BlueCare Senior

Administrative Services Agreement

Part 1 - Outline of Coverage

Company Name:	NEPMIC - City of Lock Haven	**Group Number(s):**	10207529
Company Code:	203605	**Domestic Partners:**	Not Covered
Effective Date:	1/1/2016	**Credit (initial benefit period only)**	
Renewal Date:	1/1/2017	**Claim Fiduciary**	BCNEPA
Date - Part II Benefit Schedule:	1/1/2016	**Benefit Period**	Calendar Year
Revision Date:	11/30/2015		
Grandfathered Status	No		

	Plan Responsibility
Medicare Part A Inpatient Hospitalization	
Inpatient Hospital Days 1-60	Part A deductible
Inpatient Hospital Days 61-90	Part A coinsurance
Inpatient Hospital Days 91-150 (lifetime reserve days)	Part A coinsurance
Additional Inpatient hospital days (365 additional days/benefit period; 30 of the 365 days may be used for inpatient psychiatric care)	100% of Medicare allowance contracting; 90% of Medicare allowance non-contracting
Skilled nursing facility days 1-20	Not Covered
Skilled nursing facility days 21-100	Part A coinsurance
Skilled nursing facility days 101 and beyond	Not Covered
Other Services	
Blood (First 3 pints per calendar year)	100% (Part A & Part B combined limit)
Hospice (inpatient respite care)	5% of Medicare approved allowance
Medicare Part B	
Medical and surgical supplies	Part B coinsurance
Outpatient hospital services	Part B deductible (Except for physician services) and Part B coinsurance
Additional Benefits (Not covered by Medicare and may not be covered by Major Medical)	
Foreign travel/emergency care	
Facility	80%
Professional	100%

MAJOR MEDICAL COVERED SERVICES*	**Participant Responsibility**	**Limitations**	**Benefit Change/Customized Benefit Change Date**
Deductible	$125	Member responsibility Per Benefit Period. Deductible must be met first prior to claim payment.	
Coinsurance	20%	After Major Medical deductible is satisfied.	
Coinsurance Maximum	Total $2,500/Member $500	Member is responsible per Benefit Period.	
Lifetime Maximum	$1,000,000		
Ambulance	20%	Emergency/Non-emergency	
Chiropractic Manipulative Benefits	20%	20 treatments per year, ages 13 and up.	
Durable medical equipment, prothestics and orthotics	20%	$5,000 maximum per benefit period. Diabetic items are excluded from this dollar maximum.	

Emergency Physician Services	20%	All associated emergency physician services.	
Outpatient Physician Office Visits	20%	Routine visits not covered.	
Outpatient Occupational Therapy	20%	12 visits per Benefit Period.	
Outpatient Physical Therapy	20%	20 visit per Benefit Period.	
Outpatient Speech Therapy	20%	12 visits per Benefit Period.	
Prescription Drugs	Not Covered		
Outpatient Mental Health Services	20%	Unlimited	

Prescription Drugs

	Participant Responsibility	**Limitations**	**Benefit Change/Customized Benefit Change Date**
Deductible per person	$125		
Maximum per person	$500		
Yearly maximum	None		
Lifetime maximum	None		
Formulary	Multi-tier		
Retail	Covered	30-day supply.	
Tier 0	Does not Apply		
Tier 1	20%		
Tier 2	20%		
Tier 3	20%		
Tier 5 (Specialty Drugs)	Does not Apply		
Mail Order	Covered	Up to a 90-day supply.	
Tier 0	Does not Apply		
Tier 1	20%		
Tier 2	20%		
Tier 3	20%		
Contraceptives	Covered	Excludes non-drug containing devices.	
Exclusive Home Delivery	Does not Apply		
Select Home Delivery	Applies	Participants are required to make a choice about their maintenance prescription drugs. Participants will have 2 fills at the retail pharmacy and then be required to contact Express Scripts with a decision on their third fill to continue through the retail pharmacy or switch to a mail order program.	
Generics Preferred	Does not Apply		
Quantity Management Limits	Applies	Certain medications identified on the prescription drug formulary apply a quantity limit.	
Specialty Injectable Network	Applies	Specialty prescription drugs identified on the prescription drug formulary are required to be purchased through specialty pharmacies.	
Metabolic Supplement	Covered	Prescriptions for medically necessary nutritional supplements for the therapeutic treatment of PKU, Homocystinuria, branched - chain ketonuria and Galactosemia.	
Step Therapy	Applies	The program requires the use of a first step drug (s) before use of a 2nd or 3rd step drug.	

Prior Authorization	Applies	Certain medication identified on the prescription drug formulary as requiring prior authorization.	
Vaccine Program	Does not Apply		
Weight Loss Drugs	Not Covered		
Medicare B Drugs	Not Covered		

Exclusions (Please see attached)

Part II Administrative Services Agreement Benefit Schedule is the Covered Service descriptions and will apply as stated, unless otherwise indicated on Part I Outline of Coverage.

* Note: Major Medical may only cover: (Unless otherwise indicated) Services not covered by Medicare, services which exceed the Medicare benefit limits, and professional services applied toward Part B deductible.

Senior

Standard Exclusions

This amends the Administrative Service Agreement Blue Care Senior as follows:

EXCLUSIONS is amended by adding the Standard Exclusions as indicated below:		**Exclusion Change Date**
A. Except as may be specifically provided in the Covered Services, the following are not covered under the Agreement:		
Blue Cross Exclusions		
1	Inpatient accommodations when the admission is principally for diagnosis, diagnostic study or medical observation, which could have been performed on an outpatient basis, even though therapy directed toward the relief of symptoms may have been rendered. Covered services will be provided for diagnostic proce-dures which would have been eligible for coverage if received on an outpatient basis.	
2	Services not reasonable or Medically Necessary for the diagnosis or treatment of illness or injury.	
3	Convalescent or custodial care or rest cures.	
4	Treatment of an occupational condition, illness or injury arising out of, or in the course of employment, for which hospitalization coverage is or was available in full or in part under Workers' Compensation laws or similar state or federal legislation, even though the Participant's rights have been waived or expired.	
5	Expenses to the extent paid or which the Participant is entitled to have paid or obtain without cost in accordance with law or the regulations of Medicare, CHAMPUS--CHAMPVA, the Department of Defense for Active Personnel, the Veterans' Administration, the National Health Service or the Bureau of Vocational Rehabilitation.	
6	Any services, if the cost may be recoverable by or on behalf of the Participant in any action at law or in compromise or settlement of any claim against any party other than an insurer of the Participant, or where excluded by law.	
7	Physician services even if usually provided and billed for by the Hospital or Skilled Nursing Facility.	
8	Private duty nursing services.	
9	Ambulance services.	
10	Drugs and medications, except when used during an inpatient stay in a Hospital or outpatient visit to a Hospital.	
11	Purchase or rental of durable medical equipment.	
12	Cosmetic surgery, except as related to accidental injury or to correct a functional deformity.	
13	Dental care except for admissions which qualify for coverage under Medicare.	
14	Personal comfort or convenience items such as barber service, guest meals, television, radio and telephone, whether or not recommended by a doctor.	
15	Treatment or services 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 insurance plan, or payable under the Catastrophic Loss Trust Fund established under the Pennsylvania Motor Vehicle Financial Responsibility Law.	
Medical Surgical Exclusions		
1	Routine physical examinations.	
2	Eye examinations, refractions, eyeglasses, hearing examinations or hearing aids.	
3	Routine dental services such as the care, filling, removal or replacement of teeth, root canal therapy, surgery for impacted teeth; and other surgical procedures involving the teeth or structures directly supporting the teeth.	

4	Routine foot care, including hygienic care, treatment of flat feet, removal of corns, warts, and calluses; partial dislocations of the joints of the feet; orthopedic shoes or other supportive devices for the feet, except those which are part of leg braces.	
5	Adult immunization (unless directly related to immediate risk of infection from injury).	
6	Drugs the Participant can administer (such as insulin), and any outpatient drugs, except drugs used in immunosuppressive therapy.	
7	Services and supplies that are not medically necessary.	
8	Medical expenses for which the Participant is not legally obligated to pay.	
9	Any part of the annual Deductible for medical insurance covered services and outpatient immunosuppressive drugs.	
10	Hospital services which are provided under Medicare Part A.	
11	Identical services performed on the same date for the same patient for which both a Certified Registered Nurse and another Provider submit a claim.	
12	Services performed prior to the Participant's Effective Date.	
13	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 legislation of any governmental unit. This exclusion applies whether or not the Participant claims the benefits or compensation.	
14	Covered Services, to the extent they are provided by any governmental unit; unless required by law.	
15	Services for which the Participant incurs no charge.	
16	Services 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.	
17	Treatment or services 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.	
18	Any services other than those specifically provided.	
19	For routine neonatal circumcision.	
20	For personal hygiene and convenience items such as, but not limited to, air conditioning, humidifiers, or physical fitness equipment, whether or not recommended by a Professional Provider.	
21	Any services, supplies or charges not allowed by Medicare Part B.	

Major Medical Exclusions

1	Services which are not Medically Necessary, except those that are provided within the Agreement for preventive services or those mandated by law.	
2	Any service in connection with or required by a procedure not set forth in the foregoing Covered Medical Expenses Section, except as necessitated by subsequent complications.	
3	Services in excess of any benefit maximum as stated in Payment for Covered Services.	
4	Charges for services or supplies incurred prior to the Participant's Effective Date.	
5	Charges for services or supplies incurred after the date of termination of the Participant's coverage, except as provided in the Agreement.	
6	Charges which exceed the Allowable Charge.	
7	Services or supplies, which are not prescribed by or performed by or under the direction of a Physician or Professional Provider when pre-approval is required.	
8	Services which the Blue Cross initially determines are Experimental or Investigative; the fact that a treatment, procedure, equipment, drug, device or supply is the only available treatment for a particular condition will not result in coverage if the service is considered to be Experimental or Investigative. Coverage will not be provided for services related to medical research.	
9	Deductibles, copayments and/or Coinsurance applied under the Agreement.	
10	Charges for any services received as a result of injury or illness due to an act of war, whether declared or undeclared.	
11	Treatment or services received as a result of a Participant's participation in a riot or insurrection.	
12	SServices as a result of injuries sustained during a Participant's commission of or attempt to commit a felony.	
13	Treatment of obesity.	

14	Cosmetic or Reconstructive Procedure/Surgery to improve the appearance or performed for psychological or psychosocial reasons, unless required for correction of a condition directly resulting from accidental injury; for a newborn to correct a congenital birth defect; when reconstruction is pursuant to breast reconstruction following Mastectomy; or for the treatment of complications resulting from Surgery.	
15	The following procedures are not covered: removal of skintags; treatment of alopecia; dermabrasion; diastasis recti repair; ear or body piercing; electrolysis for hirsutism; excision or treatment of decorative or self-induced tattoos; salabrasion; chemosurgery and other such skin abrasion procedures associated with the removal of scars; hairplasty; lipectomy; panniculectomy; otoplasty; rhytidectomy; blepharoplasty; chemical peels; surgical treatment of acne; removal of port wine lesions, except when involving the face; augmentation mammoplasty, except to establish symmetry following a Mastectomy; removal, repair or replacement for an implant, except when reconstruction and implant are pursuant to breast reconstruction following Mastectomy; reduction mammoplasty, except to establish symmetry following Mastectomy; gynecomastia, except when mandated for breast disease; Echosclerotherapy for treatment of varicose veins; non-invasive laser treatment of superficial small veins, and treatment of spider veins, or superficial telangiectasias.	
16	All dental services including preventive dental care, regardless where or by whom performed, related to the care, filling, removal or replacement of natural teeth, dentures or bridges and treatment of diseases of the teeth or gums, including, but not limited to: treatment of dental cavities, periodontics, endodontics, orthodontics, and orthognathic Surgery, except as required for correction of a condition caused by accidental injury, for hospital and anesthesia charges associated with Medically Necessary dental procedures requiring sedation, other than the removal of bony impacted wisdom teeth, which cannot be safely or adequately performed on an Outpatient basis for children under the age of 18 and for adults with severe mental retardation upon authorization by a Medical Director of Blue Cross and for dental services for baby bottle syndrome prior to age four (4) once per life time. Treatment of temporomandibular joint (TMJ) or myofascial (MPD) pain dysfunction or craniomandibular (CMD) pain syndrome, including surgical and non surgical exam, invasive and non invasive procedures and tests, and all related medical and surgical services. Examples of non-covered services include, but are not limited to: physiotherapy, therapeutic muscle exercises, occlusal appliances or other oral prosthetic devices and their adjustments, braces, crowns, or bridgework.	
17	Charges to the extent payment has been made under Medicare or when Medicare is the primary carrier, or under another governmental program, except Medicaid.	
18	Charges to the extent payment has been made under a state or federal workers' compensation, employer's liability or occupational disease law, or local governmental program.	
19	Charges incurred as a result of illness or bodily injury covered by any Workmen's Compensation Act or Occupational Disease Law or by United States Longshoreman's Harbor Worker's Compensation Act and first party valid and collectible claims covered by a motor vehicle policy issued or renewed pursuant to the Pennsylvania Motor Vehicle Financial Responsibility Law or any applicable federal or state law. This exclusion applies regardless of whether the Patricipant claims the benefit compensation.	
20	The following, applicable to the treatment of Autism Spectrum Disorder: • Diagnostic assessment and treatment of Autism Spectrum Disorder in excess of the Benefit Maximum provided for ASD under the Agreement and for Participants age twenty-one (21) and over. • Treatment of mental retardation, defects, deficiencies and specific delays in development, learning, and speech. This exclusion does not apply to medical treatment of such Participants in accordance with the Covered Services provided in Section DB – Description of Covered Services. • Treatment of Autism Spectrum Disorder through the use of Chelation Therapy. • Treatment of Autism Spectrum Disorder through therapeutic day treatment and/or summer camp. • Any services listed in an Individual Education Plan (IEP) are not covered.	
21	Services for the treatment of anti-social personality, conduct disorders and paraphilias.	
22	Methadone or methadone-like equivalents (except for Suboxone equivalents and Subutex equivalents.)	
23	Biofeedback/neurofeedback.	
24	Charges for the procurement of blood or for blood storage or the cost of securing the services of professional blood donors; cord blood collection, preparation or storage.	
25	Routine and cosmetic foot care, except care provided as a result of diabetes.	
26	The repair and replacement of Orthoses, except if the Orthosis was provided as a result of diabetes.	
27	Sports medicine treatment plans, corrective appliances, or artificial aids primarily intended to enhance athletic functions, or work hardening programs.	
28	Custodial care, domiciliary care, convalescent care, or rest cures, Private Duty Nursing or specialized nursing care.	

29	Physical, psychiatric or psychological examinations, testing, reports, vaccinations, immunizations or treatments, when such services are: (a.) for purposes of obtaining, maintaining or otherwise relating to career, education, sports or camp, travel, employment, insurance, marriage or adoption; (b.) relating to judicial or administrative proceedings or orders; (c.) conducted for purposes of medical research; or (d.) to obtain or maintain a license of any type.	
30	Nutritional therapy, vitamin, mineral and electrolyte supplements, food, special diets, and feedings for adults, children and infants, given enterally by mouth or gastrointestinal tract tube, or parenterally. Infant formulas including those prescribed for reasons of fat absorption, lactose intolerance, milk protein intolerance and/or milk allergies.	
31	The purchase of organs, which are sold rather than donated to transplant recipients, and charges for organ donor searches are also excluded from coverage.	
32	Long-Term Residential Care.	
33	Outpatient cognitive rehabilitation services, which have been initially determined by Blue Cross not to be Medically Necessary and appropriate for the treatment of brain injury.	
34	Therapy or devices to correct stuttering or pre-speech deficiencies or to improve speech skills that are not fully developed.	
35	Pulmonary rehabilitation therapy on an Inpatient basis.	
36	Reversal of voluntary sterilization.	
37	Transsexual Surgery and treatment and services in support of transsexual Surgery, except for treatment resulting from a complication of such transsexual Surgery	
38	Charges in connection with penile implants.	
39	Routine neonatal circumcision.	
40	Abortions, except, however, services which are necessary to avert the death of the woman and services to terminate pregnancies caused by rape or incest will be covered.	
41	Separate charges by interns, residents and other health care professionals who do not have a Contracting Provider Agreement with the Plan, who are directly, or indirectly, employed by a Hospital or Facility Other Provider makes their services available.	
42	Corneal Surgery to change the shape of the cornea to correct vision problems, except for accidental injury or Medically Necessary conditions resulting from corneal Surgery.	
43	Routine eye examinations; refractions for eyeglasses or contact lenses; all services associated with eyeglasses or contact lenses, including related diagnostic tests such as, but not limited to: visual fields testing, orthoptics, syntonics, optometric therapy, vision augmentation devices and vision enhancement systems.	
44	Services or supplies for personal hygiene, physical fitness or convenience items, whether or not prescribed by a Physician, such as but not limited to, allergen filtration systems including allergy products.	
45	Charges for music therapy; counseling of and consultation with members of the family other than the patient; Hospital charges for parents, children or guests of the patient.	
46	Charges for telephone calls or consultations, for failure to keep a scheduled visit, for completion of forms, transfer or copying of records or generation of correspondence.	
47	Maintenance Therapy.	
48	Charges for services, use of facilities, or supplies that any covered person has no legal obligation to pay.	
49	Services for which a Participant would have no legal obligation to pay.	
50	Assisted fertilization techniques such as, but not limited to, In Vitro Fertilization (IVF) of any kind, including the office visits, drugs, diagnostic monitoring (ultrasound) and other services and supplies related to these procedures, including, but not limited to: oral or injectable prescription medication treatment, embryo acquisition, storage and transport, human chorionotropin, urofollitropin, menatropins or derivatives, donor ovum and semen and related costs, including collection, preparation, preservation or storage.	

51	Provision or replacement of the following items, including but not limited to: (a) deluxe equipment of any sort or equipment which has been otherwise determined by the Plan to be non-standard; (b) items which are primarily for personal comfort or convenience, including but not limited to: bedboards, air conditioners, and over-bed tables; (c) disposable supplies, such as elastic bandages, support stockings, ostomy supplies, or self-administered catheters or prosthetic socks, except when administered by a home health agency as part of the home health benefit; (d) exercise equipment; (e) self-help devices, including, but not limited to: lift-chairs, saunas, humidifiers, and air purifiers; (f) repair or replacement of any device or piece of equipment; (g) any device or piece of equipment which is no longer Medically Necessary; (h) motor vehicles, or any modification to any vehicle for use of a disabled person; (i) dental services or appliances of any sort, including, but not limited to: dentures, bridges, dental implants, or intra-oral Prostheses; (j) hearing aids, eyeglasses or contact lenses; (k) corsets; (l) supportive back brace without metal stays; (m) knee brace made of elastic fabric support or sports braces; (n) comfort, non-therapeutic cast-brace; (o) pro-glide Orthosis; (p) garter belts, rib belts, or pressure leotards; (q) spinal pelvic stabilizers; (r) nose braces; (s) tongue retainers (equalizer, positioner); (t) slings and other non-sterile or over-the-counter supplies; (u) other special appliances, supplies, or equipment, including bio-mechanical devices; and (v) modification or customization of any Durable Medical Equipment.	
52	Examinations for the prescription, fitting or adjustment of hearing aids.	
53	Travel or transportation expenses, even though prescribed by a Physician, except ambulance service as outlined in Section Covered Medical Expenses.	
54	Services for which a Participant would have no legal obligation to pay.	
55	Services performed by a provider with the same legal residence as a Participant or who is a family member, including spouse, brother, sister, parent or child.	
56	Adult circumcision in the absence of disease.	
57	Charges for a private room when a semi-private room is available.	
58	Services which are not prescribed, performed, or directed by a Provider licensed to do so.	
59	Educational classes, nutritional counseling programs, support groups and disease management programs unless sponsored or provided by Blue Cross, except as required for diabetes education services.	
60	Charges for care or services in a Skilled Nursing Facility.	
61	Hospice services, home health care services and home infusion therapy services. This exclusion does not apply to infusion services performed in a Hospital or Physician's office, which will be considered a Covered Medical Expense.	
62	Unattended Services.	
63	Take home drugs, both prescription and non-prescription, dispensed by a Pharmacy, Facility Provider or Professional Provider; injectable or implantable contraceptive drugs and devices that are not self-administrable (except when used for an approved medical condition other than contraception), and fertility drugs regardless of use; drugs in certain drug classes specifically designated by Blue Cross as Specialty Drugs including, but not limited to self-administrable injectables, such as antihemophilic agents, hematopoietic agents, anticoagulants, growth hormones, enzyme replacement agents, immunomodulators, monoclonal antibodies, and other biotech drugs; except those drugs administered by a Professional Provider who is a Contracting Provider, that are not self-administrable and/or that are provided incident to a Covered Service; and those drugs that are mandated to be covered by law; and/or which are covered under a Prescription Drug Amendment to the Agreement. [Or as indicated on the Outline Of Coverage]	