

# HEALTH

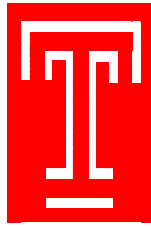
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# BENEFITS

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# PROGRAM

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TEMPLE  
UNIVERSITY

**65 SPECIAL PROGRAM**



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This booklet has been prepared so that you may become acquainted with your Independence Blue Cross and Highmark Blue Shield health care programs available to retired *employees* who are eligible and enrolled for them. The benefits described are subject to the terms of the group contract issued by Independence Blue Cross and Highmark Blue Shield (known as the Plan).

Benefits will not be available for services to a greater extent or for a longer period than is *medically necessary*, as determined by the Plan. The amount of benefits for any *covered service* will not be more than the amount charged by the health care provider and will not be greater than any *maximum* amount or limit described or referred to in this booklet.

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## HOW TO USE THIS BOOKLET

This booklet contains pertinent information about your health care program, including covered and non-covered services, copayment and *deductible* amounts, program limitations, etc.

The section titled "General Information" includes important information about claims filing information, etc.

The "Definitions of Terms" section is a resource designed to help you better understand the terminology used to describe specific elements of your coverage. All words defined in the "Definitions of Terms" are printed in *bold italics* wherever they appear in the text.

## GENERAL INFORMATION

### Eligibility

You may enroll in this Program if you are eligible to receive retirement benefits from your employer and have retired at age 65 or later; and are enrolled in Medicare Parts A and B.

### Changes in Your Address

It is important that you notify your employer promptly of any change in your address. Change forms and application cards should not be given directly to the Blue Cross Plan office.

### How Benefits are Received

#### Blue Cross 65-Special/Medicare

Medicare Part A together with your Blue Cross 65-Special covers your *hospital* bills. The *hospital* should apply for Medicare and Blue Cross 65-Special payments. You need only to present your Medicare Health Insurance Card and your Blue Cross 65-Special card to the admitting clerk. If the *hospital* will not file for your Blue Cross 65-Special, forward a copy of the Medicare Hospital, Extended Care and Home Health Benefits record to Independence Blue Cross, 1901 Market Street, Philadelphia, PA 19103. Be sure to note your "65-Special" Blue Cross group and identification numbers on all correspondence.

#### Blue Shield 65-Special/Medicare

Medicare Part B together with your Blue Shield 65-Special covers doctor's reasonable charges. A Medicare claim form must be submitted to the Medicare Part B carrier in the state where the services were performed. After Medicare Part B makes its payment, the balance not covered is processed by Pennsylvania Blue Shield. If the services were performed in Pennsylvania, the processing is automatic. If the services were performed outside of Pennsylvania, the Explanation of Medicare Benefits (EOMB) that you receive must be sent to Pennsylvania Blue Shield, P. O. Box 890065, Camp Hill, PA 17089-0065 for processing. Be sure to note your "65-Special" Blue Shield group and identification numbers on all correspondence.

### Subrogation

If any benefit is provided to the *Subscriber* under this Agreement, Blue Cross and Blue Shield shall be subrogated and succeed to the *Subscriber's* rights of recovery with respect to the services and supplies involved against a responsible third party and/or insurance company.

Subrogation means that if you or your enrolled *dependent(s)* are injured because of the negligence or wrongdoing of another party, Blue Cross and Blue Shield have the right to seek recovery of benefits paid for related expenses. You are expected to take any action necessary to protect and to assure the subrogation rights of Blue Cross and Blue Shield. This provision does not apply to an individual insurance policy covering you or your *dependents*.

### Consumer Rights

Each Covered Person has the right to access, review and copy their own health and membership records and request amendments to their records. This includes information pertaining to claim payments, payment methodology, reduction or denial, medical information secured from other agents, plans or providers.

For more information about accessing, reviewing or copying records call Member Services at the toll-free number on your ID card.

## **Termination of Coverage**

When your eligibility terminates, all benefits of this Program will cease. However, arrangements may be made to continue both Blue Cross and Blue Shield under the direct payment type of Subscription Agreements.

## BLUE CROSS 65 SPECIAL PROGRAM

### Inpatient Hospital Care

Blue Cross pays the initial Medicare Deductible for *covered services* during the first 60 days of any benefit period. A new "Benefit Period" begins when you have not been a bed patient in a *hospital* or *skilled nursing facility* for 60 consecutive days.

If you remain in the *hospital* for more than 60 days during a benefit period, Blue Cross pays your daily Medicare co-payment for up to 30 days.

Blue Cross pays your daily Medicare co-payment for use of your 60 Medicare lifetime reserve days during one or several benefit periods.

After you have used your 90 days of care during a benefit period and your reserve days are no longer available, Blue Cross covers all the *hospital* benefits offered under Medicare in addition to those covered under Blue Cross for 365 *additional lifetime days* (non-renewable). NOTE: Benefits for *inpatient* psychiatric care are limited to 30 of the 365 non-renewable days during a *Subscriber's* lifetime.

During an approved *inpatient* admission, Blue Cross will pay for the cost of the first 3 pints of unreplaced blood or blood plasma during each calendar year (which are not covered under Medicare) while an *inpatient*.

### Skilled Nursing Facility Care

Blue Cross will cover the co-payment in a *skilled nursing facility* from the 21st through the 100th day for covered *skilled nursing facility* services.

After you have used the 100 days in a *skilled nursing facility* which were covered by Medicare Part A, Blue Cross provides additional days of skilled care in the facility. You are entitled to up to 365 *non-renewable additional days during your lifetime*. (These are part of and NOT in addition to, the 365 lifetime *hospital* days. See the 4th paragraph of Inpatient Hospital Care.)

In a *skilled nursing facility* which is not a member of any Blue Cross Plan but which is approved by the Joint Commission on the Accreditation of Healthcare Organizations or by the Blue Cross Plan, the Plan will pay you an allowance of up to \$12.00 per day toward the facility's regular charges for *covered services* described in this section.

### Outpatient Hospital Care

Medicare Part A does not cover *outpatient* services for *emergency care*, minor *surgery*, diagnosis or therapy. Eighty percent of reasonable charges for these services when *medically necessary* are covered by Medicare Part B after you have paid the Medicare Part B *deductible* applying to all your covered medical services during a calendar year.

Blue Cross pays up to the Medicare Part B *deductible* and 20% of the balance which would be owed by you for covered *emergency care*, minor *surgery*, diagnosis or therapy in the *hospital's outpatient* department during a calendar year even if you do not have Medicare Part B.

### Professional Services

When rendered by staff personnel, Blue Cross will pay reasonable and customary charges for X-ray, laboratory and *anesthesia* services when performed in the *hospital* up to the extent not covered by Medicare, Part B.



## Care in Foreign Countries

Blue Cross pays for all the *hospital* benefits normally offered under Medicare in addition to those provided under this Blue Cross program when the patient who is a United States resident is hospitalized in any foreign country.

## LIMITATIONS

Under the program Blue Cross does not provide:

- Benefits in *hospitals* that do not participate in the Medicare program (except for foreign *hospitals*).
- Care for any person not entitled to benefits under Medicare.
- Routine physical examinations.
- *Inpatient* accommodations when admission for diagnosis, diagnostic study or medical observation could have been performed on an *outpatient* basis.
- Services not *medically necessary* for diagnosis or treatment of an illness or injury.
- Convalescent, custodial or rest cures or intermediate nursing home care.
- Services covered by programs created by federal or state laws or regulations, such as Medicare, or the Veteran's Administration; or, benefits paid or payable under a policy of motor vehicle insurance, through the Catastrophic Loss Trust Fund for accidents occurring on or before June 1, 1989; or through qualified self insurance.
- Services furnished for a condition arising in the course of employment for which coverage is or was available under Worker's Compensation or similar laws.
- Services for which the cost may be recoverable by the *Subscriber* from or in any action at law or by compromise or settlement of any claim except as prohibited by the "Health Care Services Malpractice Act."
- Non-*hospital* or non-*skilled nursing facility* services.
- Private duty nurses.
- Ambulance services except as provided and billed for by *hospitals* or Independence Blue Cross member skilled nursing facilities.
- Drugs and medications not administered while an *inpatient* in a *hospital* or *skilled nursing facility* or *outpatient* visit to a *hospital*.
- Blood or blood plasma to the extent donated or replaced without cost to the *Subscriber*.
- Cosmetic *surgery* except as related to *accidental injury* which occurred after the *Subscriber's effective date*.
- Purchase or rental of *durable medical equipment*.
- Care of gums, teeth or extraction of teeth.
- Personal comfort or convenience items.
- Professional services which are provided under Medicare Part B.
- Any benefit paid for by Medicare, or benefits excluded under Medicare other than those outlined here.

## **BLUE SHIELD 65 SPECIAL**

### **Medicare Part B Supplemental Coverage**

Under Medicare Part B, the beneficiary is responsible for the Medicare Part B *deductible* each calendar year. Thereafter, Medicare pays 80% of reasonable charges for eligible medical services and supplies. Payment of the remaining 20% is the beneficiary's responsibility.

However, when the beneficiary also is enrolled under a Blue Shield 65 Special agreement, Blue Shield pays this 20% *coinsurance*.

In-*hospital* services included under 65 Special are:

- Surgeon's charges.
- Provider's fee for *anesthesia*.
- Provider's *hospital* visits.
- Provider's fee for radiation treatments.
- Provider's fee for X-ray examinations.
- Provider's fee for laboratory tests.
- Dentist's fee for dental *surgery* (See Exclusions).
- Provider's fee for diagnostic tests.
- Charges for braces, artificial legs, arms, eyes.
- Medical consultation by providers.
- Physical therapy and other therapy services by a licensed physical therapist.
- Hemodialysis services associated with chronic kidney disease.

Some services in the Provider's office covered under Blue Shield 65 Special are:

- Visits to the provider's office.
- Surgical dressings, splints, casts.
- Drugs administered by the provider.
- Professional services and examinations such as X-ray, electrocardiograms and pathological tests; radiation treatments and podiatry services.

Some of the services in your home covered under Blue Shield 65 Special when *medically necessary* are:

- Provider's visits.
- Diagnostic X-ray services.
- Surgical dressings, splints, casts.
- Rental or purchase of durable equipment such as wheelchair, *hospital* bed, oxygen tent, etc.
- Drugs administered by a provider.
- Charges for braces, artificial legs, arms, eyes.

## 65 SPECIAL EXCLUSIONS:

- Routine physical examinations.
- Eye examinations, refractions, eyeglasses, hearing examinations or hearing aids.
- Dental services such as the care, filling, removal or replacement of teeth, or treatment of gum areas. However, services involving *surgery* of the jaw or related structures or setting of fractures of the jaw or facial bones are covered.
- Routine foot care, treatment of flat feet and partial dislocations of the joints of the feet, orthopedic shoes or other supportive devices for the feet except those which are a part of leg braces.
- Immunization (unless directly related to immediate risk of infection from injury).
- *Prescription drugs* and drugs the *subscriber* can administer himself (such as insulin).
- Medical expenses for which the *subscriber* is not legally obligated to pay.
- Services provided and billed for by *skilled nursing care facilities*.
- Care for any person not covered by Medicare Part B.
- Benefits excluded under Medicare Part B other than those outlined in this booklet.
- Benefits for services occurring prior to the *effective date* of your Blue Shield 65 Special coverage.
- Payment of charges not deemed reasonable by Medicare Part B.
- Any benefit paid for by Medicare Part A or B.
- Payment of the Medicare Part B *deductible* amount.

## MAJOR MEDICAL BENEFITS



Major Medical supplements the provisions of the basic Blue Cross and Blue Shield Plans, so that you and your *dependents* have the extra protection needed in case of especially lengthy and costly sicknesses or accidents.

### How Major Medical Works

Major Medical benefits are determined as follows: From the Covered Medical Expenses described on the following pages which are *incurred* in any calendar year by any enrolled person, there is subtracted the sum of \$100 (the *deductible* amount) plus the amount of benefit allowable under the terms of the *Basic Plans*. (Your designated *Basic Plans* are described on the preceding pages.) Major Medical will pay 80% of the remaining Covered Medical Expenses; except for special provision for psychiatric treatment and services (see heading, *Psychiatric Care*).

## HOW MAJOR MEDICAL WORKS

**You Pay**

**Annual Deductible**

(3 per family)

**Plan Pays**

**\*80%**  
of allowable expenses

The 80% coinsurance amount is calculated as follows:

For services rendered by a Facility Provider, Covered Medical Expense is the lesser of (a) the Facility Provider's actual charges; (b) the Medicare Allowable Payment; and (c) the Major Medical Allowance for the Covered Services. For services rendered by a Professional Provider, Covered Medical Expense is the Professional Provider's charge, or the Major Medical Allowance, whichever is less. For services provided by a Contracting Ancillary Provider or Contracting Pharmacy, the Covered Medical Expense is the amount that the Plan has negotiated or the charge, whichever is less. For services rendered by a Non-Contracting Ancillary Provider or Non-Contracting Pharmacy, the Covered Medical Expense is the lesser of (a) the Provider's actual charge; (b) the Medicare Allowable Payment; and (c) the Major Medical Allowance.

## Deductibles

The following provisions pertain to the *deductible* amount:

- There is a Major Medical *deductible* each calendar year in which Covered Medical Expenses are *incurred*; but any part of a *deductible* applicable to expenses *incurred* during the last calendar quarter of any year will be credited toward the *deductible* payable in the succeeding calendar year.
- Copayments or *deductibles* when required by the *Basic Plans* may not be credited toward this Major Medical *deductible*.
- In the case of an accident involving you and/or one or more *dependents*, only one *deductible* is applied in any calendar year to expenses for injuries to the family members which resulted from that accident.
- In the case of a single contract, the *subscriber* must satisfy a \$100 *deductible* amount each calendar year.
- In the case of a family contract, in each calendar year, a family *deductible* amount equal to three (3) times the individual *deductible* amount will be applied for all family members covered under a family coverage. A *deductible* will not be applied to any covered individual family member once that covered individual has satisfied the individual *deductible*, or the family *deductible* has been satisfied for all covered family members combined.
- The *deductible* applies to all services except *Medical Foods*, pediatric immunizations and routine gynecological exams and pap smears.

## Covered Medical Expenses

Covered Medical Expenses include charges for the types of services and supplies specified below when performed or prescribed for the treatment of an illness or injury by a professional provider. (Covered Medical Expenses are determined as defined previously under the subsection “How Major Medical Works”.) These services must be deemed Medically Necessary and Appropriate by the Plan.

- Services of a *professional provider*
- *Medically necessary outpatient* and office visits
- *Surgery* and assistant surgery
- *Anesthesia*
- Diagnostic laboratory tests
- Diagnostic radiology
- Diagnostic medical tests (eg EKG)
- Dialysis
- *Outpatient* Physical Therapy
- *Medical Foods* and *Nutritional Formulas*
- *Hospital* room, board (including special diets), and general nursing care this expense does not include any charges in excess of an amount equal to the *hospital's* average daily charge for semi-private accommodations, plus \$10.00 per day
- Other *hospital* services required for medical or surgical care or treatment such as operating room, drugs, dressings, medicines, blood transfusions, including blood or blood plasma to the extent it is not donated or otherwise replaced, oxygen and its administration, anesthetics and their administration, diagnostic x-ray and laboratory examinations (receipted, paid bills must be submitted to the Blue Cross Plan in order to receive benefits for blood or plasma)

Services of a private nurse (who is neither a member of the patient's household nor a close relative) when certified by a *physician* as *medically necessary*, as follows:

- a *registered graduate nurse* (R.N.) or a *licensed practical nurse* (L.P.N.), except that these services are limited to a *maximum* of 240 hours per calendar year when rendered outside the *hospital*
- (Nursing services in the patient's home are *medically necessary* when the care given must be administered by a medically trained person. Some specific examples of the type of care requiring a medically trained person are

intravenous injections on a regular basis, irrigation and care of drainage tubes, care of infected or open wounds, administration of oxygen on a continuing basis, etc. Regardless of the state of the patient's health, nursing care is not considered **medically necessary** when it is merely custodial in nature. This involves care that primarily consists of bathing, feeding, exercising, homemaking, moving the patient, giving oral medication, etc. If the services performed could be performed by an untrained lay person with minimal instruction or supervision, then such services are not **medically necessary**.)

### **The Following Preventive Care Services are covered:**

- Pediatric immunizations
- Routine gynecological examinations and pap smears
- Expenses for one routine mammogram every calendar year for a female **subscriber** age 40 or older. For female **subscribers** under age 40, expenses shall be payable for any mammogram recommended by a **physician**.

### **The Following Medical Services and Supplies not Furnished by a Hospital:**

- Diagnostic x-ray and laboratory examinations
- Radiation therapy
- **Anesthesia** and the administration
- Oxygen and its administration
- Blood or blood plasma to the extent it is not donated or otherwise replaced (requires submission to the Blue Cross Plan of paid, receipted bills)
- Rental of **durable medical equipment** or surgical supplies required for temporary use for restorative purposes (purchase of such items may be covered in certain instances)
- Prosthetics (artificial limb) and orthotics (braces) prescribed by a **physician** --replacements will be provided when **medically necessary**. Coverage is also provided for the initial and subsequent prosthetic devices to replace a removed breast or portion thereof.
- Physical therapy
- Professional ambulance service used in **emergency situations** to transport the patient from the place of **accidental injury** or serious medical incident to the nearest **hospital**. Local professional ambulance service is also covered if required to transport patient from one **hospital** to another for required treatment. No other charges for transportation or travel are covered.

Skilled nursing services in semi-private accommodations in an approved **skilled nursing facility** if:

- Your condition required at least three days of **hospital** confinement following which you are transferred to the **skilled nursing facility** within 14 days after discharge from the **hospital**
- You are transferred to the **skilled nursing facility** for continued treatment of the same or a related condition for which you were being treated in the **hospital**



- Such services were required because you needed skilled nursing care on a daily basis which requires skilled nursing personnel that could only be provided in a *skilled nursing facility* on an *inpatient* basis
- The attending *physician* certifies in writing, at the time the services are obtained, that the continued skilled nursing care in a *skilled nursing facility* is *medically necessary*

## **Diabetic Supplies and Equipment**

Subject to any applicable *coinsurance* and *deductible*, benefits will be provided for the following diabetic equipment and diabetic supplies furnished by a *Durable Medical Equipment Supplier*.

### 1. Diabetic Equipment

- a) blood glucose monitors;
- b) insulin pumps;
- c) insulin infusion devices; and
- d) orthotic and podiatric appliances for the prevention of complications associated with diabetes.

### 2. Diabetic Supplies

- a) blood testing strips;
- b) visual reading and urine test strips;
- c) injection aids;
- d) insulin syringes;
- e) lancets and lancet devices;
- f) glucagon emergency kits.

3. Insulin, insulin analogs and pharmacological agents for controlling blood sugar levels - benefits will be provided for a 30-day supply per *prescription order* or refill dispensed by a *Pharmacy*.

## Major Medical Exclusions What is Not Covered

*Some of the following services may be covered under other parts of your health benefits program.*

No benefits will be provided for services, supplies or charges:

- Which are not Medically Necessary/Medically Appropriate as determined by the Plan for the diagnosis or treatment of illness or injury;
- Which are Experimental or Investigative in nature;
- Which were Incurred prior to the Subscriber's Effective Date of coverage;
- Which were or are Incurred after the date of termination of the Subscriber's coverage except as provided in the General Information section of this booklet;
- For any loss sustained or expenses Incurred during military service while on active duty; or as a result of enemy action or act of war, whether declared or undeclared.
- For which a Subscriber would have no legal obligation to pay;
- Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;
- For payment made under Medicare when Medicare is primary or would have been made if the Subscriber had enrolled for Medicare and claimed Medicare benefits; however, this exclusion shall not apply when the Group is obligated by law to offer the Subscriber all the benefits of this coverage and the Subscriber so elects this coverage as primary;
- For any occupational 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 the Worker's Compensation Law or any similar Occupational Disease Law or Act. This exclusion applies whether or not the Subscriber claims the benefits or compensation;
- To the extent benefits are provided by the Veteran's Administration or by the Department of Defense for members of the armed forces of any nation while on active duty;
- For injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid under a plan or policy of motor vehicle insurance, including a certified self-insured plan, or payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Law;
- Rendered by a member of the Subscriber's 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 and are provided through a hospital or university;
- For services and operations for cosmetic purposes which are done to improve the appearance of any portion of the body, and from which no improvement in physiologic function can be expected, except as otherwise required by law. However, benefits are payable to correct a condition resulting from an accident. Benefits are also payable to correct functional impairment which results from a covered disease, injury or congenital birth defect;
- For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;
- For music therapy;
- For marriage counseling;
- For equipment costs related to services performed on high cost technological equipment as defined by Blue Shield, such as but not limited to computed tomography (CT) scanners, magnetic resonance imagers (MRI) and extracorporeal shock wave lithotripters, unless the acquisition of such equipment by a Professional Provider was approved through the Certificate of Need (CON) process and/or by Blue Shield;
- Directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth, except as specifically stated under this coverage. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, dentures, dental implants, soft tissue impactions, alveolectomy and treatment of periodontal disease, except orthodontic treatment for congenital cleft palates;
- For treatment of temporomandibular joint syndrome (TMJ), also known as craniomandibular disorders (CMD), with intraoral devices, or with any non-surgical method to alter vertical dimension;

- For any treatment leading to or in connection with transsexual Surgery except for sickness or injury resulting from such surgery;
- For assisted fertilization techniques such as, but not limited to, in-vitro fertilization, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT);
- For treatment of sexual dysfunction not related to organic disease or injury;
- For treatment of obesity, except for surgical treatment of morbid obesity when weight is at least twice the ideal weight specified for frame, age, height and sex;
- For weight reduction;
- For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, physical fitness or exercise equipment, radio and television, beauty/barber shop services, guest trays, elevators, spa or health club memberships, whether or not recommended by a Provider;
- For eyeglasses, lenses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses;
- For correction of myopia or hyperopia by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy and all related services;
- For preventive services except as specifically stated under this coverage;
- For diagnostic screening examinations, except for mammograms and preventive care services as provided under the coverage;
- For premarital blood tests;
- For acupuncture;
- For travel, whether or not it has been recommended by a Professional Provider or if it is required to receive treatment at an out of area Provider;
- For care in a nursing home, home for the aged, convalescent home, school, institution for retarded children, Custodial Care in a Skilled Nursing Facility;
- For counseling or consultation with a patient's relatives or Hospital charges for a patient's relatives or guests;
- For medical supplies such as but not limited to thermometers, ovulation kits, early pregnancy or home pregnancy testing kits, and home blood pressure machines, except for subscribers with pregnancy-induced hypertension and hypertension complicated by pregnancy;
- For Prescription Drugs, except: (a) when administered on an inpatient basis; or (b) for insulin, insulin analogs and pharmacological agents for controlling blood sugar levels;
- For amino acid supplements, appetite suppressants, and nutritional formulas. Coverage does not include basic milk, soy or casein hydrolyzed formulas (e.g., Nutramagen, Alimentun, Pregestimil) for the treatment of lactose intolerance, milk protein intolerance, milk allergy or protein allergy. This exclusion does not apply to Medical Foods and Nutritional Formulas;
- For Inpatient Private Duty Nursing services;
- Any care that extends beyond traditional medical management for autistic disease of childhood, pervasive development disorders, attention deficit disorder, learning disabilities, behavioral problems, or mental retardation; or treatment or care to effect environmental or social change;
- For charges Incurred for expenses in excess of Benefit Maximums as specified in the "Benefits at a Glance" section;
- For research studies;
- Facility charges for the treatment of alcohol and drug abuse or dependency;
- Charges for any services or supplies which are provided or would be provided under the Subscriber's Designated Basic Plans; or any co-payments, penalties, coinsurance or deductible required under such Plan to be made by the Subscriber;
- Charges for vocational or religious counseling or activities that are primarily of an educational nature;
- Charges for psychiatric treatment modalities, such as, but not limited to primal therapy, rolfing or structural integration, bioenergetic therapy and obesity control therapy;
- Charges for family counseling services;
- Charges for services performed by a person practicing psychology without benefit of psychologist licensure;
- Charges for ambulance services for the purpose of moving the patient to a facility closer to the patient's home, with no medical justification;

- Charges for palliative or cosmetic foot care not related to organic diseases including, but not limited to, flat foot conditions, the treatment of subluxations of the foot, care of corns, bunions (except by capsular or bone Surgery), calluses, toe nails (except Surgery for ingrown nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet;
- For supportive devices for the foot (orthotics) for palliative care, except for orthotics and podiatric appliances for the prevention of complications associated with diabetes;
- Charges in excess of what is determined to be the "Major Medical Allowance" as defined under the Defined Terms section of this booklet;
- Charges for any other services or treatment except as provided under this coverage.

## DEFINITION OF TERMS

For the purposes of this booklet, the terms below have the following meaning.

**ACCIDENTAL INJURY** - a bodily injury which results from an accident directly and independently of all other causes and which occurs after the effective date of coverage.

**ANESTHESIA** - consists of the administration of regional or rectal anesthetic or the administration of a drug or other anesthetic agent by injection or inhalation, the purpose and effect of which is to obtain muscular relaxation, loss of sensation or loss of consciousness.

**BASIC PLANS** - the Blue Cross Basic *hospital* benefits, the Blue Shield Basic Medical/Surgical benefits, and/or other benefits provided for the *subscribers* under the group's program of benefits.

**BLUE CROSS** - for the purpose of this booklet, Independence Blue Cross.

**BLUE SHIELD** - for the purpose of this booklet, Highmark Blue Shield.

**COINSURANCE** - the specific percentage of *covered expenses* which must be paid by the *subscriber*.

**COVERED EXPENSE** - means charges for a service or supply for which benefits will be provided.

**COVERED SERVICE** - a service or supply specified in this booklet for which benefits will be provided.

**CUSTODIAL CARE** - provided primarily for maintenance of the patient or which is designed essentially to assist the patient in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition. Custodial care includes but is not limited to help in walking, bathing, dressing, feeding, preparation of special diets and supervision over self-administration of medications, which do not require the technical skill for professional training of medical or nursing personnel in order to be performed safely and effectively.

**DEDUCTIBLE** - a specified amount of *covered expenses* for the *covered services* usually expressed in dollars that must be paid by the *subscriber* before the Plan will assume any liability.

**DEPENDENT** - a *subscriber's* spouse who meets the eligibility requirements outlined in the "General Information" section of this booklet.

**DURABLE MEDICAL EQUIPMENT** - is equipment which:

- A. can withstand repeated use;
- B. is primarily and customarily used to service a medical purpose;
- C. generally is not useful to a person in the absence of an illness or injury; and
- D. is appropriate for use in the home.

**DURABLE MEDICAL EQUIPMENT SUPPLIER** – an entity that provides *Durable Medical Equipment and Supplies*.

**EFFECTIVE DATE** - the date on which coverage for a *subscriber* begins.

**EMERGENCY CARE** - the initial treatment of a sudden, unexpected onset of a medical condition or traumatic injury. This shall not include treatment for an occupational injury for which benefits are provided under any Worker's Compensation Law or any similar Occupational Disease Law. The symptoms or injury must be of sufficient severity to warrant immediate attention.

- A. Emergency Accident Services - the initial treatment of traumatic bodily injuries resulting from an accident.
- B. Emergency Medical Services - the initial treatment of a sudden onset of a medical condition with acute

symptoms of sufficient severity that the absence of immediate medical attention could reasonably result in:

1. permanently placing the *subscriber's* health in jeopardy;
2. causing other serious medical consequences;
3. causing serious impairment to bodily functions; or
4. causing serious and permanent dysfunction of any bodily organ or part.

**ENTERAL NUTRITION** is the provision of nutritional requirements through a tube into the stomach or small intestine.

**HOME HEALTH CARE AGENCY** - a facility provider, approved by the Plan, that is engaged in providing, either directly or through an arrangement, health care services on an intermittent basis in the patient's home in accordance with an approved home health care Plan of treatment.

**HOSPITAL** - a short-term, acute care, general *hospital* which has been approved by the Joint Commission on Accreditation of Healthcare Organizations and/or by the American Osteopathic Hospital Association or by the Plan and which:

- (a) is a duly licensed institution;
- (b) is primarily engaged in providing *inpatient* diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of physicians;
- (c) has organized departments of medicine and major surgery;
- (d) provides 24-hour nursing service by or under the supervision of registered nurses;
- (e) is not, other than incidentally, a:
  - Skilled Nursing Facility;
  - Nursing Home;
  - Custodial Care Home;
  - Health Resort, spa or sanitarium;
  - Place for rest;
  - Place for aged;
  - Place for treatment of Mental Illness;
  - Place for treatment of alcoholism or drug abuse;
  - Place for provision of rehabilitation care;
  - Place for treatment of pulmonary tuberculosis;
  - Place for provision of hospice care.

**IDENTIFICATION CARD** - the currently effective card issued to the Applicant-*Subscriber* by the Plan.

**INCURRED** - a charge shall be considered incurred on the date a *subscriber* receives the service or supply for which the charge is made.

**INPATIENT ADMISSION or (INPATIENT)** - the actual entry into a *hospital*, extended care facility or facility provider of a *subscriber* who is to receive *inpatient* services as a registered bed patient in such *hospital*, extended care facility or facility provider and for whom a room and board charge is made; the *inpatient* admission shall continue until such time as the *subscriber* is actually discharged from the facility.

**LICENSED PRACTICAL NURSE (LPN)** - a nurse who has graduated from a formal practical or nursing education program and is licensed by the appropriate state authority.

**MAXIMUM** - the greatest amount payable by the Plan for *covered services*. This could be expressed in dollars, number of days, or number of services for a specified period of time.

- A. Benefit *Maximum* the greatest amount payable by the Plan for a specific *covered service*.
- B. Lifetime *Maximum* the greatest amount payable by the Plan in a *subscriber's* lifetime.

**MEDICAL FOODS** - liquid nutritional products which are specifically formulated to treat one of the following

genetic diseases: phenylketonuria, branched-chain ketonuria, galactosemia, homocystinuria.

**MEDICALLY NECESSARY (OR MEDICAL NECESSITY)** - services or supplies provided by a professional provider that the Plan determines are:

- A. Appropriate for the symptoms and diagnosis or treatment of the *subscriber's* condition, illness, disease or injury;
- B. Provided for the diagnosis, or the direct care and treatment of the *subscriber's* condition, illness, disease or injury;
- C. In accordance with current standards of good medical practice;
- D. Not primarily for the convenience of the *subscriber*, or the *subscriber's* professional provider; and
- E. The most appropriate supply or level of service that can safely be provided to the *subscriber*. When applied to hospitalization, this further means that the *subscriber* requires acute care as a bed patient due to the nature of the services rendered or the *subscriber's* condition, and the *subscriber* cannot receive safe or adequate care as an *outpatient*.

The *Subscriber* or the *Subscriber's Professional Provider* may contact Highmark Blue Shield to determine whether a service is considered to be Medically Necessary.

**MENTAL ILLNESS** - includes mental disorders, psychiatric illnesses, mental conditions and psychiatric conditions. This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders, psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

**NUTRITIONAL FORMULA** - liquid nutritional products which are formulated to supplement or replace normal food products.

**OUT-OF-POCKET LIMIT** - a specified dollar amount of coinsurance expense incurred by a *subscriber* for *covered services* in a benefit period. Such expense does not include any *deductible*, penalties, psychiatric care services, copayment amounts, or charges in excess of the provider's reasonable charge. When the out-of-pocket limit is reached, the level of benefits is increased.

**OUTPATIENT** - a *subscriber* who receives services or supplies while not an *inpatient*.

**PHARMACIST** - an individual who is legally licensed to practice the profession of pharmacology and who regularly practices such profession in a *pharmacy*.

**PHARMACY** - any establishment which is registered and licensed as a pharmacy with the appropriate state licensing agency and in which *prescription drugs* are regularly compounded and dispensed by a *pharmacist*.

**PHYSICIAN** - a person who is a doctor of medicine (M.D.) or a doctor of osteopathic medicine (D.O.), licensed, and legally entitled to practice medicine in all its branches, perform surgery and dispense drugs.

**PRESCRIPTION DRUG** - (a) any medication which by Federal and or State laws may be dispensed with a *prescription order*, and (b) insulin.

**PRESCRIPTION ORDER** - the request in accordance with applicable laws and regulations for medication issued by a professional provider.

**PROFESSIONAL PROVIDER** - a facility provider or professional provider, licensed where required.

**REGISTERED NURSE (R.N.)** - a nurse who has graduated from a formal program of nursing education (diploma school, associate degree or baccalaureate program) and is licensed by the appropriate state authority.

**SERIOUS MENTAL ILLNESS** - any of the following mental illnesses as defined by the American Psychiatric Association in the most recent edition of the diagnostic and statistic manual: schizophrenia, bipolar disorder,

obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder and delusional disorder.

**SKILLED NURSING FACILITY** - an institution or a distinct part of an institution, other than one which is primarily for the care and treatment of mental illness, tuberculosis, or alcohol or drug abuse, which:

- A. Is accredited as a skilled nursing facility or extended care facility by the Joint Commission on Accreditation of Healthcare Organizations; or
- B. Is certified as a skilled nursing facility or extended care facility under the Medicare Law; or
- C. Is otherwise acceptable to the Plan.

**SUBSCRIBER** - an enrolled retiree or his spouse who has satisfied the eligibility requirements outlined in the "General Information" section of this booklet.

**SURGERY** - the performance of generally accepted operative and cutting procedures including specialized instrumentations, endoscopic examinations and other procedures. Payment for surgery includes an allowance for related *inpatient* pre-operative and all post-operative care. Treatment of burns, fractures and dislocations are also considered surgery.

**THERAPY SERVICE** - the following services or supplies prescribed by a physician and used for the treatment of an illness or injury to promote the recovery of the *subscriber*.

- A. **Radiation Therapy** - The treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.
- B. **Chemotherapy** - The treatment of malignant disease by chemical or biological antineoplastic agents.
- C. **Dialysis Treatments** - The treatment of an acute renal failure of chronic irreversible renal insufficiency for removal of waste materials from the body. This includes hemodialysis or peritoneal dialysis.
- D. **Cardiac Therapy** - Medically supervised rehabilitation program designed to improve a patient's tolerance for physical activity or exercise.
- E. **Physical Therapy** - The treatment by physical means, hydrotherapy, heat, or similar mobilities, physical agents, bio-mechanical and neurophysiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of body part.
- F. **Respiratory Therapy** - Introduction of dry or moist gases into the lungs for treatment purposes.
- G. **Occupational Therapy** - Treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.
- H. **Speech Therapy** - Treatment for the correction of a speech impairment resulting from disease, surgery, injury, congenital and developmental anomalies, or previous therapeutic processes.



# CLAIMS APPEAL PROCEDURE

## RESOLVING PROBLEMS

For purposes of this section only, the term “Member” replaces the term “Subscriber.”

### Member Complaint Process

The Plan has a process for Members to express informal complaints. To register a complaint (as opposed to an appeal as discussed below), Members should call the Member Services Department at the telephone number on the back of their identification card or write to the Plan at the following address:

Independence Blue Cross  
General Correspondence  
1901 Market Street  
Philadelphia, PA 19103

Most Member concerns are resolved informally at this level. However, if the Plan is unable to immediately resolve the Member complaint, it will be investigated, and the Member will receive a response in writing within thirty (30) days.

### Member Appeal Process

**Filing an Appeal.** The Plan maintains procedures for the resolution of Member appeals. Member appeals may be filed within 180 days of the receipt of a decision from the Plan stating an adverse benefit determination. An appeal occurs when the Member or another authorized representative requests a change of a previous decision made by the Plan by following the procedures described here. In order to authorize someone else to be your representative for the appeal, you must complete a valid authorization form. Contact the Plan as directed below to obtain a form for a member/enrollee to authorize an appeal by a provider or other representative or for questions regarding the requirements for an authorized representative.

The Member or other authorized person on behalf of the Member, may request an appeal by calling or writing to the Plan, as stated in the letter notifying the Member of the decision or as follows:

Member Appeals Department	Toll Free Phone: 1-888-671-5276
P.O. Box 41820	Toll Free Fax: 1-888-671-5274 or
Philadelphia, PA, 19101-1820.	Phila. Fax: 215-988-6558

**Types of Member Appeals and Timeframe Classifications.** Following are the two types of Member appeals and the issues they address:

- **Medical Necessity Appeal Issues** – An appeal by or on behalf of a Member that focuses on issues of Medical Necessity or Medical Appropriateness and requests the Plan to change its decision to deny or limit the provision of a Covered Service. Medical Necessity appeals include appeals of adverse benefit determinations based on the exclusions for experimental/investigative or cosmetic services.
- **Administrative Appeal Issues** – An appeal by or on behalf of a Member that focuses on unresolved Member disputes or objections regarding a Plan decision that concerns coverage terms such as contract exclusions and non-covered benefits, exhausted benefits, and claims payment issues. Although an administrative appeal may present issues related to Medical Necessity and Medical Appropriateness, these are not the primary issues that affect the outcome of the appeal.

The timeframes described below for completing a review of each appeal depend on additional classifications:

- **Standard Pre-service appeal** - An appeal for benefits that, under the terms of the Plan, must be pre-certified or pre-approved (either in whole or in part) before medical care is obtained in order for coverage to be available.
- **Standard Post-service appeal** - An appeal for benefits that is not a Pre-service appeal. (Post-service appeals concerning claims for services that the Member has already obtained do not qualify for review as expedited/urgent appeals.)
- **Expedited/Urgent appeal** – An appeal that provides faster review, according to the procedures described below, on a pre-service issue. The Plan will conduct an expedited appeal on a pre-service issue when it determines, based on applicable guidelines, that delay in decision-making would seriously jeopardize the Member’s life, health or ability to regain maximum function or would subject the Member to severe pain that cannot be adequately managed while awaiting a standard appeal decision.

**Information for the Appeal Review including Matched Specialist’s Report.** You may submit to the Plan additional information pertaining to your case. You may specify the remedy or corrective action being sought. Upon request at any time during the appeal process, the Plan will provide you or your authorized representative access to, and copies of, documents, records, and other information relevant to the appeal that is provided for the appeal decisionmaker(s) to review.

Input from a matched specialist is obtained for all Medical Necessity Appeals. A matched specialist is a licensed physician or psychologist in the same or similar specialty as typically manages the care under review. The matched specialist cannot be the person who made the adverse benefit determination at issue in the appeal and cannot be a subordinate of the person who made that determination.

**Appeal Committee Composition and Role.** Each Appeal Committee described below will be comprised of one to three persons designated by the Plan to act as decisionmaker(s) on the appeal. The Committee decisionmaker(s) did not make the adverse benefit determination at issue in the appeal and are not subordinates of the person who made that determination. Each Committee will review all relevant information for the appeal, whether from the Member or his authorized representative or obtained from other sources during the investigation of the appeal issues.

**STANDARD APPEALS:** Process and timeframes.

An acknowledgement letter and description of the appeal process is mailed following receipt of a Member appeal. A standard appeal consists of one level of internal review for which the evaluation and decision must be completed within the following timeframes:

- Standard Pre-service Appeal – within 30 days of receipt of the appeal request
- Standard Post-service Appeal – within 60 days of receipt of the appeal request

The appeal review will occur based on the information available for the Appeal Committee’s review. You are encouraged to supply additional relevant information to the appeals specialist preparing your appeal.

Written notice of the standard appeal decision will be sent within the timeframes stated above. If your appeal is denied, the decision notice will state the specific reason for the denial, refer to Plan provision(s) and guidelines on which the decision is made, tell you about relevant information that is available free of charge, and describe external appeal rights or other dispute resolution options that may be available to you.

The standard appeal decision is final with respect to your right to appeal through the Plan’s internal member appeal process.

**EXPEDITED APPEALS:** Process and timeframes

If your case involves a serious medical condition which you believe may jeopardize your life, health, ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed while awaiting a standard appeal decision, you may ask to have your case reviewed in a quicker manner, as an expedited appeal. An expedited appeal consists of one level of internal review for which the evaluation and decision must be completed within the following timeframe:

- Expedited Pre-service Appeals - within 72 hours of receipt of the appeal request.

To request an expedited appeal by the Plan, call or fax the Member Appeals Department at the phone numbers listed above under “Filing an Appeal.” Information related to your appeal will be requested and you will be promptly informed whether it qualifies for review as an expedited appeal or must instead be processed as a standard appeal.

The Expedited Appeal Committee will review all relevant information for the appeal from the Member or his authorized representative or from other sources that is received in time to permit compliance with the time limits for review of an expedited appeal. You are encouraged to supply additional relevant information to the appeals specialist preparing your appeal.

The Expedited Appeal review will be completed promptly based on your health condition, but no later than seventy-two (72) hours after receipt of your expedited appeal by the Plan. You will be notified of the decision by telephone and a letter mailed in no more than seventy-two (72) hours. If your appeal is denied, the decision notice will state the specific reason for the denial, refer to Plan provision(s) and guidelines on which the decision is made, tell you that relevant information is available free of charge, and describe external appeal rights or other dispute resolution options that may be available to you. The expedited appeal decision is then final with respect to a Member’s right to appeal through the Plan’s internal appeal process.

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**The policy and procedures for Member appeals may change due to changes that the Plan makes to comply with applicable state and federal laws and regulations, to satisfy standards of certain recognized accrediting agencies, or to otherwise improve the Member Appeals process.**

## NOTES

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## **Customer Service Information**

We all have questions about our health care coverage from time to time. To help you get accurate answers to questions and up-to-date information about your health plan, we have included this section.

Call the department or person who handles benefits for your organization first, whenever you have questions about your coverage program. If you still have questions, call Blue Cross or Blue Shield. The Customer Service Representatives have all the current information about your health care coverage at their fingertips.

When you call, give the representative your identification number (printed on your Blue Cross and Blue Shield *identification card*), so he or she can access information about your coverage.

05.661.10092184