

GUIDE TO YOUR HEALTH CARE, PRESCRIPTION DRUG AND DENTAL PROGRAM



HOCKING ATHENS PERRY COMMUNITY ACTION

3 Cardaras Drive
P. O. Box 220
Glouster, OH 45732



Benefit Assistance
CORPORATION

Administered by: Benefit Assistance Corporation
P. O. Box 790
Ripley, WV 25271

Benefit Assistance Corporation is now your Health Care, Prescription Drug and Dental Program's Third Party Administrator to process and provide claim administration for your Plan. *Hocking Athens Perry Community Action* is making a strong commitment to assure you and your family receive quality Health Benefits.

HOW DOES THIS AFFECT OUR BENEFIT PLANS?

- Medical Mutual of Ohio's SuperMed Network is still your primary PPO network.
- 4Most Health Network has been added as an additional PPO option, primarily for West Virginia providers.
- MultiPlan has been added as a travel network.
- Your Pharmacy Management Program is still Walgreens.
- Your new ID card has a unique "de-identified" ID number to comply with HIPAA. Your social security number and your ID number are interchangeable.
- Your dental benefits have not changed.
- You should continue to use your current Plan Document as a source of information until you receive a new one.

WHAT DO I DO WHEN I HAVE A CLAIM?

- A completed claim form may be required with your initial claim. You will be notified if one is needed.
- An itemized provider's bill must be submitted for payment, either directly by the provider or by you. Balance due bills do not contain sufficient information for a claim to be paid.
- If additional information is required to process a claim, such as other insurance information, accident details or full time student verification, you will receive notification through the mail from Benefits Assistance Corporation (BAC).
- All information necessary for a provider to submit a claim is provided on your new ID card.
- The number to use for precertification is located on your ID card for your convenience
- A medical and dental claim form is included and may be duplicated as needed. Claim forms are also available on-line at www.bacwv.com .

Plan Name:

Return this form to the claims processor:

MEDICAL CLAIM FORM	HOCKING ATHENS PERRY COMMUNITY ACTION	Benefit Assistance Corporation
	HEALTH CARE, PRESCRIPTION DRUG AND DENTAL PROGRAM	PO Box 790, Ripley, WV 25271 Phone: (304)372-7035
	Plan Administrator and Sponsor: Hocking Athens Perry Community Action	Electronic Claims Submission: www.eedi.net Clearinghouse ID: 135221807
		PRE-CERTIFICATION # 1-800-247-8956

Group Accident and Sickness - Hospital - Surgical - Medical Benefits

*****IMPORTANT*** COMPLETE CLAIM FORM FULLY AND ACCURATELY. FILING OF FALSE CLAIMS WILL RESULT IN LEGAL ACTION TO THE FULLEST EXTENT POSSIBLE AND THE DENIAL OF FUTURE BENEFITS.**

PART 1 - TO BE COMPLETED BY EMPLOYEE

EMPLOYEE NAME		SOCIAL SECURITY OR MEMBER ID NUMBER	
EMPLOYEE ADDRESS	NUMBER AND STREET	CITY	STATE ZIP CODE
<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH	OCCUPATION
NAME OF SPOUSE	SPOUSE'S EMPLOYER	SPOUSE'S EMPLOYER ADDRESS	

IF AN ACCIDENT WAS INVOLVED, ANSWER THE FOLLOWING

When did the accident happen? Date: _____ at (hour) _____ a.m. p.m.

Was the injured person at work when the accident happened? Yes No Was an automobile accident involved? Yes No

Give a brief description of the accident. _____

IF PATIENT IS THE EMPLOYEE, ANSWER THE FOLLOWING:

On what date were you first totally disabled by the sickness or injury? _____

On what date were you first treated by a physician? _____

On what date did you last work? _____

Have you returned to work? _____ If so, on what date? _____ If not, when do you expect to return to work? _____

IF CLAIM IS FOR DEPENDENT, ANSWER THE FOLLOWING:

DEPENDENT NAME		RELATIONSHIP	
DEPENDENT ADDRESS (IF DIFFERENT)	NUMBER AND STREET	CITY	STATE ZIP CODE
<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH	FULL-TIME STUDENT? <input type="checkbox"/> Yes <input type="checkbox"/> No
NAME OF SCHOOL			
If child is 19 years old or older is s(he) employed on a full-time basis? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, name of employer: _____	
Are any other <u>group benefits</u> provided to <u>you</u> or <u>your</u> dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, policy number: _____	
Name and address of the Insurance Plan or Company: _____			

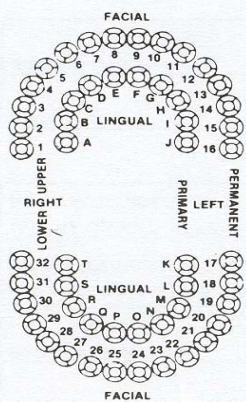
I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true, correct and complete. I hereby authorize any physician, or any hospital, to furnish and disclose all known facts concerning this medical claim to Hocking Athens Perry Community Action Agency, Inc. Health Care, Prescription Drug and Dental Program in which I am a Participant. A copy or photocopy of this authorization shall be valid as the original.

Date this Claim _____ Employee's
Form Signed: _____ Signature: _____

**THE ATTENDING PHYSICIAN MAY COMPLETE THE REVERSE SIDE OF THIS FORM
OR PROVIDE AN ITEMIZED STATEMENT.**

DENTAL CLAIM FORM (CHECK ONE) <input type="checkbox"/> Pre-treatment Estimate (Services in Excess of \$200)* <input type="checkbox"/> Actual Charges	HOCKING ATHENS PERRY COMMUNITY ACTION HEALTH CARE, PRESCRIPTION DRUG AND DENTAL PROGRAM Plan Administrator and Sponsor: Hocking Athens Perry Community Action	Benefit Assistance Corporation PO Box 790, Ripley, WV 25271 Phone: (304)372-7035 Electronic Claims Submission: www.eedi.net Clearinghouse ID: 135221807
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TO BE COMPLETED BY EMPLOYEE			
EMPLOYEE NAME		SOCIAL SECURITY OR MEMBER ID NUMBER	
EMPLOYEE ADDRESS	NUMBER AND STREET	CITY	STATE ZIP CODE
<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH	TELEPHONE NUMBER
ARE GROUP HEALTH INSURANCE BENEFITS PAYABLE FROM ANY OTHER SOURCE FOR THE EXPENSES SUBMITTED? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF "YES": (A) INSURING ORGANIZATION: (B) EMPLOYER:	
IF CLAIM IS FOR DEPENDENT ANSWER THE FOLLOWING QUESTION:			
DEPENDENT NAME		RELATIONSHIP	
DEPENDENT ADDRESS (IF DIFFERENT)	NUMBER AND STREET	CITY	STATE ZIP CODE
<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH	EMPLOYER OF DEPENDENT
AUTHORIZATION			
I authorize release to Hocking Athens Perry (The Plan) in which I am a Participant of any information required to process my claim. A photocopy of this authorization may be honored.		I authorize payment directly to the provider of service.	
EMPLOYEE'S SIGNATURE		EMPLOYEE'S SIGNATURE	

TO BE COMPLETED BY THE DENTIST													
DENTIST NAME						IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?		NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES			
ADDRESS						IS TREATMENT RESULT OF AUTO ACCIDENT?							
CITY, STATE, ZIP						IS TREATMENT RESULT OF OTHER ACCIDENT?							
DENTIST SS OR TAX ID NO.		DENTIST LICENSE NO.		DENTIST PHONE NO.		ARE ANY SERVICES COVERED BY ANOTHER PLAN?				IF NO, REASON FOR REPLACEMENT		DATE OF PRIOR PLACEMENT	
FIRST VISIT DATE	PLACE OF TREATMENT OFFICE HOSP ECF OTHER			RADIOGRAPHS OR MODELS ENCLOSED	NO	YES	HOW MANY	IS PROSTHESIS, IS THIS INITIAL PLACEMENT?		IF SERVICES ALREADY COMMENCED ENTER	DATE APPLIANCES PLACED	MOS. TREATMENT REMAINING	
INDICATE MISSING TEETH WITH AN X 						EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THROUGH 32 USE CHARTING SYSTEM SHOWN						FOR OFFICE USE ONLY <input type="checkbox"/> USUAL & CUSTOMARY	
						TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICES INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.		DATE SERVICE PERFORMED MO DAY YR		PROCEDURE NUMBER	FEE
REMARKS:						NOTES:						TOTAL	
						TOTAL COVERED						TOTAL	
I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED ON THE DATES INDICATED.						TOTAL							
						DENTIST'S SIGNATURE:						DATE:	

* PLEASE NOTE: PRE-DETERMINATION OF BENEFITS DOES NOT GUARANTEE PAYMENT. This estimate of benefits has been calculated based on current available benefits and employee eligibility. This estimate is subject to modification based upon remaining benefits available and eligibility which applies at the time services are completed and claim is submitted for payment.




WHAT DO I PRESENT TO THE HOSPITAL, DOCTOR/DENTIST OFFICE OR PHARMACY TO SHOW I HAVE MEDICAL, DENTAL AND PHARMACY COVERAGE?

- You should present your new ID card you received from Benefit Assistance Corporation (BAC).
- Please notify your providers that it is a *new card replacing the old one*.
- You should destroy your old ID card.
- For your convenience, your new ID card has the PPO providers and Rx customer service numbers and website addresses which should make it easy for you to contact them if you need assistance or information from them.

(A sample ID card is on the next page.)


HAPCAP
SAMPLE ID CARD

FRONT

BAC Benefit Assistance Corporation Administrators & Consultants	 
EMPLOYER: HOCKING ATHENS PERRY COMMUNITY ACTION EMPLOYEE NAME: JOHN A DOE ID: 550301621 GROUP #: HAPCAP-001 EFFECTIVE DATE: 05/01/10 MEDICAL COVERAGE: FAMILY DENTAL COVERAGE: FAMILY	
	
BENEFIT ASSISTANCE CORPORATION INQUIRIES: 304.372.7035	
RxBIN:603286 RxPCN:01410000 RxGrp:516225 PRESCRIPTION MEMBER SERVICES: 800.207.2568	

BACK

NON-SUPERMED PROVIDERS SEND CLAIMS TO:

BENEFIT ASSISTANCE CORPORATION PO BOX 790, RIPLEY, WV 25271 ELECTRONIC CLAIMS SUBMISSION: EDI#135221807 www.eedl.net	
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SUPERMED NETWORK PROVIDERS SUBMIT CLAIMS TO:
PO BOX 94648, CLEVELAND, OH 44101 Emdeon Payor ID: 29076
SUPERMED PROVIDERS: 800.601.9208 www.supermednetwork.com

4MOST HEALTH NETWORK: 888.258.6477 www.4mosthealth.com

MULTIPLAN PROVIDERS: 888.342.7427 www.multiplan.com

PRE-CERTIFICATION REQUIRED ON ALL HOSPITAL CONFINEMENTS
CONTACT MEDWATCH 800.432.8421 OR www.urmedwatch.com

THIS CARD SERVES ONLY TO IDENTIFY

WILL I STILL RECEIVE AN EXPLANATION OF BENEFITS?

When your claim is received and processed by BAC, an Explanation of Benefits (EOB) will be mailed to you and another will be mailed to your provider. The provider EOB will have the payment check attached, if there is a payment due.

The Explanation of Benefits is self explanatory. It will show the provider, procedure code, date of service, amount charged, amount allowed, rate that the balance payable is paid at, any deductibles required, patients responsibility and remarks regarding any adjustments or additional information needed.

If you receive an EOB and have questions, please call our Customer Service Department at 1-800-982-7838. Please have your claim number and date of service ready to provide to our customer service representative.

COPY

Claims Processed by
BENEFIT ASSISTANCE CORPORATON
PO BOX 29
RIPLEY, WV 25271

Return Service Requested

Administrator and Sponsor
HOCKING ATHENS PERRY COMMUNITY

If you have any questions please contact
PH:(304)372-7035 FAX:(304)372-8285

Group Number: HAPCAP -001
Claim No: 491 5
Subscriber Name:
Claimant:
Check Date: 05/07/2010
Check #: 0000001002

Provider:
Account No:
PPO Name:



EMPLOYEE SAMPLE EOB

ENV 102 19 OF 113

Services Provided	Proc Code	Dates of Services	Charged	Allowed	Not Payable	Remark Code	Balance Payable	
							80%	50%
IMMEDIATE UPPER	5130D3	03/09/10	700.00	700.00				700.00
IMMEDIATE LOWER	5140D3	03/09/10	700.00	700.00				700.00
	7140D2	03/09/10	75.00	75.00			75.00	
	7140D2	03/09/10	75.00	75.00			75.00	
	7140D2	03/09/10	75.00	75.00			75.00	
	7140D2	03/09/10	75.00	75.00			75.00	
Claim Totals			1,700.00	1,700.00			300.00	1,400.00
Less Plan Deductibles								50.00
Balance Payable							300.00	1,350.00
Co-Insurance Percent							80%	50%
Payable Benefits							240.00	675.00
Total Payable Benefits								915.00
Less Adjustments See Remarks								
Total Paid Benefits								915.00
Patient Responsibility								

Code Remarks
C: AMOUNT PAID BY OTHER INSURANCE.
BENEFITS ARE ASSIGNED TO THE PROVIDER
TOTAL DEDUCTIBLE TAKEN ON THIS CLAIM \$ 50.00

COPY

Claims Processed by
BENEFIT ASSISTANCE CORPORATON
PO BOX 29
RIPLEY, WV 25271

Return Service Requested

Administrator and Sponsor
HOCKING ATHENS PERRY COMMUNITY

If you have any questions please contact
PH:(304)372-7035 FAX:(304)372-8285

Group Number: HAPCAP -001
Claim No: 491
Subscriber Name:
Claimant:
Check Date: 05/07/2010
Check #: 0000001002

Provider:
Account No:
PPO Name:



PROVIDER SAMPLE EOB

Services Provided	Proc Code	Dates of Services	Charged	Allowed	Not Payable	Remark Code	Balance Payable	
							80%	50%
IMMEDIATE UPPER	5130D3	03/09/10	700.00	700.00				700.00
IMMEDIATE LOWER	5140D3	03/09/10	700.00	700.00				700.00
	7140D2	03/09/10	75.00	75.00			75.00	
	7140D2	03/09/10	75.00	75.00			75.00	
	7140D2	03/09/10	75.00	75.00			75.00	
	7140D2	03/09/10	75.00	75.00			75.00	
Claim Totals			1,700.00	1,700.00			300.00	1,400.00
Less Plan Deductibles								50.00
Balance Payable							300.00	1,350.00
Co-Insurance Percent							80%	50%
Payable Benefits							240.00	675.00
Total Payable Benefits								915.00
Less Adjustments See Remarks								
Total Paid Benefits								915.00
Patient Responsibility								

Code Remarks

C: AMOUNT PAID BY OTHER INSURANCE.
BENEFITS ARE ASSIGNED TO THE PROVIDER
TOTAL DEDUCTIBLE TAKEN ON THIS CLAIM \$ 50.00

HAPCA HEALTH/RX/DENTAL PLAN
3 CARDERAS DRIVE
GLOUSTER, OH 45732

FIRST NATIONAL BANK
GLOUSTER OFFICE
MCCONNELSVILLE, OH 43756

CHECK DATE	CHECK NO
05/07/2010	0000001002

AMOUNT
\$*****915.00

PAY Nine Hundred Fifteen Dollars

TO THE
ORDER OF

Christina...
Phoebe...
VOID

⑈0000001002⑈ ⑆044106384⑆ 700702694⑈

WHO DO I CALL WITH QUESTIONS?

<p>BAC CUSTOMER SERVICE – For claims and eligibility questions. Customer Service Hours are 9:00 a.m. through 4:00 p.m. Monday through Friday (except for Holidays)</p>	<p>1-800-982-7838 - Toll Free</p>
<p>WALGREEN’S HEALTH INITIATIVES For questions related to prescriptions.</p>	<p>1-800-207-2568 – Toll Free</p>
<p>MEDWATCH – Pre-Certification Company Pre-Certification is required on all hospital confinements and outpatient services. Usually the provider calls for pre-certification. However, it is the member’s responsibility to be sure that services are pre-certified as required.</p>	<p>1-800-432-8421 – Toll Free</p>

WHERE ARE CLAIMS FILED?

MMO SuperMed Network Providers Submit Claims to:

**P. O. Box 94648
Cleveland, OH 44101
Emdeon Payor ID: 29076**

Non-SuperMed Providers Submit Claims to:

**Benefit Assistance Corporation
P. O. Box 790
Ripley, WV 25271
Electronic Claims: EDI# 135221807**

WHAT IS REQUIRED TO ENROLL, TERMINATE OR MAKE CHANGES TO MY COVERAGE UNDER THE PROGRAM?

On the next page you will find an ***Enrollment / Change / Termination Form***. This is the form needed to make any changes, terminations or additions to your coverage under the Health Care, Prescription Drug and Dental Program. You can make copies of the form, download and print them from the BAC website (instructions included in this booklet), or obtain them from your Human Resources Department.

This form is used to do any of the following:

- Enroll initially in the plan
- Change the level of coverage you have when a qualifying event occurs, for example:
 - Adding a new child
 - Adding a spouse
 - Deleting a child when they are no longer eligible for coverage
 - Deleting a spouse
- Changing your address.
- Cancel coverage
- Adding coverage at open enrollment or when a qualifying event occurs

A completed enrollment form must be received by the Plan Administrator no later than 31 days after the person becomes eligible for coverage, otherwise they will have to wait until the next open enrollment to be covered.

WHY DO I HAVE TO NOTIFY BAC THAT MY CHILD IS A FULL TIME STUDENT SO OFTEN?

If your child is over age 19, they are eligible for coverage as long as they are enrolled as a full time student as defined in your plan document. This must be verified each semester/quarter.

After the *Enrollment/Change/Termination* form you will find a “*Full Time Student*” letter. This letter explains what is required to prove full time student status to BAC. Claims cannot be paid until the information is provided each semester. You may duplicate the attached form as needed.

Benefit Assistance Corporation
 PO Box 790, Ripley, WV 25271
 Phone (304)372-7035 * Fax (304)372-8285

ENROLLMENT / CHANGE / TERMINATION FORM
 (Complete or check all that apply)

Group Name Hocking Athens Perry Community Action Health Care, Prescription Drug and Dental Program	Division	Class	Effective Date of Coverage or Change
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E M P L O Y E R	Reason For Completion: <input type="checkbox"/> Enrollment <input type="checkbox"/> Change in Coverage <input type="checkbox"/> Termination <input type="checkbox"/> Re-enrollment <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Other Changes: <input type="checkbox"/> Change Name <input type="checkbox"/> Change Address <input type="checkbox"/> Change Coverage <input type="checkbox"/> Loss / Acquisition of Spouse's Group Coverage <input type="checkbox"/> Other - Specify _____ Date of Above Event _____	Dependent Changes: Add Dependents due to: <input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Step-child <input type="checkbox"/> QMCSO <input type="checkbox"/> Other _____ Drop Dependents due to: <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Other _____ Date of Above Event _____	Cancel Coverage Due To: <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Reduction of Hours / Layoff <input type="checkbox"/> Voluntary Termination of Coverage / Other Coverage <input type="checkbox"/> Death <input type="checkbox"/> Other - Specify _____ Date of Above Event _____	(Check one or explain) <input type="checkbox"/> Involuntary <input type="checkbox"/> Voluntary <input type="checkbox"/> Gross Misconduct
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 Authorized Employer Representative Signature

LEVEL OF BENEFITS APPLIED FOR

MEDICAL / PRESCRIPTION DRUG
 Employee Family

DENTAL
 Employee Family

EMPLOYEE IDENTIFICATION

Last Name	First Name	Middle Initial	Social Security Number	Date of Birth (Month / Day / Year)
			- -	/ /
Address			Telephone	Date of Hire (Month / Day / Year)
				/ /
City, State, Zip			E-mail Address (Optional)	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female			Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
			Employment Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> COBRA	

DEPENDENT INFORMATION

(Complete only if you have elected dependent coverage)

Plan reserves the right to request that legal documentation (Birth Certificate, Court Decree, Guardianship Papers, Federal Income Tax Return, etc.) be attached to this Application if relationship is Adoption, Step-Child, QMCSO or Other.

Relationship (Spouse, Child, Step-child, Adoption, Other)	Name			Gender M / F	Date of Birth			Social Security Number	Status Over Age 19	
	First	MI	Last		Month	Day	Year		FT Student	Disabled
Spouse								-	-	
								-	-	
								-	-	
								-	-	

Other Coverage: If you, your spouse and/or children are covered under another group plan, list participant name and name of health insurance provider below:

Prior Coverage: If you, your spouse and/or children have had group health coverage in the past 18 months prior to enrolling in this Plan, please provide a copy of the Certificate of Group Health Plan Coverage provided by the prior carrier.

WAIVER OF COVERAGE

(Complete only if you wish to decline coverage)

I hereby decline coverage: for Myself for My Dependent Spouse for My Dependent Children for the Following Person(s) _____

I hereby certify that I have been given the opportunity to participate in the group insurance plan provided by my employer. If I and/or any of my Eligible Dependents desire to apply for this insurance at a later date, eligibility will be subject to any eligibility requirements, special enrollment, open enrollment, late enrollment and other terms and provisions as specified in the group Plan Document.

EMPLOYEE ENROLLMENT / CHANGE AUTHORIZATION

I hereby apply for the coverage or changes to my existing coverage under the group benefit plan as indicated above. This application shall supercede any previous application as of the effective date indicated above.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. I have read the above statements and represent that the information provided is true and complete to the best of my knowledge. I understand that the provision of any false information on this application may result in the termination of my benefits and may subject me to legal action by the Plan Administrator.

 Date

 Employee Signature

BENEFIT ASSISTANCE CORPORATION

P. O. Box 790, Ripley, WV 25271
304.372.7035 or 800.982.7838

Date: _____

Name _____

Address: _____

Address: _____

ID # _____

Employer Name _____ Group # **HAPCAP**

In order for your student aged dependent to be eligible under this plan he/she must be enrolled on a full-time basis in an institution of higher education. Please assist us by providing any one of the following as proof of full time student status:

1. A copy of the form that shows full time student status from the National Clearinghouse data base if your dependent's school participates in this program
2. A copy of the student's schedule that shows the number of credit hours for which they are enrolled
3. Completion of the bottom portion of this form by the school they are attending.

If your child is not enrolled as a full time student and is age 19 or older, please provide the date on which they ceased full time enrollment. _____

Employee Signature _____ Date _____

Return this form with the appropriate documentation to the address shown above. Please note that claims for an eligible student cannot be processed for reimbursement until the applicable semester information is received by our office.

TO BE COMPLETED BY AN ACCREDITED EDUCATIONAL INSTITUTION

Name of School Registrar's Telephone Number

School's Address

Name of Student _____ is registered as a
SS# _____

_____ Full Time _____ Part Time student for the _____ Spring _____ Fall 20_____ semester

which begins on _____ 20_____ and ends on _____ 20_____.

Registrar's Signature School Seal Date

WHEN DO I NEED TO HAVE A PROCEDURE PRE-CERTIFIED AND HOW DO I DO IT?

All in-patient hospital confinements must be pre-certified by the Plan's Utilization Review Service, MedWatch, except when in connection with childbirth as specified in your plan document. Also, out-patient services must be pre-certified for medical necessity as specified in your plan document.

There may be a reduced benefit reimbursement if required services are not pre certified.

For pre-certification you or your provider should call:

MEDWATCH, LLC
1-800-432-8421

Your provider will usually call the pre-certification company; however, it is your responsibility to see that it is done.

You and your provider will receive an approval (or denial) letter similar to the one on the following page.



Post Office Box 952679
 Lake Mary, FL 32795-2679
 (800) 432-8421 / Fax: (407) 333-8928

Thursday, May 13, 2010

SAMPLE PRECERTIFICATION LETTER

P O BOX 29
 RIPLEY, WV 25271

Case No.: 1-210972
 Group: HOCKING ATHENS PERRY COMMUNITY ACTION
 Patient:
 Employee:

Policy:
 Refer Date: 5/7/2010
 ID#:
 ID#:

Admit Date: Procedure Date: 7/20/2010

Discharge Date:

Providers: RIVER VIEW SURGERY CENTER

Tax Id: 311479971 (740) 681-2700
 Tax Id: 311273995 (740) 687-3346

ICD:
 727.41

CPT:
 25111

As the medical management company for your insurance claims office we have been notified of your out-patient procedure scheduled as noted above. After review of the available medical information, we have certified the procedure as medically necessary. We will be contacting your doctor and/or hospital on the follow-up date noted above either to verify discharge or gain medical information which would verify your need for continued hospital confinement.
 If any changes were made to the above procedure(s) date or facility, please notify us immediately.

This letter pertains only to the medical necessity of the above referenced health care. It does not verify benefits that such care is covered under the health plan or that your provider is in the participating provider network as that is the responsibility of the plan administrator. **THIS LETTER DOES NOT VERIFY BENEFITS NOR GUARANTEE PAYMENT. Please contact your TPA office, BENEFIT ASSISTANCE CORPORATION/RIPLEY at the number listed on the back of your insurance card regarding benefits/payment information.**

If you have any questions regarding Medical Certification, please call us at 1-800-432-8421 between 8am - 5pm EST.

Sincerely,
 Mia Allen R.N.B.S.N
 1-800-432-8421 ext 355
 Mia.Allen@urmedwatch.com

CC: RIVER VIEW SURGERY CENTER,

The information contained in this message is privileged and confidential information intended for the use of the addressee and no one else. If you are not the intended recipient, please contact the sender by telephone.

WILL I BE ABLE TO ACCESS MY CLAIMS INFORMATION ON LINE?

Yes. Instructions for web access are below.

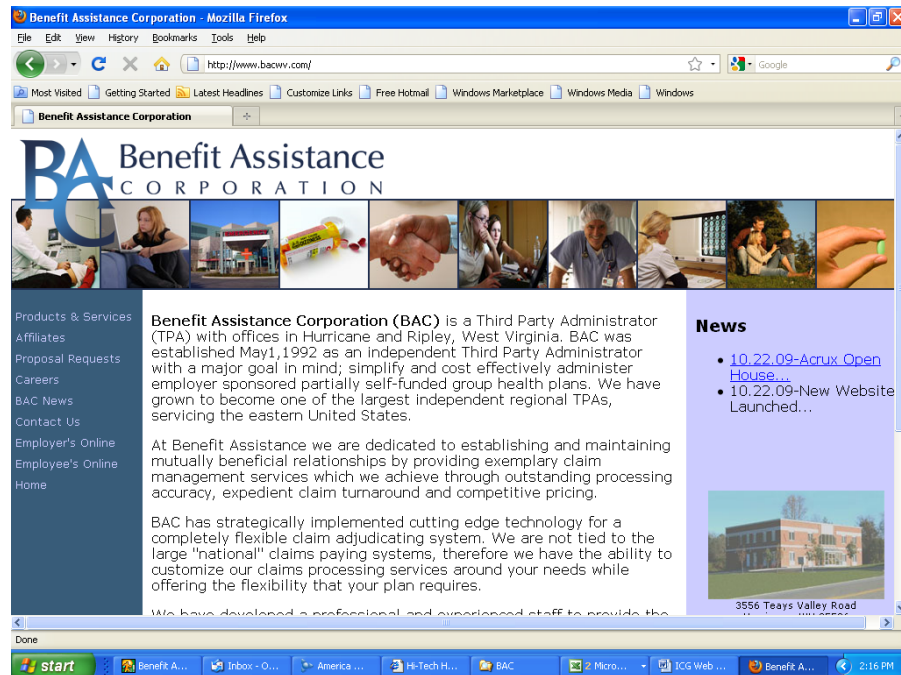
EMPLOYEE ACCESS

www.bacwv.com

Follow these simple instructions to sign on and begin tracking your medical claims.

Just a few simple steps and you are on your way.....

- Go to www.bacwv.com
- Click on **"Employee's Online"**
- Move your mouse to **"Username"**
 - Enter your SSN or member ID
- Move your mouse to **"Password"**
 - Enter your eight digit birth date
 - You will be prompted to change your password



You have now gained personal and private access to use the web to:

- Check claims
- Verify eligibility
- View and print EOB's
- View and print online documents, such as claim forms, etc.

AUTHORIZATION TO RELEASE INFORMATION

From time to time you may need information released to someone other than yourself, such as a spouse, guardian, ex-spouse, etc. If that person is not enrolled under your group Health Care, Prescription Drug and Dental Program, we are not allowed to release any information to them containing Protected Health Information (PHI).

The Exhibit A, on the next page, is an authorization to release information that you must complete and fax to Julye Knox at 304-372-8285. She will make a notation in your file regarding this authorization being given and that it is on file.

Also, if you ever need a third party to release PHI to Benefit Assistance Corporation, Exhibit B can be used for that purpose.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I, _____,
(Print Employee Name) (Social Security Number)

hereby authorize Benefit Assistance Corporation to furnish and disclose all known facts concerning health claims processed by Benefit Assistance Corporation for me or my dependents listed below.

Name _____, D.O.B. _____

Name _____, D.O.B. _____

Name _____, D.O.B. _____

Name _____, D.O.B. _____

to _____
(Representative Name and Relationship)

I further authorize _____ to act on my behalf
(Representative's Name)

In responding to any requests for additional information necessary to process or discuss health claims on myself or the above referenced dependents.

This authorization also permits my medical providers, employer, Union representative, insurance company and/or third-party insurance administrator to discuss in person, by telephone, electronically, or by mail any information pertaining to _____

Expiration Date. This Authorization shall remain valid from the date of its execution until revoked by me, in writing.

Signature of Employee

Date

Mailing Address

Telephone Number

City, State, Zip

Mail or Fax completed release to:

Benefit Assistance Corporation
PO Box 790, Ripley, WV 25271
Phone: 304.372.7035
Fax 304.372-8285

EXHIBIT B

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

I. Class of Persons Authorized to Make the Requested Disclosure: I, _____, hereby authorize any physician, hospital, medical facility, insurance company, health care provider, health plan, or any other person, individual or entity that has furnished medical treatment, given medical advice, and/or possesses medical records, information or documents pertaining to my medical or mental health history or treatment to release such information, records or documents as described below to Benefit Assistance Corporation, Inc..

II. Persons or Class of Persons to Whom Disclosure May Be Made: The disclosure permitted by this Authorization may be made to Benefit Assistance Corporation, Inc., or its agents or legal representatives at P. O. Box 790, Ripley, WV 25271.

III. Description of Information to be Disclosed. I authorize the release and disclosure of any and all individually identifiable protected health information, including but not limited to medical records, reports, and other records or documents containing information relating to my medical history and treatment, and to also include any mental health information and documents, from (insert earliest date of records to be released) _____, to the date this release is presented, to the persons or entities identified in Section II of this Authorization.

IV. Purpose of Disclosure. The authorized disclosure is for the purpose of group health plan claim evaluation, determination and processing.

V. Expiration Date. This Authorization shall remain valid for a period of one (1) year from the date of its execution, unless sooner revoked by me, in writing, as provided for in Section VI.

VI. Right to Revoke. I understand that I have the right to revoke this authorization at any time by notifying the health care provider to whom this authorization has been provided at its U.S. postal service address. I understand that any such revocation will only be effective fifteen (15) days after its receipt by such health care provider, and that any use or disclosure made prior to the effective date of such revocation will not be affected by such revocation.

VII. No Conditions Imposed; Right to Copy of Authorization. I understand that my treatment, payment, enrollment or eligibility for benefits may not be conditioned upon my execution of this authorization, but that my health plan may condition my enrollment or eligibility for benefits upon the provision of this authorization, prior to my enrollment in the plan, when the authorization is sought for the purposes of underwriting or risk rating determinations. I understand that I am entitled to receive a copy of this authorization upon written request, and that a photocopy of this authorization shall have the same force and effect as the original.

VIII. Possible Re-disclosure. I understand that after such information is disclosed, federal law might not protect it and the recipient might re-disclose it to others in connection with the specified purposes of the disclosure.

This authorization is intended to be compliant with the privacy regulations of the Health Insurance Portability and Accountability Act (HIPAA).

Signature of Individual _____

Date _____

Social Security No.: _____

Date of Birth: _____

SUMMARY OF PLAN BENEFITS

Attached for your convenience is a summary of your medical and dental benefits.

This Summary of Benefit provides a quick reference, but is not a complete description of the Plan. If you need additional clarification regarding a specific benefit, please contact your plan document, or call our customer service department at 1-800-982-7838.

**HOCKING ATHENS PERRY COMMUNITY ACTION
HEALTH CARE, PRESCRIPTION DRUG AND DENTAL PROGRAM
MEDICAL SUMMARY OF BENEFITS**

Maximum Individual Limit per Lifetime		\$5,000.000
Deductible Calendar Year	Network	Non-Network
Individual Maximum	\$200	\$250
Family Maximum	\$400	\$500

Coinsurance Calendar Year	Network	Non-Network
Benefit Payable	80%	70%
Individual Maximum	\$1,000	\$1,000
Family Maximum	\$2,000	\$2,000

Services:	Network Benefits	Non-Network
Adult Preventive Care	100% following a \$15 copay	70% after deductible
Physician Office Visit	100% following a \$15 copay	70% after deductible
Laboratory Studies	80% after deductible	70% after deductible
X-Ray Services	80% after deductible	70% after deductible
Physical, Speech & Occupational Therapy	80% after deductible	70% after deductible
Chiropractic Services	80% after deductible	70% after deductible
Outpatient Services	80% after deductible	70% after deductible
Inpatient Services	80% after deductible	70% after deductible
Surgery Services	80% after deductible	70% after deductible
Anesthesia Services	80% after deductible	70% after deductible
Supplemental Accident	First \$300 payable at 100% Remaining 80% after deductible	First \$300 payable at 100% Remaining 70% after deductible

Prescription Drug Benefit	
Pharmacy Option	
Generic	\$10 copayment
Brand	\$15 copayment
Brand when Generic available	\$15 copayment plus cost difference between brand and generic
Mail Order Option	
Brand	\$20 copayment plus cost difference between brand and generic for 90 day supply
Generic	\$20 copayment for 90 day supply

This Summary of Benefits provides a quick reference but is not a complete description of the Plan. Please read the entire Plan carefully for a full explanation of Plan benefits, limitations and exclusions. In addition, Participating Employees and Participating Dependents may contact the Plan Administrator for additional information concerning coverage for specific benefits, tests, and procedures. There shall be no cost to the Participating Employee or Participating Dependent for requesting and being provided such information.

**HOCKING ATHENS PERRY COMMUNITY ACTION
HEALTH CARE, PRESCRIPTION DRUG AND DENTAL PROGRAM
DENTAL SUMMARY OF BENEFITS**

Dental Deductible	Individual	Family
Calendar Year	\$50	\$150
Dental Maximum per Individual	\$2,000 per Calendar Year	

Dental Percentage Payable	
Class A Services (Preventive) Deductible does not apply	100%
Class B Services (Basic) Deductible applies	80%
Class C Services (Major) Deductible applies	50%
Orthodontia Services	Not Covered

Dental Charges

Dental charges are the usual and reasonable charges made by the dentist or other physician for necessary care, appliances or other dental material listed as a covered dental service.

A dental charge is incurred on the date the service or supply for which it is made is performed or furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Claims Administrator will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

CLASS A SERVICES – PREVENTATIVE AND DIAGNOSTIC

The Maximum Covered Dental Expense for any Class A Service is 100% of the Usual, Customary and Reasonable Charge.

CLASS B SERVICES – BASIC RESTORATIONS, ENDODONTICS, PERIODONTICS, PROSTHODONTIC MAINTENANCE AND ORAL SURGERY

The Maximum Covered Dental Expense for any Class B Service is 80% of the Usual, Customary and Reasonable Charge.

CLASS C SERVICES – MAJOR RESTORATION, DENTURES AND BRIDGEWORK

The Maximum Covered Dental Expense for any Class C Service is 50% of the Usual, Customary and Reasonable Charge.

This Summary of Benefits provides a quick reference but is not a complete description of the Plan. Please read the entire Plan carefully for a full explanation of Plan benefits, limitations and exclusions. In addition, Participating Employees and Participating Dependents may contact the Plan Administrator for additional information concerning coverage for specific benefits, tests, and procedures. There shall be no cost to the Participating Employee or Participating Dependent for requesting and being provided such information.