**I.B.E.W. LOCAL 712**

**Basic Plan - 10670039**

**Effective Date: January 1, 2023**

**Produced: October 2022**

**Introduction to your Health Care Program**

This booklet provides you with the information you need to understand your health care program. We encourage you to take the time to review this information, so you understand how your health care program works.

**How Your Benefits Are Applied**

**Benefit Period**

The specified period of time during which charges for covered services must be incurred in order to be eligible for payment by your program. A charge shall be considered incurred on the date you receive the service or supply for which the charge is made.

**Coinsurance**

The coinsurance is the specific percentage of the plan allowance for covered services that is your responsibility. You may be required to pay any applicable coinsurance at the time you receive care from a provider.

**Copayment**

The copayment for certain covered services is the specific upfront dollar amount which will be deducted from the plan allowance and is your responsibility.

**Deductible**

The deductible is a specified dollar amount you must pay for covered services each benefit period before the program begins to provide payment for benefits. You may be required to pay any applicable deductible at the time you receive care from a provider.

**Family Deductible**

The family deductible is a specified dollar amount of covered services that must be incurred by covered family members before the program begins to provide payment for benefits.

**Out-of-Pocket Limit**

The out-of-pocket limit refers to the specified dollar amount of expense incurred for covered services in a benefit period.

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| --- | --- | --- |
| **IBEW Local Union 712 Electrical Employees Welfare Trust Fund Keystone (Broad) - Basic Plan - 10670039 PPO Blue** | | |
|  |  |  |
| **Benefit** | **Network** | **Out-of-Network** |
| **General Provisions** | | |
| **Benefit Period** | **Calendar Year** | |
| **Deductible** *per* *benefit* *period*  Individual  Family | $2,000 $4,000 | $4,000 $8,000 |
| **Plan Pays** - payment based on allowance | 80% after deductible | 60% after deductible |
| **Out-of-Pocket Limit** *(Includes deductible and copays) Once met, plan pays 100% coinsurance for the rest of the benefit period* IndividualFamily | $5,000 $10,000 | $10,000 $20,000 |
| **Total Maximum Out-of-Pocket** *(Includes deductible, coinsurance, copays, and other qualified medical expenses, Network Only) Once met, the plan pays 100% of covered services for the rest of the benefit period.* IndividualFamily | $5,000  $10,000 | NA NA |
| **Office/Clinic/Urgent Care Visits** | | |
| **Retail Clinic Visits & Virtual Visits** | 80% after $20 copayment | 60% after deductible |
| **Primary Care Provider Office Visits & Virtual Visits** | 80% after $20 copayment | 60% after deductible |
| **Specialist Office Visit & Virtual Visits** | 80% after $25 copayment | 60% after deductible |
| **Virtual Visit Originating Site Fee** | 80% after deductible | 60% after deductible |
| **Urgent Care Center Visits** | 80% after $30 copayment | 60% after deductible |
| **Preventive Care** | | |
| **Routine Adult** |  |  |
| Physical Exams | 100% (deductible does not apply) | 60% after deductible |
| Adult Immunizations | 100% (deductible does not apply) | 60% after deductible |
| Colorectal cancer screening | 100% (deductible does not apply) | 60% after deductible |
| Routine gynecological exams, including a  Pap Test | 100% (deductible does not apply) | 60% (deductible does not apply) |
| Mammograms, annual routine and  medically necessary | Routine: 100% (deductible does not apply) Medically Necessary: 80% after deductible | 60% after deductible |
| Diagnostic services and procedures | 100% (deductible does not apply) | 60% after deductible |
| **Routine Pediatric** |  |  |
| Physical Exams | 100% (deductible does not apply) | 60% after deductible |
| Pediatric Immunizations | 100% (deductible does not apply) | 60% (deductible does not apply) |
| Diagnostic services and procedures | 100% (deductible does not apply) | 60% after deductible |
| **Emergency Services** | | |
| **Emergency Room - Emergency** | 80% after $100 copayment (waive if admitted) | |
| **Emergency Room - Non-Emergency** | 80% after $200 copayment (waive if admitted) | |
| **Ambulance - Emergency** | 80% after Network deductible | |
| **Ambulance - Non-Emergency** | 80% after deductible | 60% after deductible |
| **Hospital and Medical/Surgical Expenses (including maternity)** | | |
| **Hospital Inpatient** | 80% after deductible | 60% after deductible |
| **Hospital Outpatient** | 80% after deductible | 60% after deductible |
| **Maternity***(non-preventive facility and professional services) Including dependent daughter* | 80% after deductible | 60% after deductible |
| **Medical Care**/**Surgical Expenses***(including inpatient visits and consultations)* | 80% after deductible | 60% after deductible |
| **Therapy and Rehabilitation Services** | | |
| **Physical Medicine** *(unlimited visits/benefit period)* | 80% after $20 copayment | 60% after deductible |
| **Respiratory Therapy** | 80% after deductible | |
| **Speech & Occupation Therapy** *(unlimited visits per therapy/benefit period)* | 80% after $20 copayment | 60% after deductible |
| **Spinal Manipulations** *(unlimited visits/benefit period)* | 80% after $20 copayment | 60% after deductible |
| **Other Therapy Services***(Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)* | 80% after deductible | 60% after deductible |
| **Mental Health/Substance Abuse** | | |
| **Inpatient** | 80% after deductible | 60% after deductible |
| **Inpatient Detoxification/Rehabilitation** | 80% after deductible | 60% after deductible |
| **Outpatient - Includes Virtual Behavioral Health Visits** | 80% after $25 copayment | 60% after deductible |
| **Other Services** | | |
| **Allergy Extracts and Injections** | 80% after deductible | 60% after deductible |
| **Autism Spectrum Disorder including Applied Behavioral Analysis** *Coverage for eligible members to age 21;*  *After initial analysis, services paid*  *according to benefit category (e.g.*  *speech therapy). Treatment for autism*  *spectrum disorders do not reduce  visit/day limits.* | 80% after deductible | 60% after deductible |
| **Assisted Fertilization Procedures** | Not Covered | Not Covered |
| **Dental Services Related to Accidental Injury** | 80% after deductible | 60% after deductible |
| **Diagnostic Services – Advanced Imaging**  *MRI, CAT, PET scan, etc.* | 80% after deductible | 60% after deductible |
| **Diagnostic Services – Basic Services**  *standard imaging, diagnostic medical,*  *lab/pathology, allergy testing)* | 80% after deductible | 60% after deductible |
| **Durable Medical Equipment, Orthotics, and Prosthetics** | 80% after deductible | 60% after deductible |
| **Home Health Care** | 80% after deductible | 60% after deductible |
| **Hospice** | 80% after deductible | 60% after deductible |
| **Infertility Counseling and Testing** | 80% after deductible | 60% after deductible |
| **Private Duty Nursing** | 80% after deductible | |
| **Skilled Nursing Facility Care**  *Limit: 100 days/benefit period Network and   Out-of-Network combined* | 80% after deductible | 60% after deductible |
| **Transplant Services** | 80% after deductible | 60% after deductible |
| **Precertification Requirements** | YES | |
| **Prescription Drug Program** | **Rx Not Covered Medical Specialty Drugs are carved out directly to SavRx Contact SavRx customer service at the following: 1-800-228-3108** | |
|  |  |  |
| On the chart Above you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge, or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital. | | |
|  |  |  |
| This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/plan documents, as limitations and exclusions apply. | | |
|  |  |  |
| Your group's benefit period is based on a Calendar Year which runs from January 1-December 31 | | |
|  |  |  |
| The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government, TMOOP must include deductible,  coinsurance, copays, and any qualified medical expense. | | |
|  |  |  |
| Preventive Care is limited to those listed on the Preventive Schedule (Women's Health Preventive Schedule may apply). | | |
|  |  |  |
| Medical Management must be contacted prior to planned inpatient admission or within 48 hours of an emergency or maternity related inpatient admission. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered | | |
|  |  |  |
| Medically necessary air ambulance services rendered by out-of-network providers will be covered at the highest network tier level of benefits | | |

**Covered Services – Medical Program**

Your health care program may provide benefits for the following services you receive from a provider when such services are determined to be medically necessary and appropriate. All benefit limits, deductibles, and copayments amounts are described in the Summary of Benefits included at the beginning of this booklet.

***Network care is covered at a higher level of benefits than out-of-network care.***

**Ambulance Service**

Ambulance services providing local transportation by means of specially designed and equipped vehicle used only for transporting the sick and injured:

* from your home, the scene of an accident or medical emergency to a hospital or skilled nursing facility;
* between hospitals; or
* between a hospital and a skilled nursing facility

when such facility is the closest institution that can provide covered services appropriate to your condition. If there is no facility in the local area that can provide covered services appropriate for your condition, then ambulance service means transportation to the closest facility outside the local area that can provide the necessary care.

Transportation and other emergency services provided by an ambulance service will be considered emergency ambulance service if the injury or condition is considered emergency care.

Use of an ambulance as transportation to an emergency room for an injury or condition that does not satisfy the criteria of emergency care will not be covered as emergency ambulance services.

Local transportation by means of specially designed and equipped vehicle used only for transporting the sick and injured:

* from a hospital to your home, or
* from a skilled nursing facility to your home.

**Anesthesia for Non-Covered Dental Procedures (Limited)**

Benefits will be provided for general anesthesia and associated hospital and medical services normally related to the administration of general anesthesia which are rendered in connection with non-covered dental procedures or non-covered oral surgery. Benefits are provided for members age seven or under and for the developmentally disabled members when determined to be medically necessary and appropriate and when a successful result cannot be expected for treatment under local anesthesia, or when a superior result can be expected from treatment under general anesthesia.

**Autism Spectrum Disorders**

Benefits are provided to members under 21 years of age for the following:

**Diagnostic Assessment of Autism Spectrum Disorders**

Medically necessary and appropriate assessments, evaluations, or tests

performed by a physician, licensed physician assistant, psychologist or

certified registered nurse practitioner to diagnose whether an individual

has an autism spectrum disorder.

**Treatment of Autism Spectrum Disorders**

Services must be specified in a treatment plan developed by a physician or

psychologist following a comprehensive evaluation or reevaluation

performed in a manner consistent with the most recent clinical report or

recommendations of the American Academy of Pediatrics.

Treatment may include the following medically necessary and appropriate

services.

**Psychiatric and psychological care**

Direct or consultative services provided by a psychologist or by a physician

who specializes in psychiatry.

**Rehabilitative care**

Professional services and treatment programs, including Applied Behavioral

Analysis, provided by an autism services provider to produce socially

significant improvements in human behavior or to prevent loss of an

attained skill or function.

**Therapeutic care**

Services that are provided by a speech language pathologist, occupational

therapist, or physical therapist.

**Dental Services Related to Accidental Injury**

Dental services initially rendered by a physician which are required as a result of accidental injury to jaws, sound natural teeth, mouth or face. Follow-up services, if any, that are provided after the initial treatment are not covered. Injury as a result of chewing or biting shall not be considered an accidental injury.

**Diabetes Treatment**

Coverage is provided for the following when required in connection with the treatment of diabetes and when prescribed by a physician legally authorized to prescribe such items under the law:

* Equipment and supplies: Blood glucose monitors, monitor supplies, injection aids, syringes, and insulin infusion devices
* Diabetes Education Program\*: When your physician certifies that you require diabetes education as an outpatient, coverage is provided for the following when rendered through a diabetes education program:
* Visits medically necessary and appropriate upon the diagnosis of diabetes
* Subsequent visits under circumstances whereby your physician: a) identifies or diagnoses a significant change in your symptoms or conditions that necessitates changes in your self-management, or b) identifies, as medically necessary and appropriate, a new medication or therapeutic process relating to your treatment and/or management of diabetes

**\*Diabetes Education Program:** an outpatient program of self-management, training and education, including medical nutrition for therapy, for the treatment of diabetes. Such outpatient program must be conducted under the supervision of a licensed health care professional with expertise in diabetes.

**Diagnostic Services**

Benefits will be provided for the following covered services when ordered by a professional provider:

**Advanced Imaging Services**

Include, but are not limited to, computed tomography (CT),

computed tomographic angiography (CTA), magnetic resonance

imaging (MRI), magnetic resonance angiography (MRA), positron

emission tomography (PET scan), positron emission

tomography/computed tomography (PET/CT scan).

**Basic Diagnostic Services**

* **Standard Imaging Services –** procedures such as skeletal x-rays, ultrasound and fluoroscopy
* **Laboratory and Pathology Services –** procedures such as non-routine Papanicolaou (PAP) smears, blood tests, urinalysis, biopsies and cultures
* **Diagnostic Medical Services –** procedures such as electrocardiograms (ECG), electroencephalogram (EEG), echocardiogram, pulmonary studies, stress tests, audiology testing
* **Allergy Testing Services –** allergy testing procedures such as percutaneous, intracutaneous, and patch tests

**Durable Medical Equipment**

The rental or, the purchase, adjustment, repairs and replacement of durable medical equipment for therapeutic use when prescribed by a professional provider within the scope of their license. Rental costs cannot exceed the total cost of purchase.

**Enteral Foods**

Enteral foods is a liquid source of nutrition equivalent to a prescription drug that is administered orally or enterally and which may contain some or all nutrients necessary to meet minimum daily nutritional requirements.

Coverage is provided for enteral foods when administered on an outpatient basis for:

* amino acid-based elemental medical formulae ordered by a physician for infants and children for food protein allergies, food protein-induced enterocolitis syndrome, eosinophilic disorders and short bowel syndrome; and
* nutritional supplements administered under the direction of a physician for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria and;
* enteral formulae prescribed by a physician, when administered on an outpatient basis, considered to be your sole source of nutrition and provided:
* through a feeding tube (nasogastric, gastrostomy, jejunostomy, etc.) and utilized instead of regular shelf food or regular infant formulas; or
* orally and identified as one of the following types of defined formulae with: hydrolyzed (pre-digested) protein or amino
* acids, specialized content for special metabolic needs, modular components, or standardized nutrients.

Coverage for enteral formulae **excludes** the following:

* blendarized food, baby food, or regular shelf food
* milk or soy-based infant formulae with intact proteins
* any formulae, when used for the convenience of you and your family members
* nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation or maintenance
* semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates, when provided orally
* normal food products used in the dietary management of the disorders included above.

**Home Health Care/Hospice Care Services**

This program covers the following services you receive from a home health care agency, hospice or a hospital program for home health care and/or hospice care:

* skilled nursing services of a Registered Nurse (RN) or Licensed Practical Nurse (LPN), excluding private duty nursing services
* physical medicine, speech therapy, and occupational therapy
* medical and surgical supplies provided by home health care agency or hospital program for home health care or hospice care
* oxygen and its administration
* medical social service consultations
* health aide services when you are also receiving covered nursing services or therapy and rehabilitation services
* respite care
* family counseling related to the member’s terminal condition

Coverage for home health care/hospice benefits **excludes** the following:

* dietician services;
* homemaker services;
* maintenance therapy;
* dialysis treatment;
* custodial care; and
* food or home delivered meals

**Home Infusion and Suite Infusion Therapy Services**

Benefits will be provided when performed by a home infusion and/or suite infusion therapy provider at an infusion suite or in a home setting. This includes pharmaceuticals, intravenous solutions, medical/surgical supplies and nursing services associated with infusion therapy. Specific non-intravenous therapies are included when administered only in conjunction with infusion therapy.

**Hospital Services**

This program covers the following services received in a facility provider. Benefits will be covered only when, and as long as, they are determined medically necessary and appropriate for the treatment of the patient’s condition.

**Inpatient Services**

**Bed and Board**

Bed, board and generally nursing services are covered when you

occupy

* a room with two or more beds;
* a private room. Private room allowance is the average semi-private room charge; or
* a bed in a special care unit which is a designated unity which has concentrated all facilities, equipment and supportive services for the provision of an intensive level of care for critically ill patients.

**Ancillary Services**

Hospital services and supplies including, but not restricted to:

* use of operating, delivery and treatment rooms and equipment;
* drugs and medicines provided to you while you are an inpatient in a facility provider;
* whole blood, administration of blood, blood processing, and blood derivatives;
* anesthesia, anesthesia supplies and services rendered in a facility provider by an employee of the facility provider. Administration of anesthesia ordered by the attending professional provider and rendered by a professional provider other than the surgeon or assistant at surgery;
* medical and surgical dressings, supplies, casts and splints;
* therapy and rehabilitation services.

**Outpatient Services**

**Ancillary Services**

Hospital services and supplies including, but not restricted to:

* use of operating, delivery and treatment rooms and equipment;
* drugs and medicines provided to you while you are an outpatient in a facility provider;
* whole blood, administration of blood, blood processing, and blood derivatives
* anesthesia, anesthesia supplies and services rendered in a facility provider by an employee of the facility provider. Administration of anesthesia ordered by the attending professional provider and rendered by a professional provider other than the surgeon or assistant at surgery;
* medical and surgical dressings, supplies, casts, and splints;
* diagnostic services; or
* therapy and rehabilitation services.

**Emergency Services**

Emergency care services are services and supplies, including drugs and medicines, for the outpatient emergency treatment of bodily injuries resulting from an accident or a medical condition. Also included is a medical screening examination and ancillary services necessary to evaluate such injury or emergency medical condition and further medical examination and treatment as required to stabilize the patient.

In the event the member receiving such emergency care services for an out-of-network provider requires an inpatient admission or observation immediately resulting from such an injury or emergency medical condition and upon stabilization;

1. is unable to travel using non-medical transportation or non-emergency medical transportation to an available network provider within a reasonable travel distance; or
2. does not consent to be transferred

Covered services directly related to such injury or emergency medical condition and received during the inpatient admission or observation will be covered at the network level of benefits. You will not be subject to any balance billing amounts.

**Pre-Admission Testing**

Tests and studies, required in connection with your admission rendered or accepted by a hospital on an outpatient basis prior to a scheduled admission to the hospital as an inpatient.

**Surgery**

Hospital services and supplies for outpatient surgery including removal of sutures, anesthesia, anesthesia supplies and services rendered by an employee of the facility provider, other than the surgeon or assistant at surgery.

**Inpatient Medical Services**

Medical care by a professional provider when you are an inpatient for a condition not related to surgery, pregnancy, or mental illness, except as specifically provided.

**Concurrent Care**

Medical care rendered concurrently with surgery during one inpatient stay

by a professional provider other than the operating surgeon for treatment

of a medical condition separate from the condition for which surgery was

performed. Medical care by two or more professional providers rendered

concurrently during one inpatient stay when the nature or severity of your

condition requires the skills of a separate physician.

**Consultation**

Consultation services rendered to an inpatient by another professional

provider at the request of the attending professional provider. Consultation

does not include staff consultations which are required by facility provider

rules and regulations.

**Inpatient Medical Care Visits**

**Intensive Medical Care**

**Routine Newborn Care**

Benefits will be provided for routine care of a newborn infant by a provider

during the mother’s confinement in an accredited hospital.

**Maternity Services**

Hospital, medical, and surgical services rendered by a facility provider or professional provider for:

**Complications of Pregnancy**

Physical effects directly caused by pregnancy but which are not considered

from a medical viewpoint to be the effect of normal pregnancy, including

conditions related to ectopic pregnancy or those that require cesarean

section.

**Maternity Home Health Care Visit**

You are covered for one maternity home health care visit provided at your

home within 48 hours of discharge when the discharge from a facility

provider occurs prior to: (a) 48 hours of inpatient care following a normal

vaginal delivery or (b) 96 hours of inpatient care following cesarean

delivery. This visit shall be made by a network provider whose scope of

practice includes postpartum care. The visit includes parent education,

assistance and training in breast and bottle feeding, infant screening,

clinical tests, and the performance of any necessary maternal and neonatal

physical assessments. The visit may, at your sole discretion occur at the

office of your network provider.

Under Federal law, your self-insured group health program may not restrict

benefits for any hospital length of stay in connection with childbirth for the

mother or newborn child to less than 48 hours following a vaginal delivery;

or less than 96 hours following a cesarean section.

**Normal Pregnancy**

Normal pregnancy includes any condition usually associated with the

management of a difficult pregnancy but is not considered a complication

of pregnancy

**Nursery Care**

Covered services provided to the newborn child if eligible from the moment

of birth, including care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity, and routine nursery care.

**Mental Health Care Services**

Your program covers the following services you receive from a provider to treat mental illness:

**Inpatient Facility Services**

Hospital services are provided for the inpatient treatment of mental illness by a facility provider. Inpatient facility services must be provided twenty-

four hours a day, seven days a week by or under the direction of a

psychiatrist, a psychiatric nurse practitioner or a psychologist when legally

authorized by the state.

**Inpatient Medical Services**

Covered inpatient medical services provided by a professional provider:

* Individual psychotherapy
* Group psychotherapy
* Psychological testing
* Family counseling (counseling with family members to assist in your diagnosis and treatment)
* Convulsive therapy treatment (electroshock treatment or convulsive drug therapy including anesthesia when administered concurrently with the treatment by the same professional provider); and
* Medication management

**Partial Hospitalization Program**

Benefits are only available for mental health care services provided on a

partial hospitalization program. A mental health care services provided on a

partial hospitalization basis will be deemed an outpatient care visit and is

subject to any outpatient care cost-sharing amounts.

**Outpatient Mental Health Care Services**

Inpatient facility service and inpatient medical benefits provided by a

facility provider or professional provider as previously described, are also

available when provided for the outpatient treatment of mental illness by a

facility provider, or a professional provider. Benefits are also provided for

mental health care services received through an Intensive Outpatient

Program.

**Orthotic Devices**

Purchase, fitting, necessary adjustment, repairs and replacement of a rigid or semi-rigid supportive device which restricts or eliminates motion of a weak or diseased body part.

**Outpatient Medical Care Services (Office Visits)**

Medical care rendered by a professional provider when you are an outpatient for a condition not related to surgery, pregnancy or mental illness, except as specifically provided. Covered services include medical care visits and consultations for the examination, diagnosis, and treatment of an injury or illness.

**Allergy Extract/Injections**

**Therapeutic Injections**

Therapeutic injections required in the diagnosis, prevention and

treatment of an injury or illness.

**Pediatric Extended Care Services**

Benefits are provided for care received from a pediatric extended care facility that is licensed by the state and is primarily engaged in providing basic non-residential services to infants and/or young children who have complex medical needs requiring skilled nursing and therapeutic care and who may be technologically dependent.

* Skilled nursing services of a Registered Nurse (RN) or Licensed Practical Nurse (LPN)
* Physical medicine, speech therapy and occupational therapy
* Respiratory therapy
* Medical and surgical supplies provided by the pediatric extended care facility
* Acute health care support
* Ongoing assessments of health status, growth and development

Pediatric extended care services will be covered for children eight years of age or under, pursuant to the attending physician’s treatment plan only when provided in a pediatric extended care facility.

A prescription from the child’s attending physician is necessary for admission to such facility.

No benefits are payable after the child has reached the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment other than routine supportive care.

**Preventive Care Services**

**Covered Preventive Services for Adults**

* One adult routine physical exam every 12 months
* One-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65-75 years who have ever smoked
* Alcohol misuse screening and counseling
* Adherence counseling
* Pre-Exposure Prophylaxis (PrEP) medications
* Aspirin use to prevent cardiovascular disease and colorectal cancer for adults 50-59 years with a high cardiovascular risk
* Blood pressure screening
* Cholesterol screening
* Colorectal screening for adults 50-75
* Depression screening
* Diabetes (Type 2) screening for adults 40-70 years who are overweight or obese
* Diet counseling for adults at higher risk for chronic disease
* Falls prevention for adults 65 and over, living in a community setting
* Hepatitis B screening
* Hepatitis C screening
* HIV screening for everyone ages 15 to 65, and other ages at increased risk
* Immunization vaccines for adults
  + Diphtheria
  + Hepatitis A
  + Hepatitis B
  + Herpes Zoster
  + Human Papillomavirus (HPV)
  + Influenza (Flu shot)
  + Measles
  + Meningococcal
  + Mumps
  + Pertussis
  + Pneumococcal
  + Rubella
  + Tetanus
  + Varicella (Chickenpox)
* Lung cancer screening
* Obesity screening and counseling
* Sexually transmitted infection (STI) prevention counseling
* Sexually transmitted infection (STI) prevention screening
* Statin prevention medications for adults 40-75 at high risk
* Tobacco use screening for all adults and cessation interventions for tobacco users
* Tuberculosis screening for certain adults without symptoms at high risk
* Creatine testing and calculated estimated creatine clearance or glomerular filtration rate

**Covered Preventive Services for Women, Including Pregnant Women**

* Anemia screening on a routine basis
* Breastfeeding comprehensive support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women
* Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs).
* Folic acid supplements for women who may become pregnant
* Gestational diabetes screening for women 24-28 weeks pregnant and those at high risk of developing gestational diabetes
* Gonorrhea screening for all women at higher risk
* Hepatitis B screening for pregnant women at their first prenatal visit
* Preeclampsia prevention and screening for pregnant women and follow-up testing for women at higher risk
* Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
* Syphilis screening
* Expanded tobacco intervention and counseling for pregnant tobacco users
* Urinary tract or other infection screening
* Breast cancer genetic test counseling (BRCA) for women at higher risk
* Breast cancer mammography screening every 1 to 2 years for women over 40
* Breast cancer chemoprevention counseling for women at higher risk
* Cervical cancer screening
  + Pap test (also called a Pap smear) every 3 years for women 21 to 65
  + Human Papillomavirus (HPV) DNA test with the combination of a Pap smear every 3 to 5 years for women 30 to 65
* Chlamydia infection screening for younger women and other women at higher risk
* Diabetes screening for women with a history of gestational diabetes who aren’t currently pregnant and who haven’t been diagnosed with type 2 diabetes before
* Domestic and interpersonal violence screening and counseling for all women
* Gonorrhea screening for all women at higher risk
* HIV screening and counseling for sexually active women
* Osteoporosis screening for women over age 60 depending on risk factors
* Rh incompatibility screening follow-up testing for women at higher risk
* Sexually transmitted infections counseling for sexually active women
* Syphilis screening for women at increased risk
* Tobacco use screening and interventions
* Urinary incontinence screening for women yearly
* Pregnancy testing
* Well-woman visits

**Covered preventive services for children**

* Alcohol, tobacco, and drug use assessments for adolescents
* Autism screening for children at 18 and 24 months
* Behavioral assessments for children ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
* Bilirubin concentration screening for newborns
* Blood pressure screening for children ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
* Blood screening for newborns
* Cervical dysplasia screening for sexually active females
* Depression screening for adolescents beginning routinely at age 12
* Developmental screening for children under age 3
* Dyslipidemia screening for all children once between 9 and 11 years and once between 17 and 21 years, and for children at higher risk of lipid disorders ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, and 15 to 17 years
* Fluoride chemoprevention supplements for children without fluoride in their water source
* Fluoride varnish for all infants and children as soon as teeth are present
* Gonorrhea prevention medication for the eyes of all newborns
* Hearing screening for all newborns; and for children once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years
* Height, weight, and body mass index
* Hematocrit or hemoglobin screening for all children
* Hemoglobinopathies or sickle cell screening for all newborns
* Hepatitis B screening
* Hepatitis C screening
* Pre-Exposure Prophylaxis (PrEP) medications
* Sexually transmitted infection (STI) screening and counseling
* Creatine testing and calculated estimated creatine clearance (eCRCI) or glomerular filtration rate (eGFR)
* Adherence counseling
* Pregnancy testing
* HIV screening and testing
* Hypothyroidism screening for newborns
* Immunization vaccines
  + Diphtheria, tetanus, pertussis (whooping cough)
  + Haemophilus influenza type b
  + Hepatitis A
  + Hepatitis B
  + Human Papillomavirus (HPV)
  + Inactivated Poliovirus
  + Influenza (flu shot)
  + Measles
  + Meningococcal
  + Pneumococcal
  + Rotavirus
  + Varicella (chickenpox)
* Iron supplements for children ages 6-12 at risk for anemia
* Lead screening for children at risk of exposure
* Maternal depression screening for mothers of infants at 1, 2, 4, and 6-month visits
* Medical history for all children throughout development ages
* Obesity screening and counseling
* Oral health risk assessment for young children: ages 0-10 years
* Phenylketonuria (PKU) screening for newborns
* Sexually transmitted infection (STI) prevention counseling and screening
* Tuberculin testing for children at higher risk of tuberculosis
* Vision screening for all children

**Adult Immunizations**

Benefits are provided for adult immunizations, including the immunizing agent, when required for the prevention of disease.

**Colorectal Cancer Screenings**

Benefits are provided for the following tests and procedures when ordered by a physician for the purpose of early detection of colorectal cancer:

* Basic diagnostic laboratory and pathology screening services such as a fecal-occult blood or fecal immunochemical test
* Basic diagnostic standard imaging screening services such as barium enema
* Surgical screening services such as flexible sigmoidoscopy and colonoscopy and hospital services related to such surgical screening services
* Such other basic diagnostic laboratory and pathology, basic diagnostic standard imaging, surgical screening tests, basic diagnostic medical and advanced imaging screening services consistent with approved medical standards and practices for the detection of colon cancer

Benefits are provided for members 45 years of age or older as follows, or more frequently and regardless of age when prescribed by a physician:

* An annual fecal-occult blood test or fecal immunochemical test
* A sigmoidoscopy every five years
* A screening barium enema or test consistent with approved medical standards and practices to detect colon cancer every five years
* A colonoscopy every 10 years

If you are determined to be at high or increased risk, regardless of age, benefits are provided for a colonoscopy or any other combination of covered services related to colorectal cancer screening when prescribed by a physician and in accordance with the American Cancer Society guidelines on screening for colorectal cancer as of January 1, 2008.

Colorectal cancer screening services which are otherwise not described herein and are prescribed by a physician for a symptomatic member are not considered preventive care services. The payment for these services will be consistent with similar medically necessary and appropriate covered services.

**Diabetes Prevention Program**

Benefits are provided if you meet certain medical criteria of having a high risk of developing type 2 diabetes and when you are enrolled in a diabetes prevention program that is offered through a network diabetes prevention provider. Coverage is limited to one enrollment in a diabetes prevention program per year, regardless of whether you complete the diabetes prevention program.

**Mammographic Screening**

Benefits are provided for the following:

* An annual routine mammographic screening starting at 40 of age or older pursuant to the 2002 recommendations by the United States Preventive Services Task Force
* Mammographic screenings for all members regardless of age when such services are prescribed by a physician

**Pediatric Immunizations**

Benefits are provided to members under 21 years of age and dependent children for those pediatric immunizations, including the immunizing agents, which conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control and U.S. Department of Health and Human Services. Benefits are not subject to the program deductibles or dollar limits.

**Prescription Drugs (Outpatient)**

Coverage will be provided for prescription and over-the-counter drugs that are prescribed for preventive purposes.

**Routine Gynecological Examination and Pap Test**

Benefits are provided for one routine gynecological examination, includinga pelvic and clinical breast examination, and one routine Papanicolaou

smear (pap test) per calendar year. Benefits are not subject to program deductibles or maximums.

**Routine Screening Tests and Procedures**

Benefits are provided for routine screening tests and procedures,

regardless of medical necessity and appropriateness.

**Tobacco Use, Counseling and Interventions**

Benefits are provided for screenings for tobacco use and, for those who use

tobacco products, two tobacco cessation attempts per year. A tobacco

cessation attempt includes four tobacco cessation counseling sessions.

**Private Duty Nursing**

Services of an actively practicing Registered Nurse (RN) or Licensed Practical Nurse (LPN) when ordered by a physician, providing such nurse does not ordinarily reside in your home or is not a member of your immediate family.

* If you are an inpatient in a facility provider only when the nursing services required are of a nature or degree of complexity or quantity that could not be provided by the regular nursing staff
* If you are at home only when nursing services require the skills of an RN or an LPN

**Prosthetic Appliances**

Purchase, fitting, necessary adjustments, repairs, and replacements of prosthetic devices and supplies which replace all or part of an absent body organ and its adjoining tissues, or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses). Initial and subsequent prosthetic devices to replace the removed breast(s) or a portion thereof are also covered.

**Skilled Nursing Facility Services**

Services rendered in a skilled nursing facility to the same extent benefits are available to an inpatient of a hospital.

**No benefits are payable:**

* after you have reached the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care
* when confinement is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience; or
* for treatment of substance abuse or mental illness

**Spinal Manipulations**

Spinal manipulations for the detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation for or in the vertebral column.

Services that are not included:

* maintenance or preventive treatment provided to prevent recurrence or to maintain patient’s current status
* charges for Chiropractic care not provided in an office setting
* vitamin therapy

**Substance Abuse Services**

Benefits are provided for the detoxification services, individual and group counseling and psychotherapy, psychological testing, and family counseling for the treatment of substance abuse when rendered by a facility provider or professional provider and include the following:

* Detoxification services rendered;
* on an inpatient bases in a hospital or substance abuse treatment facility; or
* on an outpatient basis
* Substance abuse treatment facility services for non-hospital inpatient residential treatment and rehabilitation services. Residential treatment and rehabilitation services include medically monitored high intensity inpatient services with twenty-four-hour nursing care and physician availability and medically managed intensive inpatient services with twenty-four-hour nursing care and daily physician oversight; and
* Outpatient services rendered in a hospital, substance abuse treatment facility or through an Intensive Outpatient Program or Partial Hospitalization Program, and outpatient substance abuse treatment facility services for rehabilitation therapy

For purposes of this benefit, a substance abuse services provided on a partial hospitalization basis shall be deemed an outpatient care visit and is subject to any outpatient care cost-sharing amounts. Benefits are also provided for substance abuse services rendered through an Opioid Treatment Program or Office Based Opioid Treatment Program.

**Surgical Services**

This program covers the following services you receive from a professional provider.

**Anesthesia**

Administration of anesthesia for covered surgery when ordered by

the attending professional provider and rendered by a professional

provider other than the surgeon or the assistant at surgery. Benefits

will also be provided for the administration of anesthesia for covered

oral surgical procedures in an outpatient setting when ordered and

administered by the attending professional provider

**Assistant at Surgery**

Services of a physician who actively assists the operating surgeon in

the performance of covered surgery.

**Mastectomy and Breast Cancer Reconstruction**

Benefits are provided for a mastectomy performed on an inpatient or

outpatient basis for the following:

* all stages of reconstruction of the breast on which the mastectomy has been performed
* surgery and reconstruction of the other breast to produce a symmetrical appearance
* prostheses; and
* treatment of physical complications of mastectomy, including Lymphedema

**Special Surgery**

Oral Surgery

Benefits are provided for the following limited oral surgical

procedures determined to be medically necessary and

appropriate:

* Extraction of impacted third molars when partially or totally covered by bone
* Extraction of teeth in preparation for radiation therapy
* Mandibular staple implant, provided the procedure is not done to prepare the mouth for dentures
* Lingual frenectomy, frenotomy or frenoplasty (to correct tongue-tie)
* Facility provider and anesthesia services rendered in a facility setting in conjunction with non-covered dental procedures when determined to be medically necessary and appropriate due to your age and/or medical condition
* Accidental injury to the jaw or structures contiguous to the jaw except teeth
* The correction of a non-dental physiological condition which has resulted in sever functional impairment
* Treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof and floor of the mouth
* Orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus

Sterilization

Sterilization and its reversal regardless of medical necessity

and appropriateness

**Second Surgical Opinion**

A consulting physician’s opinion and directly related diagnostic

services to confirm the need for recommended elective surgery.

* Elective surgery is covered surgery that may be deferred and is not an emergency;
* Use of a second surgical opinion is at your option;
* If the first opinion for elective surgery and the second opinion conflict, a third opinion and directly related diagnostic services are covered services; and

**Surgery**

Surgery performed by a professional provider. Separate payment will

not be made for pre-and post- operative services.

**Therapy and Rehabilitation Services**

Benefits will be provided for the following services when such services are ordered by a physician:

* Cardiac rehabilitation
* Chemotherapy
* Dialysis treatment
* Infusion therapy when performed by a facility provider or ancillary provider and for self-administration if the components are furnished and billed by a facility provider or ancillary provider
* Occupational therapy
* Physical medicine
* Radiation therapy
* Speech therapy

**Transplant Services**

Benefits will be provided for covered services furnished by a hospital which are directly and specifically relate to the transplantation of organs, bones, tissue, or blood stem cells.

If human organ, bone, tissue or blood stem cell transplant is provided from a living donor to a human transplant recipient:

* When both the recipient and the donor are members, each is entitled to the benefits of their program;
* When only the recipient is member, both the donor and the recipient are entitled to the benefits of this program. Benefits provided to the donor will be charged against the recipient’s coverage under this program to the extent that benefits remain and are available under this program after benefits for the recipient’s own expenses have been paid;
* When only the donor is a member, the donor is entitled to the benefits of this program, subject to the following additional limitations: 1) the benefits are limited to only those not provided or available to the donor for any other source in accordance with the terms of this program; and 2) no benefits will be provided to the non-member transplant recipient; and
* If any organ, tissue or blood stem cell is sold rather than donated to the member recipient, no benefits will be payable for the purchase price of such organ, tissue or blood stem cell; however, other costs related to evaluation and procurement are covered up to the member recipients program limit

**What Is Not Covered**

Except as specifically provided in this booklet or as mandated or required to cover based on state or federal law, regulation or other directive, no benefits will be provided for services, supplies or charges:

* Acupuncture
* Assisted Fertilization
* Related to treatment provided specifically for the purpose of assisted fertilization, including pharmacological or hormonal treatments used in conjunction with assisted fertilization
* Comfort/Convenience Items
* For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifies, or physical fitness equipment, stair glides, elevators/lifts or “barrier free” home modifications, which or not specifically recommended by a professional provider
* Cosmetic Surgery
* For cosmetic or reconstructive procedure or surgery done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except: a) as otherwise provided herein, b) when required to correct a condition directly resulting from an accident; c) when necessary to correct a functional impairment which directly results from a covered disease or injury, or d) to correct a congenital birth defect
* Court Ordered Services
* For otherwise covered services ordered by a court or other tribunal unless medically necessary and appropriate or if the reimbursement of such services is required by law
* Custodial Care
* For custodial care, domiciliary care, protective and supportive care including educational services, rest cures and convalescent care
* Dental Care
* Directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or disease of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease, except for dental expenses related to accidental injury, anesthesia for non-covered dental procedures and orthodontic treatment for congenital cleft palates as provided
* Diabetes Prevention Program
* For a diabetes prevention program offered by other than a network diabetes prevention provider
* Effective Date
* Rendered prior to your effective date of coverage
* Enteral Foods
* For the following services associated with the additional enteral foods benefits provided under your program: blenderized food, baby food, or regular shelf food; milk or soy based infant formulae with intact proteins and formulae, when used for the convenience of you or your family members; nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation or maintenance; semisynthetic intact protein/protein isolates natural intact protein/protein isolates, when provided orally; normal food products used in the dietary management of the disorders provided herein
* Experimental/Investigational
* Which are experimental/investigative in nature, except as provided herein for Routine Patient Costs incurred in connection with an Approved Clinical Trial
* Eyeglasses/Contact Lenses
* For eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses (except for the initial pair of contact lenses/glasses prescribed following cataract extraction in place of surgically implanted lenses, or sclera shells intended for use in treatment of disease or injury)
* Felonies
* For any illness or injury, you suffer during your commission of a felony, as long as such illness or injuries are not the result of a medical condition or an act of domestic violence
* Foot Care
* For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, corrective shoes, the treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toe nails (except surgery for ingrown toe nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of feet, except when such devices or services are related to the treatment of diabetes
* Health Care Management program
* For any care, treatment, prescription drug or service which has been disallowed under the provisions of Health Care Management program
* Hearing Care Services
* For hearing aid devices, tinnitus maskers, or examinations for the prescription or fitting of hearing aids
* Home Health Care
* For the following services you receive from a home health care agency, hospice or a hospital program for home health care and/or hospice care: dietician services; homemaker services; maintenance therapy; dialysis treatment; custodial care; food or home-delivered meals
* Immunizations
* For immunizations required for foreign travel or employment, except as provided herein
* Inpatient Admissions
* For inpatient admissions which are primarily for diagnostic studies
* For inpatient admissions which are primarily for physical medicine services
* Learning Disabilities
* For any care that is related to conditions such as hyperkinetic syndromes, learning disabilities, behavioral problems or intellectual disabilities, but not including care related to autism spectrum disorders, which extends beyond traditional medical management or for inpatient confinement for environmental change. Care which extends beyond traditional medical management or for inpatient confinement for environmental change includes the following: a) services that are primarily educational in nature, such as academic skills training or those for remedial education or those that may be delivered in a classroom-type setting, including tutorial services; b) neuropsychological testing, educational testing (such as I.Q., mental ability, achievement and aptitude testing), except for specific evaluation purposes directly related to medical treatment; c) services provided for purposes of behavioral modifications and/or training; d) services related to treatment of learning disorders or learning disabilities; e) services provided primarily for social or environmental change or for respite care; and f) developmental or cognitive therapies that are not restorative in nature but used to facilitate or promote the development of skills which you have not yet attained
* For any care that is related to autism spectrum disorders which extends beyond traditional medical management, except as otherwise provided herein. Care which extends beyond traditional medical management includes the following: a) services that are primarily educational in nature, such as academic skills training and vocational training including tutorial services; b) neuropsychological testing, educational testing (such as I.Q., mental ability, achievement and aptitude testing); except for specific evaluation purposes directly related to medical treatment; and c) services provided primarily for respite care.
* Legal Obligation
* For which you would have no legal obligation to pay
* Medically Necessary and Appropriate
* Which are not medically necessary and appropriate
* Medicare
* To the extent payment has been made under Medicare when Medicare is primary
* Methadone Hydrochloride
  + For Methadone Hydrochloride treatment for which no additional functional progress is expected to occur
* Military Service
* To the extent benefits are provided to members of the armed forces while on active duty or to patients in Veteran’s Administration facilities for service connected to illness or injury, unless you have a legal obligation to pay
* For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form
* For any other medical or dental service or treatment or prescription drug except as provided herein
* For any tests, screenings, examinations or any other services required by: a) an employer or governmental body or agency in order to begin or to continue working or as a condition to performing the functions of any employments in a particular setting; b) a school, college or university in order to enter onto school property or a particular location regardless of purpose, or, c) a governmental body or agency for public surveillance purposes; and that does not relate to the furnishing or administration of an individualized test, screening or evaluation determined by the member’s attending professional provider as being medically appropriate
* Motor Vehicle Accident
* For treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including medical benefits payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act
* Nutritional Counseling
* For nutritional counseling, except as provided herein
* Obesity
* For treatment of obesity, except for medical and surgical treatment of morbid obesity or as otherwise set forth in the predefined preventive schedule
* Oral Surgery
* For oral surgery procedures, except as provided herein
* Physical Examinations
* For routine or periodic physical examinations, the completion of forms, and the preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, which are no medically necessary and appropriate, except as provided herein
* Prescription Drugs
* For prescriptions drugs and medications, except those which are administered to an inpatient in a facility provider or as otherwise set forth in the predefined preventive schedule
* Preventive Care Services
  + For the preventive care services, wellness services or programs, except as provided herein
  + School or sports physicals
* Provider of Service
  + Which are not prescribed by or performed by or upon the direction of a professional provider
  + Rendered by other than providers
  + Received from a dental or medical department maintained, in whole or in part, by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group
  + Which are submitted by a certified registered nurse and another professional provider for the same services performed on the same date for the same member
  + Rendered by a provider who is a member of your immediate family
  + Performed by a professional provider enrolled in an education or training program when such services are related to the education or training program
* Sexual Dysfunction
* For treatment of sexual dysfunction that is not related to organic disease or injury
* Skilled Nursing
* For skilled nursing facility services after you have reached the maximum level of recovery possible for your particular condition and no longer required definitive treatment other than routine supportive care; when confinement is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience; or for treatment of substance abuse or mental illness
* Smoking (nicotine) Cessation
* For nicotine cessation support programs and/or classes, except as otherwise set forth in the predefined preventive schedule
* Termination Date
* Incurred after the date of termination of your coverage except as provided herein
* Therapy
* For outpatient therapy and rehabilitation services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur
* TMJ
* For treatment of temporomandibular joint (jaw hinge) syndrome with intra-oral prosthetic devices, or any other method to alter vertical dimensions and/or restore or maintain the occlusion and treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma
* Transsexual surgery
  + Treatment leading to or in connection with transsexual surgery
* Vision Correction Surgery
* For the correction of myopia, hyperopia or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakic, radial keratotomy, corneal ring implants, Laser-Assisted in Situ Keratomileusis (LASIK) and all related services
* War
  + For losses sustained or expenses incurred as a result of an act of war whether declared or undeclared
* Weight Reduction
  + For weight reduction programs, including all diagnostic testing related to weight reduction programs, unless medically necessary and appropriate
* Well-Baby Care
  + For well-baby care visits, except as provided herein
* Workers’ Compensation
  + For any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government’s workers’ compensation, occupational disease or similar type legislation. This exclusion applies whether or not you claim the benefits or compensation

**Health Care Management**

Your benefits are subject to review by a designate agent as part of its health care management program. This program is to help ensure that you receive: care that is medically necessary and appropriate; and health care services in a setting which best meets your individual treatment needs.

**Case Management**

Case management is a service provided through a Review Organization, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of case management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a Hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his/her family, and the attending Physician to determine appropriate treatment options which will best meet the patient’s needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer any

questions and provide ongoing support for the family in times of crisis.

Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A Case Manager trained in the appropriate clinical

specialty area will be assigned to you or your dependent. In addition, Case Managers are supported by a panel of Physician advisors who offer guidance on up-to-date treatment programs and medical terminology. While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient’s attending Physician remains responsible

for the actual medical care.

You or your Dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary – no penalty or benefit reduction is imposed if you do not wish to participate in Case Management

Following an initial assessment, the Case Manager works with you, your family, and Physician to determine the needs of the patient and to identify what alternative programs are available (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternative

treatment program is not followed.

The Case Manager also acts as a liaison between the insurer, the patient, his or her family and the Physician as needed (for example, by helping you understand a complex medical diagnosis

or treatment plan)

Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient’s needs

While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-effective alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need

**Certification Requirements**

**All Inpatient Admissions**

* Acute
* Long-Term acute care
* Rehabilitation
* Mental Health/Substance Use Disorder
* Transplant
* Skilled Nursing Facility
* Residential Treatment Facility
* Obstetric – Prenotification only (precertification only required if days exceed Federal mandate)

**Precertification for Inpatient and Outpatient procedures that**

**could be considered Experimental/Investigational**

**Outpatient and Physician Surgery**

* Prenotification for the following:
  + Biopsies (excluding skin)
  + Vascular Access Devices for the infusion of Chemotherapy (e.g. PICC and Central Lines)
  + Thyroidectomy, Partial or Complete
  + Open Prostatectomy
  + Creation and Revision of Arteriovenous Fistula (AV Fistula) or Vessel Cannula for Dialysis
  + Oophorectomy, unilateral and bilateral
* Precertification for the following:
  + Back surgeries and hardware related to surgery
  + Osteochondral allograft, knee
  + Hysterectomy (including prophylactic)
  + Autologous chondrocyte implantation, Carticel
  + Transplant (excluding cornea)
  + Balloon sinuplasty
  + Sleep apnea related surgeries, limited to:
    - Radiofrequency ablation (Coblation, Somnoplasty)
    - Uvulopalatopharyngoplasty (UPPP) (including laser-assisted procedures)
  + Potentially Cosmetic Procedures, including but not limited to:
    - Abdominoplasty
    - Blepharoplasty
    - Cervicoplasty (neck lift)
    - Facial skin lesions (Photo therapy, laser therapy – exclusion MOHS)
    - Hernia repair, abdominal and incisional (only when associated with cosmetic procedure)
    - IDET (thermal intradiscal procedures)
    - Liposuction, lipectomy
    - Mammoplasty, augmentation and reduction (including removal of implant)
    - Morbid obesity procedures
    - Orthognathic procedures (e.g. Genioplasty, LeFort osteotomy, Mandibular ORIF, TMJ)
    - Otoplasty
    - Panniculectomy
    - Rhinoplasty
    - Rhytidectomy
    - Scar revisions
    - Septoplasty
    - Varicose vein surgery/sclerotherapy

**Outpatient and Physician Diagnostic Services**

* Prenotification for the following:
  + CT for non-orthopedic
  + MRI for non-orthopedic
* Precertification for the following:
  + PET
  + Capsule endoscopy
  + Genetic Testing
  + Sleep Study

**Outpatient and Physician Continuing Care Services**

* Prenotification for the following:
  + Dialysis
* Precertification for the following:
  + Gene Therapy
  + Chemotherapy (including oral)
  + Radiation therapy
  + Oncology and transplant related injections, infusions, and treatments (e.g. CAR-T, endocrine, and immunotherapy), excluding supportive drugs (e.g. antiemetic and antihistamine)
  + Hyperbaric Oxygen
  + Home Health Care
  + Durable Medical Equipment, limited to electric/motorized scooters or wheelchairs and pneumatic compression devices

**All medications processed through the medical benefit which**

**cost $2,000 or more per drug per month (excluding acute**

**oncology or transplant treatments)**

Your plan reserves the right, utilizing criteria set forth in this definition, to render the final determination as to whether a service or supply is medically necessary and appropriate. No benefits hereunder will be provided unless your plan determines that the services or supply is medically necessary and appropriate.

Medical Necessity and Appropriateness: Services, supplies, or

covered medications that a provider, exercising prudent clinical judgement, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease or its symptoms that are: (i) in accordance with generally accepted standards of medical practice; and (ii) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and (iii) not primarily for the convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient’s illness, injury or disease.

A Highmark participating provider will contact utilization management for you in order to determine whether services are medically necessary and appropriate. When the Highmark participating provider contacts utilization management, a review will determine whether an admission, procedure, or requested

service is medically necessary and appropriate or whether a specific number of days or visits is required to adequately treat the condition. If an entire admission, procedure or requested service is not medically necessary and appropriate, you and your provider will be noticed in writing that the service will not be paid under your benefits program. If you and your provider decide to proceed with a service that is not medically necessary and appropriate you will be responsible for full payment of service.

If you use a Non-Participating Facility Provider or Non-Participating Professional Provider:

For emergency and delivery related to Maternity Admissions: You or your Dependent will contact utilization management in order to determine whether services are medically necessary and appropriate. You should contact the Review Organization within 72 hours after the admission.

All Planned Admissions, Procedures, and Services: You or your Dependent will contact utilization management in order to determine whether services are medically necessary and appropriate. You should call the Review Organization 7-14 days prior to your planned admission or service.

**Coordination of Benefits**

The object of coordination of benefits is to ensure that your covered expenses will be paid, while preventing duplicate benefit payments.

* When your other coverage does not mention “coordination of benefits” then that coverage pays first. Benefits paid or payable by the other coverage will be considered in determining if additional benefit payments can be made under your plan
* When the person who received care is covered as an employee under one contract, and as a dependent under another, then the employee coverage pays first
* When a dependent child is covered under two contracts, the contract covering the parent whose birthday falls earlier in the calendar year pays first. But, if both parents have the same birthday, the plan child which covered the parent longer will be the primary plan. If the dependent child’s parents are separated of divorced, the following applies:
  + The parent with custody of the child pays first
  + The coverage of the parent with custody pays first but the stepparent’s coverage pays before the coverage of the parent who does not have custody
  + Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child’s health care expenses, the coverage of that parent pays first
* When none of the above circumstances applies, the coverage you have had for the longest time pays first, provided that:
  + The benefits of the plan covering the person as an employee other than a laid-off or retired employee or as a dependent of such personal shall be determined before the benefits of a plan covering the person as a laid-off or retired employee or as a dependent of such person and if
  + The other plan does not have this provision regarding laid-off or retired employees, and, as a result, plans do not agree on the order of benefits, then this rule is disregarded

If you receive more than you should have when your benefits are coordinated, you will be expected to repay the overpayment.

**How to File a Claim**

In most instances, hospitals and physicians will submit a claim on your behalf directly to Highmark. If your claim is not submitted directly by the provider you must submit itemized bills to the Fund office.

* An itemized bill must include:
* The name and address of the service provider
* The patient’s full name
* The date of service or supply
* A description of service or supply (CPT code)
* The amount charged
* For durable medical equipment, the doctor’s certification
* For private duty nursing, the nurse’s license number, charge per day and shift worked, and signature of provider prescribing the service
* For ambulance services, total mileage
* Please note: If you’ve already made payment for the services you received, you must also submit proof of payment (receipt from provider) with your itemized bill. Cancelled checks, cash register receipts, or personal itemizations are not acceptable as itemized bills. Reimbursement will be calculated at the Out-of-Network benefit level.
* You must submit originals, so you may want to make copies for your records. Once your claim is received itemized bills cannot be returned.

**How Your Health Care Program Works**

**Network Care**

Network care is care you receive from providers in your program’s Network. When you receive health care within the network, you

enjoy maximum coverage and maximum convenience. You present your ID card to the provider who submits your claim.

**Out-of-Network Care**

Out-of-Network care is care you receive from providers who are not in your programs network. When using out-of-network providers, you may still have coverage for most eligible services, except you will share more financial and paperwork responsibilities. In addition, you may be responsible for paying any differences between the program’s payments and the provider’s actual charges. Finally, you may need to file your own clams and obtain precertification for inpatient care. You should always check with the provider before getting care to understand what level your care will be covered.

**Provider Reimbursement and Member Liability**

Highmark uses the Plan Allowance to calculate the benefit payable and the financial liability of the member for Medically Necessary and Appropriate Services covered under this plan.

Highmark’s payment is determined by first subtracting any deductible and/or copayment liability from the Plan Allowance. The coinsurance percentage set forth in the Summary of Benefits is then applied to that amount. This amount represents Highmark’s payment. Any remaining coinsurance amount is the

member’s responsibility. The member’s total cost-sharing liability is the sum of the coinsurance plus any deductible and/or copayment obligations.

However, the following covered services when received from an out-of-network provider will be provided at the network services level of benefits and you will not be responsible for such difference:

1. Emergency Care Services
2. Ambulance services, when provided in conjunction with emergency care services or when provided by air

Additionally, you may not be liable for charges for non-emergency covered services received from certain professional providers or ancillary providers who are not part of the network. A network facility provider may have an arrangement with a professional provider or ancillary provider who is not part of the network to render certain items and professional services (such as, but not limited to, equipment, devices, anesthesiology, radiology, or pathology services) to patients of the network facility provider. The selection of such professional providers or ancillary providers may be beyond your control. In that situation, you will not be

liable, expect for applicable network deductible, copayment or coinsurance obligations, for the charges of the professional provider or ancillary provider.

**Inter-Plan Arrangements**

**Out-of-Area Services**

Highmark has a variety of relationships with other Blue Cross and/or Blue Shield licensees referred to generally as “inter-plan arrangements.” These inter-plan arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association. Whenever member access health care services outside of the geographic area served by Highmark Inc within Pennsylvania, the claim for those services may be processed through one of these inter-plan arrangements, as described generally below.

Typically, when accessing care outside of the Highmark geographic area within Pennsylvania, members obtain care from providers that have a contractual agreement (“participating providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, members may obtain care from providers in the Host Blue geographic area that do not have a contractual agreement (non-participating providers”) with the Host Blue. Highmark remains responsible for fulfilling our contractual obligations to you. Highmark’s payment practices in both instances are described below.

**BlueCard® Program**

The BlueCard® Program is an inter-plan arrangement. Under this arrangement, when members access covered services outside of the

Highmark geographic area within Pennsylvania, the Host Blue will be

responsible for contracting and handling all interactions with its participating health care providers.

**Liability Calculation Method per Claim**

Unless subject to a fixed dollar copayment, the calculation of the member liability on claims for covered services processed through the BlueCard Program will be based on the lower of the participating provider’s billed charges for covered services or the negotiated price made available to Highmark by the Host Blue. Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue’s health care provider contracts. The negotiated price made available to Highmark by the Host Blue may be represented by one of the following:

* An actual price – an actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases, or
* An estimated price – an estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim related transactions. Such transact5ions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific bases, retrospective settlements and performance-related to bonuses or incentives, or
* An average price – an average price is a percentage of billed charges for covered services in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its providers or a similar classification of its providers and other claim and non-claim related transactions. Such transactions may include the same ones as noted above for an estimated price

Host Blues determine whether or not the will use an actual price, estimated

or average price. Host Blues using either an estimated price or an average

price may prospectively increase or reduce such prices to correct for over-

or underestimation of past prices (i.e., prospective adjustment may mean

that a current price reflects additional amounts or credits for claims already

paid or anticipated to be paid to providers or refunds received or

anticipated to be received from providers). However, the BlueCard Program

requests that the amount paid by the member is a final price; no future

price adjustment will result in increases or decreases to the pricing of past

claims. The method of claims payment by Host Blues is taken into account

by Highmark in determining the member’s premiums.

**Special Cases: Value Based Programs**

If members receive covered services under a Value-Based Program inside a Host Blue’s service area, you will not be responsible for paying any of the provider incentives, risk-sharing, and/or care coordinator fees that are part of such an arrangement, except when a Host Blue passes these fees to Highmark through average pricing or fee schedule adjustments.

**Return of overpayments**

Recoveries of overpayments from a Host Blue of its participating and non-participating providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, provider/hospital bill audits, utilization review refunds and unsolicited refunds. Recoveries will be applied so that corrections will be made, in general, on either a claim by claim or prospective basis. If recovery amounts are passed on a claim by claim basis from a Host Blue to Highmark, they will be credited to your account. In some cases, the Host Blue will engage a third party to assist in identification or collection of overpayments. The fees of such a third party may be charged to you as a percentage of the recovery.

**Non-Participating Providers Outside of the Highmark Geographic Area within Pennsylvania**

**Member Liability Calculation**

When covered services are provided outside the Highmark geographic area

within Pennsylvania by non-participating providers, the amount(s) a

member pays for such services will generally be based on either the Host Blue’s non-participating provider local payment or the pricing arrangements required by applicable law. In these situations, the member may be responsible for the difference between the amount that the non-participating provider bills and the payment Highmark will make for the covered services as set forth in this paragraph. Payments for emergency services rendered by non-participating providers will be governed by

applicable federal and state law.

**Exceptions**

In some exception cases, Highmark may pay claims for non-participating

providers outside of the Highmark geographic area within Pennsylvania based on the provider’s billed charge. This may occur in situations where a member did not have reasonable access to the participating provider, as determined by Highmark in Highmark’s sole and absolute discretion or by applicable law. In other exception cases, Highmark may pay such claims based on the payment Highmark would make if Highmark were paying a non-participating provider for the same covered service inside the Plan service area as described elsewhere in this document. This may occur where the Host Blue’s corresponding payment would be more than the plan in-service area non-participating provider payment. Highmark may choose to negotiate a payment with such a provider on an exception basis.

Unless otherwise stated, in any of these exception situations, the member may be responsible for the difference between the amount that the non-participating provider bills and payment Highmark will make for the covered services as set forth in this paragraph.

**Blue Cross Blue Shield Global Core Program**

If members are outside the United States (hereinafter “BlueCard service area”), they may be able to take advantage of the Blue Cross Blue Shield Global Core Program when accessing covered services. The Blue Cross Blue Shield Global Core Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core Program assists members with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when members receive care from providers outside the BlueCard service area, they will typically have to pay the providers and submit the claims themselves and obtain reimbursement for these services.

**Inpatient Services**

In most cases, if members contact the Blue Cross Blue Shield Global Core service center for assistance, hospitals will not require members to pay for inpatient covered services, except for their cost-sharing amounts. In such cases, a Blue Cross Blue Shield Global Core contracting hospital will submit member claims to the service center to initiate claims processing. However, if the member paid in full at the time of service, the member must submit a claim to obtain reimbursement for covered services. **Members must obtain precertification or preauthorization for non-emergency inpatient services.**

**Outpatient Services**

Physicians, urgent care centers, and other outpatient providers located outside the BlueCard service area will typically require members to pay in full at the time of service. Members must submit a claim to obtain reimbursement for covered services.

**Your Provider Network**

The network includes: primary care providers; a wide range of specialists; mental health and substance abuse providers; community and specialty hospitals; and laboratories.

To determine if your physician is in the network, call the Member Service telephone number on the back of your ID card, or log onto www.highmarkbcbs.com.

**Eligible Providers**

**Facility Providers**

* Hospital
* Psychiatric hospital
* Rehabilitation hospital
* Ambulatory surgical facility
* Birthing facility
* Freestanding dialysis facility
* Freestanding nuclear magnetic resonance facility/magnetic resonance imaging facility
* Home health care agency
* Hospice
* Outpatient substance abuse treatment facility
* Outpatient physical rehabilitation facility
* Outpatient psychiatric facility
* Pediatric extended care facility
* Pharmacy provider
* Residential treatment facility
* Skilled nursing facility
* State-owned psychiatric hospital
* Substance abuse treatment facility

**Professional Providers**

* Audiologist
* Behavior specialist
* Certified registered nurse
  + Excluded from eligibility are registered nurses employed by a health care facility or by an anesthesiology group
* Chiropractor
* Clinical social worker
* Dentist
* Dietitian-nutritionist
* Licensed practical nurse
* Marriage and family therapist
* Nurse-midwife
* Occupational therapist
* Optometrist
* Physical therapist
* Physician
* Podiatrist
* Professional counselor
* Psychologist
* Registered nurse
* Respiratory therapist
* Speech-language pathologist
* Teacher of hearing impaired

**Ancillary Providers**

* Ambulance service
* Clinical laboratory
* Diabetes prevention provider
* Home infusion therapy provider
* Independent diagnostic testing facility
* Suite infusion therapy provider
* Supplies

**Contracting Suppliers (for the sale or lease of)**

* Durable medical equipment
* Supplies
* Orthotics
* Prosthetics

**Benefit Claim Processing and Appeal Procedures**

**Health Benefit Claims Processing**

**Types of Claims**

Claims for health benefits are categorized into three types for

purposes of claim and appeal processing

**Pre-Service Claim**

A Pre-Service Claim is a claim for benefits, that is filed before the

medical services or treatment is provided

**Urgent-Care Claim**

A Pre-Service claim may also be an Urgent-Care Claim. A Pre-Service

claim is considered an Urgent Care Claim if a delay in receiving the

medical services or treatment for which the claim is made:

* Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or
* In the opinion of a physician with knowledge of the claimant’s medical condition, could subject the claimant to severe pain that cannot be adequately managed without the services or treatment that is the subject of the claim

A claim that constitutes an Urgent-Care Claim should include information on the medical circumstances that make it an Urgent-Care Claim. The determination of whether a claim for benefits is an Urgent-Care Claim is generally made by the claim’s administrator based on the information provided with respect to the claim.

**Post-Service Claim**

A Post-Service Claim is a claim for health benefits that is filed after

medical services or treatment is provided. A Post-Service claim for

health benefits may include Pre-Service Claims or Urgent-Care Claims

where the medical services or treatment that was subject of the Pre-

Service Claim or Urgent-Care Claim has been provided and the only

remaining issue with respect to such claim is the payment for the

medical services or treatment.

**Processing a Pre-Service Claims (Non-Urgent)**

A Pre-Service Claim, including a request for pre-authorization, that

requires no additional information to process will be approved or

denied by the claim’s administrator no later than 15 days after

receipt. Written or electronic notice of the approval or denial will be

given to the claimant by the claim’s administrator.

If special circumstances require, the initial 15-day period may be

extended for up to an additional 15 days. The claims administrator

will provide written or electronic notice of the extension to the

claimant within the initial 15-day period. The notice will specify the

circumstances requiring the extension and the date by which the

claims administrator expects a decision.

If a claimant does not submit sufficient information, the claims

administrator will provide the claimant with written or electronic

notice of the specific information require to process the claim. Such

notice will be provided before the end of the initial 15-day period, the claimant will have 45 days to provide the required information. In

such case, the claims administrator will approve or deny the Pre-

Service Claim no more than 15 days following the earlier of: (1) the

date of the claimant’s response is received; or (2) the date such 45

day period ends.

**Processing Urgent-Care Claims**

An Urgent-Care Claim that requires no additional information to

process will be approved or denied by the claim’s administrator as

soon as possible following receipt of the claim, but no later than 72

hours after receipt. Oral, written or electronic notice of the approval

or denial will be given to the claimant by the claim’s administrator. If

given orally, written or electronic notice will be sent within 3 days of

the oral notification.

If a claimant does not submit sufficient information to allow the

claims administrator to make a decision, the claims administrator will

provide the claimant with oral, written or electronic notice of the

specific information required to decide such claim. Such notice will

be provided no later than 24 hours after receipt by the claims

administrator of the Urgent Care Claim. The claimant will have a

reasonable amount of time, but no less than 48 hours to provide the

required information. The claims administrator will approve or deny

the Urgent-Care Claim no later than 48hours following the receipt of

the claimant’s response or the end of the period for the claimant to

provide the required information but no later than 48 hours after the

earlier receipt of such response or the end of such period.

**Processing Post-Service Claims**

A Post-Service Claim that requires no additional information to

process will be approved or denied by the claim’s administrator no

later than 30 days after receipt. Written or electronic notice of the

approval or denial will be given to the claimant be the claims

administrator. If special circumstances require, the initial 30 day

period to decide the Post-Service Claim may be extended for up to an

additional 15 days. The claims administrator will provide written or

electronic notice of such extension to the claimant before the end of

the initial 30-day period. The notice will specify the circumstances

requiring the extension and the date by which the claims

administrator expect to decide the claim. If a claimant does not

submit sufficient information to allow the claims administrator to

decide a Post-Service Claim, the claims administrator will provide the

claimant with written or electronic notice of the specific information

required to decide the claim. Such notice shall be provided before

the end of the initial 30-day period, and the claimant will have 45

days to provide the required information. The claims administrator

will then approve or deny the Post-Service Claim no more than 15

days following the earlier of: (1) the date the claims administrator

receives the claimant’s response; (2) the date such 45-day period

ends

**Approval of Claim**

Other than the specific provision of an Urgent-Care Claim, the

claimant will be notified of the approval of a claim for benefits by the

claims administrator via a written or electronic Explanation of

Benefits Statement (EOB) that includes the following information:

* Actual charges
* Amount paid; and
* The amount that is the claimant’s responsibility

When a claim is approved, the provider is paid directly unless payment was already made to the provider by the claimant, in which case the claimant will be reimbursed.

**Denial of Claim**

Subject to oral notification with respect to an Urgent-Care Claim, the

claimant will be notified of the denial, in whole or in part, of a claim

for benefits by the claim’s administrator via a written or electronic

Explanation of Benefits (EOB).

**Appeal Processing**

**In General**

In connection with an appeal, the claimant is entitled to review all

relevant documents and receive copies free of charge and to submit

any comments, documents, records and information that support the

claimant’s claim for benefits

A claim on appeal, regardless of type, shall be subject to a full and

fair review by the Trustees of the Fund in accordance with the

following:

* The review shall consider all comments, documents, records and information submitted by the claimant in connection with the appeal, whether or not previously submitted or considered
* The review shall not afford any deference to a prior determination on the claim, and it shall not be made by the individual who made the prior determination or by a subordinate of that individual
* If the prior determination on the claim was based on a medical judgement, including a determination with regard to whether a particular treatment, drug or item is experimental, investigational or not medically necessary or appropriate, the review shall be made after consultation with a health care professional who has appropriate training and experience in the relevant field of medicine. Such health care professional shall not be an individual who was consulted with respect to the prior determination or a subordinate of that individual
* The review shall provide for the identification of medical or vocational experts, if any, whose advise was obtained in connection with the claim that is the subject of the review. Without regard to whether the advice was relied upon in making the prior determination on the claim

**Processing Urgent-Care Claim Appeals**

Any information regarding an appeal of an Urgent-Care Claim will be

transmitted from the Board of Trustees to the claim’s administrator

by telephone, facsimile, or other similarly expeditious methods or

transmission. The information will be transmitted from the claims

administrator to the claimant with the same methods. The Board of

Trustees will review and make a decision on the appeal of a decision

or an Urgent-Care Claim no later than 72 hours after receipt of the

claimant’s request for appeal. The decision by the Board of Trustees

will be transmitted to the claimant, if given orally written or

electronic notice will be sent within 3 days or the oral notification.

**Processing Pre-Service (Non-Urgent) Claim Appeals**

For an appeal of a decision on a Pre-Service Claim, a decision will be

made no later than 30 days after receipt. The claimant will be will be provided with written or electronic notice of the decision on appeal by the claim’s administrator on behalf of the Board of Trustees

**Processing Post-Service Claim Appeals**

The Board of Trustees will decide on the appeal by the date

of the first meeting of the Board of Trustees that follows receipt of

the appeal, provided the Board of Trustees holds regularly scheduled

meetings at least quarterly. However, if your appeal is received

within the 30-day period preceding the date of the first meeting, the

Board of Trustees will make its decision by the date of its second

meeting that follows the receipt of your appeal. If special

circumstances, such as the need to hold a hearing, require and

extension, you will be notified of that extension, thus the Board of

Trustees will make its decision by the date of its third meeting that

follows the receipt of your appeal. In the event of an extension, you

will receive notification describing the special circumstances and the

date by which a decision on your appeal is expected. The claimant

will receipt written decision on appeals within five days of the

meeting at which the decision is made.

**Notice of Denial of Appeal**

If a decision on appeal is adverse, the notice of decision will include:

* The reasons for the decision
* Reference to the plan provisions on which the decision was based
* Any internal rule, guideline, protocol or other similar criterion that was relied on for the decision, or a statement that it was relied upon and a copy will be provided free of charge upon the claimant’s request
* If the decision was based upon medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the decision, applying the plan provisions to the claimant’s medical circumstances, or a statement that such explanation will be provided free of charge upon the claimant’s request
* A statement of the claimant’s right to bring civil action under ERISA

**Final Decision**

Decisions of the Board of Trustees are the final decision under the

Fund.

**Designation of Representative**

A covered person may designate a duly authorized representative to

act on his/her behalf in filing a claim for benefits and/or to appeal any denial of a claim for benefits. Such designation must be made in writing and should include the representative’s name, address, telephone number, facsimile number, a statement indicating the extent of the representative’s authority to purse a claim and/or appeal, and an authorization to release medical information to the representative in a manner that complies with the requirements of law, including privacy regulations under the Health Insurance Portability and Accountability Act of 1996.

**Questions**

Any questions about claim and appeal procedures should be directed

to the Fund office.

**Member Service**

When you have questions about a claim, benefits or coverage just call Member Service at the number on your member ID card, 833-258-4652.