Open Access Plan

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The Open Access Plan offers a choice when you need medical care — for physician and ancillary services, you can go “in-network” by choosing a preferred provider, or you can go “out-of-network” and see any other health care provider and your claim will still be processed at the same benefit level.

The plan does not have a network for hospital and facility services, such as outpatient diagnostic and surgical facilities. You can visit any facility that provides the services you need and the Plan will reimburse your covered charges up to the Maximum Allowable Amount, which is outlined in the in the *Your Medical Plan* section.

How the Pequot Open Plan Works

The plan offers a choice. Each time you need care, you decide which provider to see. You can receive care from one of the preferred providers for physician and ancillary services or from any other provider. The plan does not have a network for hospital and facility services, such as outpatient diagnostic and surgical facilities. You can visit any facility that provides the services you need and the Plan will reimburse your covered charges up to the Maximum Allowable Amount, which is outlined in the *Your Medical Plan* section.

If you go out-of-network for physician and ancillary services …

… you have benefits and your out of pocket remains the same.

There is no requirement to see a “primary care physician” or obtain a referral before seeing a specialist.

Certain services must be pre-certified for you to receive full benefits. See “Pre-Certification” within this section for more information.

The network for physician and ancillary services may change from time to time. A change in the membership of the provider network is not considered a qualified change in status for mid-year changes in coverage.

Physician and Ancillary Services

How Benefits Are Paid

The Pequot Open Plan features a network of selected physician and ancillary service providers who have agreed to provide medical care at a fixed rate for plan participants.

For physician and ancillary services, the plan pays a portion of eligible charges for covered expenses after you pay a certain amount. Amounts are based on services which could include coinsurance, copays and annual deductibles. You are protected from catastrophically high expenses through the plan's out-of-pocket maximum, which limits the amount you and your family have to pay for covered expenses in a given year. For more information, see "Your Health Care Options at a Glance" in the *Your Medical Plan* section.

Pre-Certification

If the plan requires pre-certification for a service and you or your doctor fail to pre-certify that service, you will be financially penalized. The penalty is 20% up to $5,000 per cause. ("Cause" is defined by the Pequot Open Plan as a continuous treatment prescribed within a clinical treatment plan for a specific diagnosis.) Be sure you understand that pre-certification alone doesn't mean your care is covered — pre-certification is just a first step, and not a guarantee that benefits will be paid. After pre-certifying your care, the plan will still have to review your claim to determine what benefits, if any, are payable.

You must obtain pre-certification, or advance approval, for certain kinds of health care. Pre-certification is designed to help protect you from the cost and inconvenience of unnecessary surgery or extended hospital stays. By calling for pre-certification, you learn before you incur an expense whether your treatment is medically necessary. (If the treatment is not medically necessary, the plan will not pay any benefits for that treatment.) In addition, it is important to pre-certify when the plan requires it.

The pre-certification program for the MPTN Medical Plan is managed by a medical utilization company. You must pre-certify by calling the number listed on your benefit card in advance. Examples of services requiring pre-certification are listed below and are not inclusive of all services needing pre-certification. The list of services requiring pre-certification is subject to change at any time.

- All inpatient services
- Cosmetic procedures (e.g., reduction/enhancement mammoplasty, rhinoplasty, abdominalplasty, etc.)
- Varicose veins — stripping and ligation
- Durable medical equipment (rentals over $500.00; purchases over $1,000.00)
- Home health care
- Inpatient and partial levels of care for behavioral health and substance abuse services

If Your Request for Pre-Certification Is Denied

If your pre-certification request is denied, you may appeal. You may also appeal if your request for benefits is denied.

Call for Pre-Certification

You must pre-certify certain kinds of care by calling the medical utilization company in advance, at the number listed on your benefit card.

If you have questions about what kinds of services need pre-certification, you can call Pequot Plus Health Benefit Services at 1-888-779-6872.

The Complete List of Services

The list to the right provides examples of the services requiring pre-certification. To find out whether the list has changed and whether the health care you are seeking requires pre-certification, you or your health care provider should be sure to contact the medical utilization company at the number listed on your benefit card or call Pequot Plus Health Benefit Services at 1-888-779-6872 in advance.

The medical utilization company has a multi-level appeals process. You and your provider are able to participate in all levels in an attempt to reach resolution. If your treatment is denied during the pre-certification process, you should encourage your provider to become involved and to request an appeal.

Often, the original denial is merely the result of not enough medical information needed to approve your claim. If you supply the additional information and the pre-certification is still not granted, your doctor may request a physician-to-physician review.

Filing a Claim for Benefits

Here is the way you claim benefits under the Plan:

1. See your doctor or other health care provider. Generally, both in-network and out-of-network providers will submit your claim to the plan directly.
2. If your out-of-network provider does not submit your claim for you, you pay in full for all services received and file a claim with MPTN. Your claim must include an itemized bill showing the name and address of the patient, the name of the team member, the services rendered and the amount paid.
3. The plan will reimburse a portion of eligible charges once you meet the deductible for the year.
4. If you reach the annual out-of-pocket maximum, the plan then pays 100% of most covered expenses that you incur during the rest of the plan year.

When to File a Claim

To be reimbursed, you must submit your claim within one year of the date when the service for which you are claiming benefits was provided. For example, if you receive care on October 4, 2023, you must submit your claim for benefits for that care no later than October 3, 2024.

If You Are Enrolled in a Health Care Flexible Spending Account

If you are enrolled in a Health Care Flexible Spending Account, you must submit copies of your bills for reimbursement directly to:

Pequot Plus Health Benefit Services
Health Care Flexible Spending Account Administrator
P.O. Box 3620
Mashantucket, CT 06338-3620
1-888-779-6872

For more information on Health Care Flexible Spending Accounts, see the *Flexible Spending Accounts* section.

Properly Completed Claims Speed a Response

There are a few things you can do to ensure that your claims are processed quickly and accurately. When you visit a doctor, hospital or other medical provider, be sure to ask for an itemized bill that includes:

- the name of the patient,
- the name of the provider,
- the nature of the medical or surgical procedures and other services and supplies furnished,
- the date, and
- the amount charged for each procedure.

For More Information …

… on appealing a claim, see "Claims Review and Appeals Procedures" in the *Rules and Regulations* section

Not Sure Whether Your Expense Is Covered?

If you don't see a particular service listed in this section, check the list of excluded services under "What's Not Covered" in the *Your Medical Plan* section.

If you don't see the service listed here or under "What's Not Covered," call Pequot Plus Health Benefit Services at 1-888-779-6872 to determine coverage.

What the Pequot Open Plan Covers

This section describes the benefits covered by the Pequot Open Plan. The plan pays benefits for services, treatment, supplies, and facilities that are covered health services (as determined by the plan). See “What’s Not Covered” in the *Your Medical Plan* section for more information about services that may not be covered by the plan.

Plan benefits, features and limits are described in more detail in “Your Health Care Option at a Glance” in the *Your Medical Plan* section.

Outpatient Care

When you receive same-day care without an overnight hospital stay, your care is called outpatient or ambulatory care. Similarly, doctor’s office visits and specialist visits are considered outpatient care. In some cases — for outpatient surgery, for example — you must have the plan approve your care in order to receive maximum benefits. See “Pre-Certification” within this section for more information.

Physician Services*

Benefits cover the following doctor’s charges:

- Hospital visits
- Surgery
- Anesthesia
- Maternity care, including prenatal, delivery, and post-natal care for you and your eligible spouse only

*Note services provided by a hospital or at a facility are subject to “Referenced Based Pricing” as outlined in the *Your Medical Plan* section.

See “Your Health Care Options at a Glance” in the *Your Medical Plan* section for the amount of copays and coinsurance.

Specialist Visits

The Pequot Open Plan also covers office visits to specialists such as allergists, cardiologists, dermatologists, and neurologists. You can see a specialist without a referral from your primary care physician (PCP) or your PCP may suggest that you see a specialist.

Know Your Care Provider

Be sure you know whether the center providing your care is classified as an emergency room, an urgent care center, or a walk-in care center, and whether it is hospital-based or hospital-associated.

Preventive Care

Generally, benefits cover preventive and wellness care at 100% for each office visit.

These services are described in more detail in “Your Health Care Option at a Glance” in the *Your Medical Plan* section, and in the benefit summary included with your enrollment materials.

Be sure to check your coverage before receiving out-of-network care.

Diagnostic Testing

The plan covers a portion of eligible charges for diagnostic testing, including lab tests and X-rays.

Maternity Care*

Benefits cover a portion of the expenses related to pregnancy and childbirth for you or your spouse. The plan does not cover expenses related to pregnancy and childbirth for other eligible dependents, except as covered under the preventive care

benefits of the plan.

Your care will generally be coordinated by your PCP or your obstetrician.

*Note services provided by a hospital or at a facility are subject to “Referenced Based Pricing” as outlined in the *Your Medical Plan* section.

Outpatient Surgery

The plan covers a portion of surgery performed on an outpatient basis and necessary medical services and supplies. Keep in mind that some outpatient surgery requires pre-certification.

Emergency Care

The Pequot Open Plan covers eligible charges related to emergency care. Whenever you have a true medical emergency, you should go to the nearest emergency facility. If you are admitted, your provider must contact the medical utilization company at the telephone number shown on your benefit card within 48 hours of your admission. If your provider does not contact the medical utilization company within 48 hours, the 20%/$5,000 pre-certification penalty may apply. (See “Pre-Certification” within this section for more information on when to pre-certify a hospital admission.)

A medical emergency is generally defined as a sickness or injury that, without immediate medical attention, could place a person’s life in danger or cause serious harm to bodily functions. Examples of emergencies include an apparent heart attack, severe bleeding, loss of consciousness, and severe or multiple injuries.

Non-Emergency Services

You should visit your family physician or a walk-in center for non-emergency services, such as treatment for an ear infection or the flu. Non-emergency services should not be provided in the emergency room.

Urgent Care and Walk-In

The plan’s benefits for urgent and walk-in care, including care provided through convenience care centers, differ depending on whether the care:

- is provided through a hospital-based or hospital-associated facility, or
- is not provided through a hospital-based or hospital-associated facility.

Urgent care that is provided by a hospital-based or hospital-associated facility is subject to the emergency room copay.

Urgent and walk-in care that is not provided by a hospital-based or hospital-associated facility is subject to the office visit copay.

All emergency room visits are subject to the emergency room copays.

You do not need a referral or any pre-certification to use an urgent care or walk-in center.

Ambulance

The plan covers a portion of local professional ambulance service when medically necessary to transport a patient to the nearest hospital where appropriate treatment is available.

Hospital Emergency Room

Hospital emergency room treatment is covered if you need emergency medical treatment. For more detail see “Your Health Care Options at a Glance,” in the *Your Medical Plan* section.

Inpatient Care

Non-emergency inpatient admissions must be pre-certified to receive full benefits. If your admission is not pre-certified, you pay the *first 20% of charges, up to $5,000.*

The Pequot Open Plan covers a portion of the charges related to inpatient hospitalization. Such charges may include the following:

- Pre-admission testing up to seven days in advance of admission
- Laboratory, X-ray and radiotherapy services approved by your physician
- Room and board for semi-private hospital accommodations for treatment of illness, injury, or pregnancy up to 120 days per illness (Mental health treatment and treatment for alcohol/substance abuse is covered separately, see the *Mental Health and Alcohol/Substance Abuse Coverage* section.)
    - “Illness” is defined by the plans as treatment related to a specific ICD diagnosis as provided to the plans by the health care provider.
- Intensive care
- Treatment rooms
- Drugs and medicines
- Dressings
- Splints and casts
- Reading of X-rays, EKGs and pathological reports
- Diagnostic laboratory services
- Oxygen and its administration
- Radiation therapy and treatment
- Physical therapy
- Professional nursing services

Inpatient Surgery

The plan covers a portion of eligible charges for inpatient surgery. For non-emergency inpatient surgery, you must pre-certify to receive maximum benefits as described under “Pre-Certification” within this section. Otherwise, you pay the first 20% of charges, up to $5,000.

The plan also covers a portion of eligible expenses associated with reconstructive surgery following a mastectomy, expenses for reconstructive surgery on the other breast to achieve symmetry, the cost of prostheses, and the costs for treatment for physical complications at any stage of the mastectomy, including lymphedemas.

Transplant Benefits

Special Transplant Network Provisions

The plan arranges access to a national network of transplant facilities carefully selected for the specialized expertise in transplant. The facilities are chosen for the extensive experience with transplants and their high survival rates along with experienced surgical teams with transplant surgeon certification. The transplant centers have Medicare approval and membership in a national organ-sharing network.

Transplant services require pre-authorization. Transplant benefits are subject to all other plan exclusions, limitations and other plan provisions.

The plan covers transplant services providing:

- When the recipient is not covered by this plan and the donor is covered, the expenses will not be covered for either the recipient or the donor.
- When both the recipient and donor are covered by this plan services will be covered for each patient.
- When only the recipient is covered by this plan, benefits are provided for services for both the recipient and donor, provided benefits to the donor are not available under any other form of healthcare coverage.
- The transplant is medically necessary and is recognized by federal agencies as appropriate treatment for the active illness and injury.
- The transplant is not for cosmetic purposes unless the following apply:
    - Repair within one year of an accident which occurred while covered under the plan,
    - Replacement of tissue or diseased tissue surgically removed or altered while covered under the plan, or
    - Treatment of a birth defect in a child who has been continuously covered under the plan since the date of birth.

What Transplant Services are Covered

- Hospital services
- Physicians services
- Immunosuppressive drugs
- Donor search services
- Donor charges related to the actual transplant
- Organ procurement or acquisition charges

What Transplant Services are not Covered

- Transportation
- Lodging
- Meals
- Loss of wages

Maternity Care

If you or an eligible spouse is admitted to the hospital in connection with childbirth, the mother and newborn child or children are permitted to stay in the hospital with full benefits for at least:

- 48 hours following normal delivery, or
- 96 hours following a cesarean section.

The provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable), if the mother agrees to be discharged earlier than the 48/96-hour minimum.

No plan authorization is required if the care provider prescribes a hospital stay within the 48/96-hour minimum.

Home Health Care

The plan pays for home health care when skilled nursing or other professional services are required (i.e., physical therapy, etc.). Combined with special duty nursing, the plans cover home health care services for up to 120 days per plan year.

Physician house calls related to home health care are generally not covered.

Hospice Care

The Pequot Open Plan covers hospice services for the end of life. Beneficiaries should contact the medical utilization company at the number listed on your benefit card for assistance in coordinating all necessary services with network providers.

What the Pequot Plan Does Not Cover

The Pequot Open Plan does not pay benefits for services, treatment, supplies, and facilities that are not covered health services (as determined by the plan).

See “What’s Not Covered” in the *Your Medical Plan* section for additional information.

Routine Patient Costs for Participation in an Approved Clinical Trial

Charges for any Medically Necessary services, for which benefits are provided by the plan, when a participant is participating in a phase I, II, III or IV clinical trial, conducted in relation to the prevention, detection or treatment of a life-threatening disease or condition, as defined under the ACA, provided:

- The clinical trial is approved by any of the following:
  - The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services.
  - The National Institute of Health.
  - The U.S. Food and Drug Administration.
  - The U.S. Department of Defense.
  - The U.S. Department of Veterans Affairs.

    - An institutional review board of an institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services.
- The research institution conducting the approved clinical trial and each health professional providing routine patient care through the institution, agree to accept reimbursement at the applicable allowable expense, as payment in full for routine patient care provided in connection with the approved clinical trial.

Coverage will not be provided for:

- The cost of an investigative new drug or device that is not approved for any indication by the U.S. Food and Drug Administration, including a drug or device that is the subject of the approved clinical trial.
- The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in an approved clinical trial.
- The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular Diagnosis.
- A cost associated with managing an approved clinical trial.
- The cost of a health care service that is specifically excluded by the plan.
- Services that are part of the subject matter of the approved clinical trial and that are customarily paid for by the research institution conducting the approved clinical trial.