may have to wait for care. Be prepared before you go and make sure ahead of time that the place you go to for care is in-network.



#### Before your appointment

Customer Experience Team at 866-945-2292.

Write down all your questions or concerns so you don't forget to ask. How have you been feeling? Do you have a new health problem or an old one about which you want to check in? Make a list of all the medications you take, including dose and frequency. Don't forget to write down over-the-counter drugs as well as herbs, supplements, and vitamins. The doctor needs to know because any drug-even over the counter and herbal remedies—can interact with other prescription drugs in a harmful way. Check to make sure that your provider is in the Healthcare Highways network. Use our online Find a Medical Provider tool on www.HCHHealthPlan.com or call your



## **Healthcare Highways Network**

#### Finding an in-network provider

Welcome to Healthcare Highways! We're honored to be your healthcare partner. Let's help you find your in-network provider. You have two ways to search for a provider:

1

#### Do it yourself.

Go to www.healthcarehighways.com and follow the simple instructions below.



#### Let us help you.

Call our customer experience team at 866-945-2292. We're available Monday through Friday, 8am to 5pm CST.



## Finding your provider.

Follow our simple search instructions

#### STEP 1

Go to www.healthcarehighways.com and click on the "Find a Provider" button in the upper right of the screen.

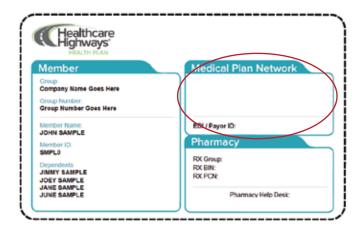
#### STEP 2

You've now accessed the provider search page. It's important to have your member ID card near by for reference when choosing your network.





A drop-down menu will appear with different networks listed. Be sure to match the network logo on the front of your member ID card with the one listed on the screen.



#### STEP 4

Start your search by entering your search location. Provide an address, city, or zip. You also have the option to allow us to use your current location.

#### STEP 5

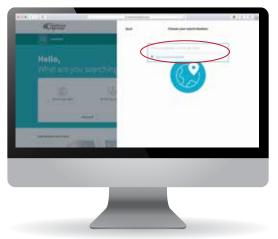
Now you can start your search for doctors, hospitals, specialists and more by selecting the icons on the main dashboard.

At any time you can check to make sure that your location and network information are correct. Do this by viewing what is displayed it in the upper right hand corner. It should reflect your location as well as your Healthcare Highways network selection next to the plan.

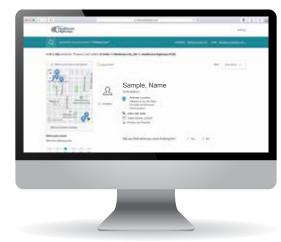
#### STEP 6

A list of one or more providers will appear, depending on your search parameters. Scroll to select your provider. Within each listing, you'll find basic contact information. You may click on "directions" to get turn-by-turn driving instructions. Print or save your results.



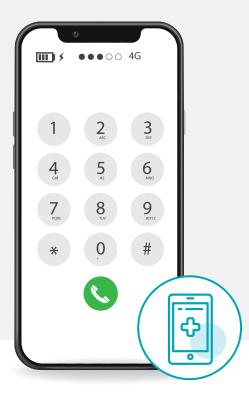








**Hospitals and Emergencies** 



#### **Prepare Now**

Before you have a medical problem, learn what your choices are. Check your member handbook for benefits details. Your Health Plan has options at time of need, however, your medical situation and your choice on where to seek care can impact what you may have to pay out-of-pocket or whether the provider is considered in-network or out-of-network.

#### Plan ahead and save these telephone numbers in your phone:

- Your provider
- The closest emergency department
- Urgent care clinic and on-demand service provider
- o Telehealth service provider

Be sure to choose a provider in your network. Your health plan includes a group of doctors, hospitals, and clinics called a network. To find out if a provider participates in the Healthcare Highways network, go to www.HCHHealthPlan.com to Find a Medical Provider.

Whenever an illness or injury occurs, you need to decide how serious it is and how soon to get medical care. This will help you choose whether it is best to:

- o Call your health care provider
- Go to an urgent care clinic
- Go to an emergency department right away

It pays to think about the right place to go. Treatment in an emergency department can cost 2 to 3 times more than the same care in your provider's office. Think about this and the other issues listed here when deciding.

#### When you need emergency care

If you or a family member experiences a life-threatening illness or injury, always call 911 or go to the nearest emergency room (ER). Whether you're at home or on the road, your plan pays in-network benefits to providers if your condition is considered an emergency. There is no need for referrals or authorizations.

#### When to go to an urgent care clinic

When you have a problem, do not wait too long to get medical care. If your problem is not life threatening or risking disability, but you are concerned and you cannot see your provider soon enough, go to an urgent care clinic. or call for on-demand in-home care\*.

#### If you are not sure, talk to someone

If you are not sure what to do, and you don't have one of the serious conditions listed here, call your provider. If the office is not open, your phone call may be forwarded to someone. Describe your symptoms to the provider who answers your call, and find out what you should do. Your benefits may also include telehealth services. Call that number for advice on what to do

#### Signs of an Emergency\*\*

#### Call 911 to have an emergency room team come to you right away if you cannot wait, such as for:

- Choking
- Stopped breathing
- o Head injury with passing out, fainting, or confusion
- Injury to neck or spine, especially if there is loss of feeling or inability to move
- Electric shock or lightning strike
- Severe burn
- Severe chest pain or pressure
- Seizure that lasts 3 to 5 minutes

#### Go to an emergency department or call 911

for help for problems such as:

- o Trouble breathing
- o Passing out, fainting
- o Pain in the arm or jaw
- Unusual or bad headache, especially if it started suddenly
- o Suddenly not able to speak, see, walk, or move
- Suddenly weak or drooping on one side of the body
- $\circ\;$  Dizziness or weakness that does not go away
- o Inhaled smoke or poisonous fumes
- Sudden confusion
- Heavy bleeding
- Possible broken bone, loss of movement, especially if the bone is pushing through the skin
- Deep wound
- Serious burn
- Coughing or throwing up blood
- Severe pain anywhere on the body
- Severe allergic reaction with trouble breathing, swelling, or hives
- o High fever with headache and stiff neck
- High fever that does not get better with medicine
- Throwing up or loose stools that does not stop
- Poisoning or overdose of drug or alcohol
- Suicidal thoughts
- Seizures

#### Preparing for a Major Medical Event

## Precertification.



Surgery is something most of us don't look forward to. From the stress of the surgery itself, to the road to recovery and everything in between, we understand it can be overwhelming. Here at Healthcare Highways we want to make the process for our members as easy and stress-free as possible. Below are some general guidelines to help you navigate the journey ahead.

If you have any further questions, please refer to your Summary Plan Description (SPD) document, accessible anytime by going to HCHHealthPlan.com and logging into the health plan member portal, located on the left side of the home page.

#### **DO YOUR RESEARCH**

As with anything, doing your research will ensure you make a more well-informed decision.

- Make sure that the facility and (if applicable) the attending physician performing your procedure are in-network. Though a facility might be in-network, that doesn't guarantee that the attending physician or specialist (i.e. anesthesiologist) will be in-network also.
- Not checking whether a facility and/or attending physician and/or specialist is in-network can result in balance billing (a "surprise" medical bill from your healthcare provider to pay the difference between the amount they charge and the amount the health plan pays).
- Don't forget that as a health plan member, you have access to complimentary care coordination services. Your care coordination team is there to work directly with you and your primary care providers (PCPs) to identify and connect with the right in-network providers.

For more information about care coordination, please call 1-844-218-3906.

#### APPROVAL FACTORS

Whether a service is covered or approved depends on many factors.

- In most instances, the attending physician or specialist will have to prove medical necessity, meaning that the procedure they're performing is medically appropriate to diagnose or treat a condition, disease, illness, or injury.
- Even if a medical procedure is determined to be medically necessary, approval is not a guarantee of payment.
- Your provider will take the necessary steps to determine if your health plan will cover the services and verify eligibility information.
- To obtain a complete list of services requiring precertification of benefits, please call us at 1-866-945-2292.

#### AS A CONSUMER, YOU HAVE RIGHTS

- There is the possibility that the medical service or procedure can be denied. In that event, it is your attending physician's responsibility to file an appeal on the denial with the precertification company and ask for a reconsideration. The appeal must be filed within 180 days of receiving the denial letter.
- During reconsideration, your performing doctor and a doctor from the precertification company will do a physician peer-to-peer review.

The process can take as little as a phone call or up to several weeks.

A procedure can still be denied after reconsideration, at which point the appeal is addressed to the health plan or an independent review organization, though it is rare.

For benefits or eligibility questions you can check your SPD online or contact the Customer Experience Team at 1-866-945-2292.

#### **MAKE SURE YOUR AFFAIRS ARE IN ORDER**

- As grim as it might sound, having a chosen health care directive can make it less stressful in the event of a serious injury or illness for which tough medical choices will be necessary.
- A health care directive is a legal document that sets forth what your wishes are if you're unable to communicate or make healthcare decisions. In this document, you would appoint the individual who is tasked with making medical decisions for you.
- Preparing for the unexpected ahead of time can make the process less stressful.
- If you have children or pets, make sure you plan for how to care for them in your absence.

#### **FOLLOW-UP CARE IS KEY TO RECOVERY**

- As part of your discharge, a nurse or other health care provider will go over any instructions on diet, medicine, and/or care before you leave.
- Make sure you have phone numbers of who to call if you experience complications.
- If you're experiencing a life-or-death complication post-surgery, call 911.
- A service of your care coordination benefit is transition of care, where our dedicated care coordination team helps you come home from a hospital or care facility.

To learn more about this benefit, please call care coordination at 1-844-218-3906.



#### **Questions?**

We are here for any questions you have. Our Customer Experience Team can be reached at 1-866-945-2292, Monday-Friday from 8am-5pm CST.





**Benefits** 

Gain control and a sustained, healthier, and more engaged workforce.

## Care Coordination.

This employee benefit includes a care coordination team dedicated to helping you navigate and make the most of your healthcare services. You have access to a confidential team of professionals that provides you with personalized, one-on-one, care coordination and navigation assistance to help eliminate barriers to your health care needs. Your care coordination team works directly with you and your primary care providers (PCPs) to identify, understand, and take control of health risks and chronic diseases so that you have the best health outcomes possible.



#### **Care decision support**

Helping members decide where and when to seek medical care



#### **Quality and prevention**

Helping members use preventive measures to maintain a healthy lifestyle



#### Chronic disease support

Helping members with chronic disease maintain a healthy lifestyle



#### **Complex care support**

Helping members maintain a healthy lifestyle when facing a major health event



#### **Medication support**

Helping members understand their medications and take them correctly



#### **Transition of care**

Helping members come home from a hospital or care facility



#### **Behavioral Health**

- Supporting members with chronic medical problems, intellectual disabilities, behavioral health issues, and substance abuse disorders in-between visits with your primary provider.
- Comprehensive care planning, care coordination and support ensures a continuous relationship between the you, your primary provider, and the care team.



#### **Provider Selection Assistance**

- Helping you locate the right doctor or facility based on your needs.
- Screening for in network/out-of-network status, if new patients are being accepted, if providers are close to home, office, or school, and if the provider is open during the hours that work for you.
- Helping you make the appointment and following up to ensure satisfaction.

## Virtual Care, Anywhere!



With MDLIVE, you can access a doctor from your home, office, or on the go—24/7/365. Our Board Certified doctors can visit with you either by phone or secure video to help treat any non-emergency medical conditions. Our doctors can diagnose your symptoms, prescribe medication\*, and send prescriptions to your pharmacy of choice.

#### Let's start. How it works.



#### 1. Activate your account

Sign up online by going to www.mdlive.com/hch or download our app.



#### 2. Choose a doctor

Choose from a large network of board-certified doctors.



#### 3. Resolve your issue

Receive care when you need it. Call (855) 848-8813.

#### How much does it cost?

#### Activating an account is free!

The cost of your visit will be presented when you're scheduling your visit.

www.mdlive.com/hch



#### What can be treated?

Acne

Allergies

Constipation

- Cough

Sinus infection

- Diarrhea
- Sore throat
- Sport injuries
- Nausea
- Pink Eye
- Rash
- Respiratory Problems
- Sore Throats
- Vomiting
- ... and more



<sup>\*</sup>Please note: Some state laws require that a doctor can only prescribe medication in certain situations and subject to certain limitations.

## Preventive Services.



Our priority here at Healthcare Highways is your health. We are laying the groundwork for a healthy tomorrow by offering preventive care with the goal of disease prevention and early detection for all our members. Many chronic diseases and conditions can be prevented and/ or managed through early detection. Preventive screenings are an important way to track your health and avoid chronic conditions before they become more serious.

Please take full advantage of your preventive care benefits and other available wellness resources. The list below is not all-inclusive, depending on the specifics of your health plan. Please refer to your Summary Plan Description (SPD) for a complete list of preventive services.

CHILDREN + ADOLESCENTS	ADULTS	WOMEN
Well-Child Exam  History and physical exam  Measurements (height, weight, and BMI)  Hearing screening Iron supplementation  Behavioral Assessments  Immunizations  Diphtheria, Tetanus, Pertussis  Hepatitis A and B  HPV  Influenza (Flu)  Measles, Mumps, Rubella  Meningococcal  Pneumococcal  Screening Tests  Screening for hearing loss, hypothyroidism, sickle cell disease, PKU  Hematocrit and Hemoglobin  Obesity screening and counseling  Lead screening  Screening for sexually transmitted infections  Depression screening  Preventive Treatments  Gonorrhea preventive medication for eyes of all newborns	Preventive Exam  History and Physical Exam Measurements (height, weight, and BMI)  Immunizations Hepatitis A and B HPV Influenza (Flu) Measles, Mumps, Rubella Meningococcal Pneumococcal Varicella (chickenpox)  Screening Tests Abdominal Aortic Aneurysm screening Blood Pressure Cholesterol Colorectal cancer screenings using fecal occult blood testing, sigmoidoscopy, or colonoscopy for adults over age 50 Depression screening Diabetes screening for adults with high blood pressure  Health Counseling Alcohol misuse screening and counseling Prevention of sexually transmitted infections Tobacco use cessation	<ul> <li>Annual well woman visit</li> <li>Breast cancer prevention medication</li> <li>Breast cancer screening / screening mammography</li> <li>Cervical cancer screening including Pap smear</li> <li>Osteoporosis screening</li> <li>Genetic counseling and evaluation for BRCA testing where family history is associated with an increased risk</li> <li>Human Papillomavirus DNA test</li> <li>Contraception</li> <li>Specifically for Pregnant Woman</li> <li>Alcohol misuse screening and counseling</li> <li>Anemia screening</li> <li>Bacteriuria screening</li> <li>Rh incompatibility screening</li> <li>Gestational diabetes screening</li> <li>HIV screening</li> <li>Screenings for STD's</li> <li>Tobacco use and cessation counseling</li> <li>Venipuncture for pregnancy required labs</li> </ul>

#### **The Care Continuity and Support Program**

Healthcare Highways (HCH) Care Continuity and Support (CCS) program for qualified members is a process of approving in-network benefits for an out-of-network provider on a limited basis. This program is a Healthcare Highways initiative to ensure members safely transition to our provider network during certain active medical treatments. HCH collaborates with the member's current care team, the Healthcare Highways (HCH) care team, and our provider network. If approved for the program, members can continue to receive care for a defined period of time at their in-network benefit level from providers that are not included in the HCH provider network. HCH is committed to working with the member and their existing care team to safely transition care to a participating HCH provider, without adversely affecting a member's health. The review process begins once HCH receives a completed CCS application form.

#### Who qualifies for Continuity of Care and Support?

To qualify for CCS, a member must:

- be eligible as a covered employee or dependent as determined by the individual's employer; and,
- 4) have a coverage policy that provides coverage for the requested services; and,
- 3) have a medical condition or require medical services that are not adequately provided in-network, could lead to a deterioration of the member's health, and qualify for transition based on medical necessity review.

to make a safe transition, HCH provides the member with a care coordination team to help manage the member's care needs as they transition to a Healthcare Highways network provider, which generally takes 30 days.

#### **EXAMPLES OF CONDITIONS OR CASES THAT MAY QUALIFY FOR CCS**

HCH reviews CCS applications on an individual basis with expert medical review and corroboration from the providers referenced in the member's application form. While each case requires a clinical review of the specific CCS request, listed below are some medical conditions that generally will receive CCS program authorization.

- Women who are more than 20 weeks pregnant
- Diagnosed high risk pregnancy
- Members hospitalized on the start date of their HCHbenefits
- Members with acute conditions that require active treatment, such as heart attacks and/or unstable chronic conditions.
- Members currently scheduled for surgery or multiple surgeries after the date of coverage begins
  with HCH (generally non-elective surgeries only or those that cannot be safely transitioned to HCH
  network providers)
- Members actively receiving chemotherapy, radiation therapy, other forms of cancer treatment, or follow-up surgery
- Members actively being treated for certain mental health conditions or substance abuse conditions
- Members who have had recent surgery and are being seen for post operative care (generally six to eight weeks following surgery)
- Members diagnosed with a terminal illness or are in palliative care or hospice
- Members who are approved for transplantation, approved and currently waiting for a transplant organ, placed on a transplant list; or have had an organ or bone marrow transplant
- Member's HCH provider leaves the network

#### **Requesting Approval for the Continuity of Care and Support Program**

Members who believe they qualify for CCS should submit a CCS application to HCH during the open enrollment process or within 30 days of the member's insurance coverage start date. Members who submit the application form 30 days or more after HCH coverage begins will need to provide an additional statement pertaining to the special circumstances for delayed submission. In the event a member does not receive authorization for CCS, costs for services rendered through non-HCH providers may be the responsibility of the member or covered under a member's out-of-network benefits, if available.

#### **Continuity of Care and Support Review and Approval Processes**

#### **Continuity of Care and Support review process**

Healthcare Highways believes that care is personalized and individualized for every member. HCH will perform a timely review of each case. CCS applications are reviewed by our clinical team who consults, as necessary, with an individual's current care providers if required to make a clinical determination before approving care continuation. Emergent or urgent situations will be prioritized. A decision on urgent reviews will be made within five business days of HCH's receipt of the completed Application Form. The individual requesting CCS services will be initially notified by telephone and provided options for continuing care in accordance with a personalized care plan. Formal written notification will occur within 21 business days.

#### **Continuity of Care and Support approval process**

Approved CCS services will be covered at the individual's in-network benefits level. Members who have out-of-network benefits may choose to continue their care at the out-of-network benefit level with providers not in the HCH provider network if their CCS request is not approved or after any CCS coverage ends.

Approved CCS requests allow for care continuation with the approved provider(s) not participating in the HCH provider network for the condition(s) approved within the time frame authorized. Individuals approved for CCS services who have additional health care conditions that have not been approved through the CCS process should receive care for such conditions from HCH network participating provider(s) or choose to use their out-of-network benefits, if available, for those services. It is rare that a request for continuing care at a health care facility, durable medical equipment or home care company, or pharmacy receive authorization under the CCS program.



#### **Application Form**

Download your application form at **www.hchhealthplan.com** 

Mail completed form to:

Healthcare Highways, Inc. 3001 Dallas Pkwy., Ste 700 Frisco, TX 75034

For more information about this program or to talk to a Healthcare Highways representative, please reach out in the way that's easiest for you. We're here to help with your healthcare needs.



#### **Diabetes and Coronary Artery Disease**

At Healthcare Highways your health is our main priority. In fact, your health is so integral to our mission that we've invested double the resources typical health insurers invest in preventive care for chronic conditions such as diabetes and coronary artery disease. This translates to double the typical benefits for chronic conditions.

We know that living with a chronic condition such as diabetes or coronary artery disease takes more than an individual; it takes a village. From seeing specialists to managing your medication, to coordinating health visits, we want you to know we are here for you every step of the way.

The services below are built into all plans and paid at 100% when rendered by an in-network provider. After the limit is met, the benefit is payable at the corresponding benefit level. Below is a list of benefits for both diabetes and coronary artery disease.



#### **Diabetes**

- Hemoglobin A1C Test 4 per year
- Lipid Profile Test 2 per year
- Dilated Eye Exam 1 per year
- Physician Office Visits 4 per year
- Glucose Sensor Required PA
- Diabetes Education First year 10 sessions, 4 hours next 2 years (a session is per service billed)
- Podiatric Visits 1 per 6 months



#### **Coronary Artery Disease**

- Physician Office Visits 2 per year
- Lipid Profile 1 per year
- Dietary Consultation or Counseling 3 per year
- · Baseline EKG

If you have any further questions, please refer to your Summary Plan Description (SPD) document, accessible anytime by going to HCHHealthPlan.com and logging into the health plan member portal, located on the left side of the home page.



#### **Questions?**

If you have further questions about these benefits, please call our Customer Experience Team at 1-(844) 869-5640 Monday through Friday, 8 am to 5 pm CST.





Here for all of your pharmacy needs.

#### CerpassRx is pleased to administer your prescription benefit plan

### Welcome!

CerpassRx is an innovative Pharmacy Benefit Administrator that offers access to pharmacies in your local community and tools to assist you in managing and navigating your prescription benefit. We are a member centric PBM with key partnerships uniquely positioned to develop best in class pharmacy solutions.

First, please review your ID card for our logo, or verify with your employer that you are covered by CerpassRx for your pharmacy benefit plan. CerpassRx members are able to access our pharmacy benefit plan resources in a number of ways:



#### **Member Services Support Center**

Available to our members 24 hours a day, 7 days a week, 365 days a year. Please contact us at 844-636-7506 for any questions regarding your pharmacy benefits, drug coverage, etc.



#### **Member Web Portal**

Visit http://www.cerpassrx.com/members-page/ to access the following information:

- Medication History
- Participating pharmacy locations
- Compare pharmacy copays to determine the most cost-effective options



#### **Mobile App**

Download the CerpassRx mobile app to access information and tools to help maximize your pharmacy benefit. These programs offer members convenience and easy access to information anytime from a mobile device.



#### **Mail Delivery and Specialty Programs**

Save time by getting medicine conveniently delivered to your home. Mail Delivery allows our members to receive maintenance and specialty prescriptions through the mail, as well as receive refill reminders and many other services. We also offer counseling, education and many other value-added services to our members involved in our specialty pharmacy programs.







Access your private secure member portal today. visit www.cerpassrx.com - Member Portal

This private, secure website is designed just for you. Your pharmacy plan information is available and kept up-to-date in real time.

#### Easy access allows you to:

- Manage all your prescriptions on a single dashboard
- Keep track of your health history
- Learn more about your prescription drugs
- Compare prices at local pharmacies
- Find your lowest prescription cost
- Transfer your prescription to a different pharmacy
- Locate your pharmacy and get driving directions
- Track your individual and family spend
- Take it all with you through the mobile app

#### **How to register:**

Visit http://www.cerpassrx.com/members-page/ and click on the member portal button. With your CerpassRx ID card handy, click "activate your account".

From there, enter your member ID (as shown on your ID card) and proceed with completing your personal information to activate your account.



#### **Mobile App**

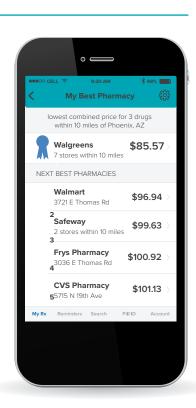
The mobile app provides easy, on-the-go access to your personalized health information.

Once you have your member ID number, download the app to take advantage of the benefits your pharmacy plan offers.

#### **How to register:**

- Review medication history
- Locate participating pharmacies
- Track individual and family spend
- Schedule refill reminders
- Learn about medication side effects and interactions
- Compare pharmacy copays for the most cost-effective options

Get the app by searching for CerpassRx at the Apple App Store or Google Play.





**Additional Plan Details** 



## **Healthcare Highways Member Portal**

Access to everything you need to quickly and easily manage your account information.

Welcome to the HCH Member Portal Guide. Your member portal provides you access to all your personal, claim, and eligibility information, plus a whole lot more. This guide will step you through setting up and using this powerful tool. Let's get started!

## Login



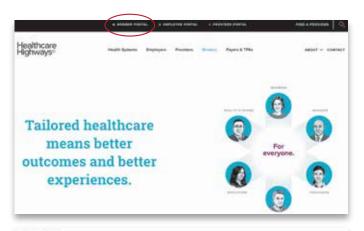
Go to www.healthcarehighways.com. You will be brought to the home page

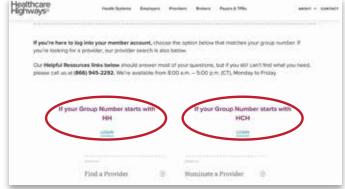
#### STEP 2

At the top of the page, select "Member Portal".

#### STEP 3

Have your ID card ready and check whether your group number starts with "HH" or "HCH". If your ID card starts with "HH", click on the button on the left-hand side that says "HH Login". If your ID card starts with "HCH", click on the button on the right-hand side that says, "HCH login". You will be taken to the member portal.







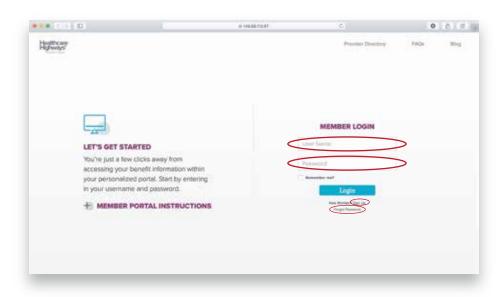
Enter your username and password if you have an existing account. If you are a new member, under the "Login" button, click on "Sign up". This will take you to a form where you will enter your information. You will then get a verification email.

Forgot your password? Click the "Forgot Password" button and enter the valid username. Click the "Send Password" button. The password is sent to the registered email.

#### STEP 5

Once logged in, you will be taken to the home page.

At the top of the home page, you will have different tabs available that allow you to view your claims and eligibility, view, print, and order new ID cards, update your personal information, search for a provider and much more.





## Coverage



#### STEP 1

At the top of the home page, click on the "Coverage" tab to access eligibility information.

#### Top toolbar navigation



Once you click on "Coverage", your information should auto-populate.

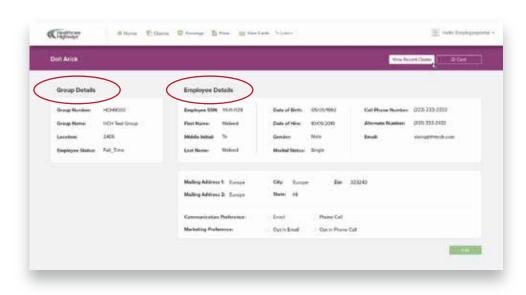
#### **Group Details**

This area allows you to view the basic details of the employee group and employment status.

#### **Employee details**

This area allows you to view the personal information of the insured employee.

Please note that you can update your personal information by clicking the green "edit" button at the bottom right.



#### **HIPAA Release Forms**

This area allows you to manage the authorized caller information for the insured employee.

To add an authorized caller for a HIPAA release form, click on the green button on the right hand side that says, "Add authorized caller". A form will appear for you to fill.

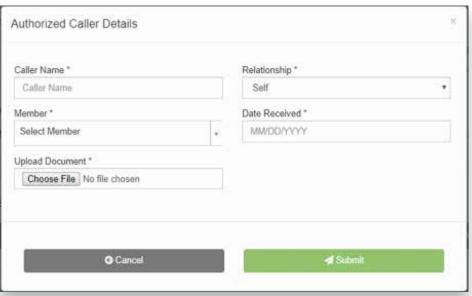
As appropriate, specify the following fields information: Caller Name, Relationship, Member, Date Received, and Upload Document.

Click the Submit button.
The new authorized caller details are added in the HIPAA Release Forms area.

#### **Member Details**

This area allows you to view and manage information about your plan.

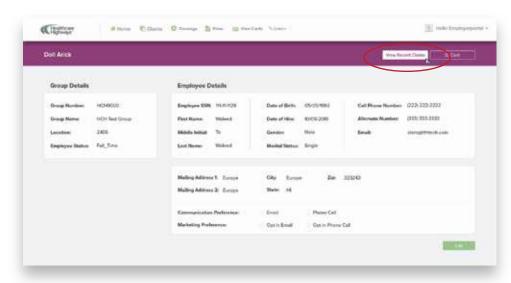






To view recent claims click the button in the purple toolbar located in the upper right corner.

This is also a quick way to view your ID card information as well. You can locate that button to the right of the "View Recent Claims" button.



#### **Recent Claims**

This area allows you to view the recent claims and EOB document information of the member.



#### **Notes**

This area allows you to view the important notes regarding your enrollment.



#### **Enrollment Forms**

This area allows you to view and manage your enrollment form details. By clicking on the icon on the left side below the word "Action" you can access enrollment information as well as add dependents. Once you have made any changes, make sure to check the box at the bottom on the left-hand side and click "submit".



#### **Employee Page History**

This area allows you to view the details of the user activity and changes made to the information on the employee page.



## ID Cards

#### STEP 1

To access ID cards, go to the home page. At the top of the page, you'll see a menu with tabs. Look for the tab that says "View Cards".



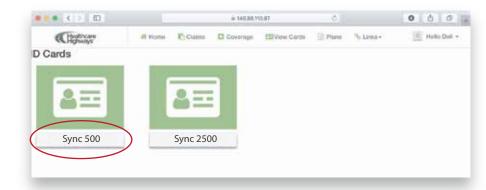
#### STEP 2

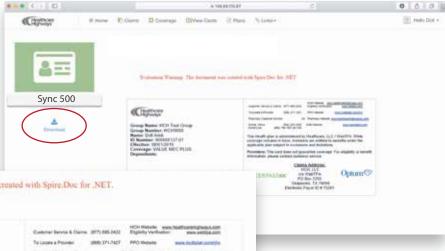
Click on the "ID Cards" tab. You will be taken to a page with your listed ID card(s).

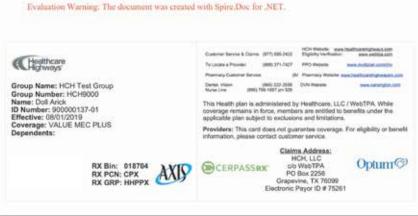
#### STEP 3

Click on the ID card(s) you wish to view. If you want to download an ID card, click on the "Download" icon on the left-hand side.

Once you download the document, feel free to use this as a temporary ID card if you're in the process of waiting for a new one to be mailed.







## Plans

#### STEP 1

To access your plan documents, go to the home page. At the top of the page, you'll see a menu with tabs. Look for the tab that says "plans".



#### STEP 2

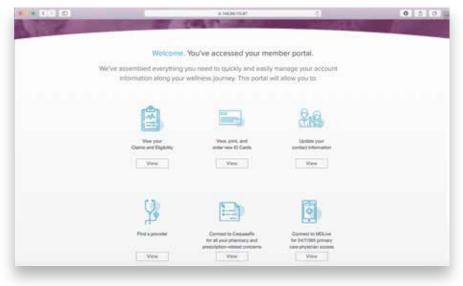
Under plan documents you can view your SPD and SBC. Click on either button to access details related to your plan. You also have the ability to upload files straight to your computer.



## Quick Tip

#### **Home Page**

In addition to your main toolbar, look for the helpful icons on your home page. They are there to assist and lead you to quick and easy access.





#### Glossary of Terms

## Member FAQ.



Understanding your health plan may require learning some new terms. We're here to help. This document includes terms frequently used within the healthcare industry. Need additional help? Our Member Services Team is here to provide extra support 8 AM to 5 PM, Monday through Friday: 1-(844) 869-5640



A: The pre-planned, organized patient care activities provided by a team of healthcare providers to ensure that patient care is efficiently and appropriately delivered across the care continuum.

Q: What is a Care Coordination Team? What Does A Care Coordination Team Do?

A: A team of healthcare professionals, led by a Registered Nurse, that includes a Care Coordination Specialist, a Pharmacist, and Social Worker that creates a personalized care plan for members.

Q: What is Co-insurance?

A: Coinsurance is a percentage of a medical charge that you pay, with the rest paid by your health insurance plan, after your deductible has been met. For example, if you have a 20% coinsurance, you pay 20% of each medical bill, and your health insurance will cover 80%.

 $\stackrel{ ext{$\widehat{\mathbb{Y}}$}}{\mathbb{Q}}$  What is a Comprehensive Deductible?

A: A deductible is your 1st dollar responsibility applied across all your medical expenses.

Those 1st dollars expenses accumulate until the total deductible amount is met.

 $\Psi \mathsf{Q}$ : What is Coordination of Benefits?

**A:** When health insurance benefits are available to one person from different sources, reviewed and arranged by your health insurer. For example, both working spouses carry insurance on each other.

**Q**∶ What is a Copayment?

A: Your copayment is a predetermined fee you pay for health care services at the time of care. For example, you may have a \$25 copay every time you see your primary care physician, a \$10 copay for each monthly medication and a \$250 copay for an emergency room visit.

**Q**: What is a Coverage Limit?

A: These costs do not apply to your deductible, but are covered by your policy to a certain dollar amount or limited to a number visits. The difference between the cost and the limit amount is paid by the policy holder.

**Q**∶ What Are Coverages?

**A:** Medical expenses or costs that are covered entirely, covered partially, or not covered at all by your health plan policy.



#### **Q**∶ What is a Cumulative Deductible?

A: Deductibles that combine all the medicial expenses of all members of a family or policy towards the deductible—a family maximum deductible.

#### Q: What is a Deductible?

A: The deductible is how much you pay before your health insurance starts to cover a larger portion of your bills. In general, if you have a \$1,000 deductible, you must pay \$1,000 for your own care out-of-pocket before your insurer starts covering a higher portion of costs. The deductible typically resets yearly.

#### **Q**∶ What is Dual Coverage?

A: Being covered by two health insurance plans and/or supplemental health insurance plans. (Often the insured is the primary enrollee in only one of the plans.)

#### **Q**∶ What are Exclusions?

A: Medical expenses or procedures not covered by your insurance plan.

## Q: What is an Exclusive Provider Organization (EPO)?

A: With an EPO a member can choose from providers within the pre-selected network without having to choose or first see a primary care physician (PCP), but any out-of-network services may not be covered.

## Q: What is Fee-for-Service (FFS) & How Does It Impact Me?

Fee-for-service is transactional and incentivizes providers to do more: more labs, more tests, and sometimes more surgeries, which means less effective care for patients. For providers, this translates to less time with patients and more time dealing with the "administration" of health care.

#### Q: What Is a Flexible Savings Account?

**A**: A Flexible Spending Account (also known as a flexible spending arrangement) is a special account you put money into that you use to pay for certain out-of-pocket health care costs. You don't pay taxes on this money.

#### Q: What is a Drug Formulary?

A: A list of covered prescription drugs. Also referred to as a "drug list."

#### ${\P}^{\mathbb{Q}}$ Q: What is a Health Insurance Grace Period?

**A**: The amount of time you have to pay your premium after the due date before losing your coverage through cancellation.

#### ${\P} {\sf Q}$ : What is a Health Insurance Waiver?

A: A health insurance waiver is a formal, signed opt-out of a health insurance plan.

## **Q**: What is a Health Maintenance Organization (HMO)?

A: An HMO is a type of medical insurance group that provides limited medical care coverage to its members via doctors and healthcare providers who are in the HMO network.

## Q: What is a Health Reimbursement Arrangement?

**A:** HRAs are provided and designed by your employer to hold pre-tax money for medical expenses not paid by your health insurance plan.

#### $^{\textcircled{\$}}\mathsf{Q}$ : What is a Health Savings Account?

A: Generally, HSAs supplement insurance coverage, by holding pre-tax money added by your (and/or) your employer for future medical expenses not covered by your health insurance that is accessed by debit card or reimbursed after care is rendered and transfers over from year to year. Only people who have a high-deductible health plan, or HDHP, can select an HSA.

#### $\stackrel{ ext{$\widehat{\mathbb{Y}}$}}{\mathbb{Q}}$ What Is High-performance Network?

A: A carefully curated network of service providers that have agreed to be held to certain financial and patient outcome metrics and demonstrated track record to provide high-quality care with a lower total cost of care.

#### $\stackrel{ ext{$\widehat{\mathbb{Y}}$}}{\mathbb{Q}}$ . What is an Indemnity Health Insurance Plan?

A: With this plan a member can choose any service provider, primary care physician (PCP), self-refer to any specialist, and have a previously set portion of the costs paid.

#### ♥Q: What is an Individual Deductible?

A: A deductible that separates how much each individual under a health plan's coverage has paid toward the deductible.

#### $\Psi \mathsf{Q}^{:}$ What is a Lifetime Maximum?

A: The most a health insurance policy will pay for the entire life of the insured/policyholder.

#### $\stackrel{ ext{$\widehat{\mathbb{Y}}$}}{\mathbb{Q}}$ What is a Managed Health Care Plan?

A: A type of cost-e ective healthcare plan that provides a health insurance policy to individual members of a group or employer. Examples of the various types of these plans are HMO, PPO, POS, EPO plans.

#### **Q**∶ What is Multi-State Insurance?

A: This kind of insurance plan operates a plan in multiple states and does not necessarily mean you are covered in all 50 United States.

#### Q: What is a Network?

A: The group of physicians, hospitals, ancillary and other providers who have contracted with your health insurer to provide in-network services.

#### Q: What does it mean to be In-network?

A: In-network providers are those that have contracted with your health plan and agreed upon the rates the provider will be paid. You receive the highest level of coverage (least out of pocket costs) when you receive in-network care from providers in your health plan network.

#### $\stackrel{ ext{$\widehat{\mathbb{Y}}$}}{\mathbb{Q}}$ What does it mean to be Out-of-network?

A: This refers to a provider with which your insurance plan has not negotiated a discounted rate. If you get care from an out-of-network provider, you may have to pay the entire bill yourself or just a portion. Your portion of out-of-network charges should be indicated in your insurance policy summary.

#### $\stackrel{ ext{$\widehat{\mathbb{Y}}$}}{\mathbb{Q}}$ What is a Non-comprehensive Deductible?

A: A deductible that only applies to specific medical expenses in your health insurance policy.

## Q: What is an Out-of-Pocket medical expense/coverage?

 $^{\textcircled{\text{P}}}$ **A**: How much your plan will cost you, personally.

#### ${\P} {\sf Q}$ : What is an Out-of-pocket maximum?

A: Out-of-pocket maximum is the most you could have to pay in one year, out of pocket, for your health care before your insurance covers 100% of the bill. In Affordable Care Act plans sold on marketplaces, the 2016 limits are \$6,850 for an individual and \$13,700 for a family, but yours may be different if you have an employer-sponsored policy.

#### Q: What is a Point of Service Plan (POS)?

A: With a POS, members can choose their own primary care physician (PCP) that has agreed to provide discounted services; however, members must always refer to their PCP first before seeing a specialist.

#### $\stackrel{ ext{$\widehat{\mathbb{Y}}$}}{\mathbb{Q}}$ . What is Population Health Management?

A: Strategies and Programs that improve service quality, reduce total cost of care, enhance patient experience, and increase provider engagement.

#### $\stackrel{ ext{$\widehat{\mathbb{Y}}$}}{\mathbb{Q}}$ . What is a Pre-existing Condition?

A: A medical condition the insured/policy holder had before an insurance policy begins.

## Q: What is a Preferred Provider Organization (PPO)?

A: A PPO reduces costs for member through negotiation with specific service provides, but allows you to choose your Primary Care Physician.

#### $^{\widehat{\Psi}}\mathsf{Q}^{:}$ What is a Health Insurance Premium?

A: A monthly payment you make to have health insurance. Like a gym membership, you pay the premium each month even if you don't use it, or you lose coverage. If you're fortunate enough to have employer-provided insurance, the company pays up all or part of the premium.

#### **ਊ**Q∶ What is Preventive Care?

A: Any medical service that helps to protect your against (often costly) health emergencies or medical interventions (drug therapies and/or surgery).

#### **Q** What is a Primary Care Physician (PCP)?

A: A health care professional who practices general medicine that is usually a doctor, but may also be a nurse practitioner or a physician assistants.

#### **Q** What Is Prior Authorization?

A: Special approval or authorization required by your health plan to have certain prescriptions prescribed by your primary care physician filled.

#### $\Psi$ Q: What is a Medical Provider?

A: A medical provider used to be known as a doctor or hospital. Because the types of professionals who treat people is so broad, the general term "medical provider" evolved. If you can substitute in your mind the name of a doctor or a hospital, it is probably a medical provider.

#### **Q**∶ What Is Step Therapy?

A: Covered prescriptions are organized in a series of steps: The first step usually includes generics, the second step brand-name more expensive options.

## Q: What is the difference between Self-Funded or Fully-Insured?

A: With a self-insured (self-funded) health plan, employers (usually larger) operate their own health plan as opposed to purchasing a fully-insured plan from an insurance carrier. Employers choose to self-insure because it provides greater savings potential; however, self-insuring exposes the company to much larger risk in the event that more claims than expected must be paid. Reinsurance is often purchased to lower the employer's exposure. This is called Partial Self-Insurance.

#### $\Psi Q$ : What is a Waiting Period?

**A:** How long you must wait until specific coverages are available to you through your health insurance plan.

#### **Member Rights.**

Healthcare Highways is committed to preserving and respecting members' rights. We expect our network providers, including individual practitioners, to act in accordance with these rights.

#### As a member, you have the right to:

- Receive accurate, easy-to-understand information about Healthcare Highways, the services we provide, the providers in our networks, fair treatment by Healthcare Highways Network providers, and facilitation of contact regarding concerns about Healthcare Highways services.
- Be treated with respect and recognition of your dignity and the right to privacy, including protecting the confidentiality of medical and other personal information and your right to review your medical and personal information on file at Healthcare Highways, as required by applicable state and federal law.
- Communicate with providers in making decisions about your healthcare without interference from Healthcare Highways.
- Register complaints about Healthcare Highways, our services, determinations, or the care provided by a
  Healthcare Highways network provider, including the right to have complaints addressed in a timely manner
  through formal procedures that are appropriate to the nature of the complaint.
- Choice of healthcare providers from the Healthcare Highways Network, consistent with the terms of your health benefit plans and applicable state and federal law.
- Receive healthcare services without discrimination, as Healthcare Highways network providers are precluded by
  contract from differentiating or discriminating against members in the provision of healthcare services because
  of certain member characteristics and are required to render such services to all members in the same manner,
  in accordance with the same standards, and with the same availability offered to the network provider's other
  patients.

#### Statement of Members' Rights and Responsibilities.

#### As a member, you have the responsibility to:

- Supply information (to the extent possible) that Healthcare Highways and its providers need to provide care Follow the plans and instructions for care to which you have agreed with your providers.
- Ask questions necessary to understand your health problems and participate with your providers in developing and complying with mutually agreed-upon treatment goals.
- Healthcare Highways uses its best efforts to ensure that all members are afforded these rights. If you feel that your rights as a member have not been met, Healthcare Highways has a formal complaint-resolution process you can use.

To begin the complaint resolution process, please describe your complaint in writing, include your complete contact information, and mail to:

Healthcare Highways P.O. Box 2476 Grapevine, TX 76099



