Verq

PLAN DOCUMENT CONFLICT ANALYSIS

Where the plan *can't answer the claim.*

ACME Health System, Inc. — Summary Plan Description

This analysis reads the Summary Plan Description the way a claim does — provision against provision — and surfaces every place the document *contradicts itself, leaves the outcome to discretion, or says nothing at all.* Each finding is tied to the plan language that creates it and the kind of claim that will expose it.

BENEFIT PLAN 006 · HDHP-FAMILY · RESTATED JANUARY 1, 2025 · TPA: ACME | PREPARED AUGUST 11, 2026

22

CONTRADICTIONS

11 HIGH · 8 MEDIUM · 3 LOW

The same claim is simultaneously payable and deniable, depending on which provision an adjudicator applies.

28

AMBIGUITIES

7 HIGH · 15 MEDIUM · 6 LOW

Language that exists but is undefined or open to two readings, leaving the outcome to discretion.

25

SILENCES

8 HIGH · 10 MEDIUM · 7 LOW

Foreseeable claims the document never addresses — no grant, no exclusion, no limit.

75 findings *across the document — each one a place a claim can be paid or denied without the plan settling the question.*

HOW TO READ EACH FINDING

PLAN LANGUAGE	The exact provisions in tension — where the language appears and, for contradictions, where it conflicts. Page cites refer to the SPD's printed page numbers.
EXAMPLE CLAIM	A real, foreseeable claim for this population that forces the question the document leaves open.
QUESTION · SUGGESTED FIX	The decision the plan sponsor needs to make, or the edit that resolves the finding.

Prepared by Verq for plan-fiduciary review — findings read provision against provision, the way a claim is adjudicated.

WHAT SEVERITY MEANS

HIGH — **Fix at or before renewal.** A claim that recurs on this plan will hit this provision, and the wrong answer is costly, clearly incorrect, or hard to defend on appeal — the kind that drives overpayments, reversed denials, or a stop-loss carrier declining reimbursement.

MEDIUM — **Put on this year's amendment roadmap.** A real conflict, but narrower — it affects a subset of claims, the dollars are moderate, or the plan's intent is clear enough to administer today. Defensible for now, exposed over time.

LOW — **Roll into the next routine amendment.** Technically wrong or unaddressed, but the triggering claim is rare and low-dollar. Worth cleaning up to keep the document tight; not worth holding a renewal over.

Severity reflects risk — how often a claim hits the provision, the dollars and member impact at stake, and how defensible the outcome is — not which category (contradiction, ambiguity, or silence) the finding falls in. A silence can be High; a contradiction can be Low.

CONTRADICTIONS

22 contradictions

The same claim is simultaneously payable and deniable, depending on which provision an adjudicator applies.

11 HIGH · 8 MEDIUM · 3 LOW

C-01 Bariatric surgery eligibility

HIGH

APPEARS Amendment 01, eff. 1/1/2025 (front of SPD)

CONFLICTS Covered Medical Benefits #45, p.45

The Amendment states members are eligible for bariatric surgery with 'two continuous years of ENROLLMENT.' The body text of Covered Medical Benefits #45 states 'two continuous years of EMPLOYMENT.' These are materially different tests: a 3-year employee who enrolled at open enrollment 14 months ago passes one and fails the other.

EXAMPLE CLAIM

Bariatric surgery claim (CPT 43644/43775) from an employee with long tenure but recent plan enrollment, or a recent hire who came from another ACME plan.

QUESTION · SUGGESTED FIX

Confirm which term controls. The amendment purports to amend this exact provision, so 'enrollment' likely governs, but the restated body text was not conformed.

C-02 Abortion

HIGH

APPEARS Covered Medical Benefits #2, p.39 (life endangerment only)

CONFLICTS General Exclusions #2, p.75 (life endangerment OR rape/incest)

The covered-benefit grant covers abortion only when a Physician certifies the mother's life is in danger. The exclusion carves out both life endangerment AND pregnancies resulting from rape or incest. A rape/incest claim is not granted by the benefits section but is not excluded by the exclusions section.

EXAMPLE CLAIM

Termination of pregnancy claim with rape or incest documentation and no life-endangerment certification.

QUESTION · SUGGESTED FIX

Align both provisions. Decide whether rape/incest is covered and state it identically in both sections.

C-03 Massage therapy

HIGH

APPEARS Schedule p.14 (30 visits/yr, 80/60) + Covered Benefits #41/#77

CONFLICTS General Exclusions #5 + Glossary 'Alternative / Complementary Treatment' p.101

Massage therapy is a scheduled benefit with a 30-visit maximum and a named covered service. But Exclusion #5 excludes all Alternative/Complementary Treatment, and the Glossary definition of that term explicitly includes 'Massage therapy.'

EXAMPLE CLAIM

Any massage therapy claim (CPT 97124) - adjudicator can cite the schedule to pay or the exclusion+glossary to deny.

QUESTION · SUGGESTED FIX

Remove massage therapy from the Alternative/Complementary glossary definition, or add 'unless covered elsewhere' language to Exclusion #5.

C-04 Infertility injections / drugs

HIGH

APPEARS Schedule p.8 (Infertility Injections in office, $500/yr max) + Covered Benefits #36

CONFLICTS General Exclusions #41 (excludes 'direct attempts to cause pregnancy by any means, including hormone therapy or drugs' and 'fertility tests')

The Plan schedules a $500/year benefit for infertility injections administered in a Physician's office, yet Exclusion #41 excludes hormone therapy/drugs that are direct attempts to cause pregnancy - which is exactly what office-administered fertility injections are. #36 also folds 'diagnostic tests' into the infertility benefit while #41 excludes 'fertility tests.'

EXAMPLE CLAIM

Claim for office-administered gonadotropin/hCG injections (J-codes + 96372); claim for semen analysis or HSG ordered in an infertility workup.

QUESTION · SUGGESTED FIX

Add an explicit carve-out to Exclusion #41 for the scheduled office-injection benefit and define which diagnostics ride the covered pathway vs. the excluded 'fertility tests.'

C-05 Sterilization reversal

MEDIUM

APPEARS General Exclusions #67 ('unless covered by the Plan in connection with Infertility Treatment')

CONFLICTS General Exclusions #41 + Glossary 'Infertility Treatment' p.105 (reversal of sterilization is excluded / defined as Infertility Treatment)

Exclusion #67 points to Infertility Treatment coverage as the exception for reversal of sterilization; Exclusion #41 and the Glossary place surgical reversal of a sterilized state squarely inside excluded Infertility Treatment. The cross-reference is circular - the exception points to a provision that excludes the same service.

EXAMPLE CLAIM

Vasectomy or tubal ligation reversal claim (CPT 55400, 58750).

QUESTION · SUGGESTED FIX

Delete the exception in #67 or state the actual condition (if any) under which reversal is payable.

C-06 Deductible design (embedded vs. aggregate)

HIGH

APPEARS Out-of-Pocket Expenses p.16 ('A Deductible applies to each Covered Person up to a family Deductible limit')

CONFLICTS Schedule p.4 note ('the FULL Family Deductible Amount Must Be Met Before The Plan Will Begin Paying')

The narrative describes an embedded per-person deductible with a family cap; the Schedule note describes a non-embedded aggregate family deductible. For a family of 4 on this HDHP, one member with $4,000 of claims either has met their deductible (narrative) or has not (schedule).

EXAMPLE CLAIM

First large claim of the year for one member of a family-tier enrollment - the payable amount differs by thousands of dollars depending on which reading applies.

QUESTION · SUGGESTED FIX

State one design. The schedule note (aggregate) matches typical family HDHP design; conform the narrative in the OOP section.

C-07 Out-of-pocket maximum (individual vs. family aggregate)

HIGH

APPEARS OOP section p.16 ('the most the Covered Person pays each year')

CONFLICTS Schedule p.4 note ('Full Family Out-Of-Pocket Maximum Amount Must Be Met Before The Plan Will Begin Paying Covered Expenses In Full')

The narrative frames the OOPM as an individual protection; the Schedule requires the full family OOPM ($10,000 Tier 1 / $12,000 Tier 2) to be met before anything pays at 100%. With no embedded individual OOPM stated, a single family member could pay $10,000-$12,000 - above the ACA embedded self-only OOPM limit (~$9,200 for 2025) - a compliance exposure as well as an internal conflict.

EXAMPLE CLAIM

One catastrophically ill member of a family enrollment accumulating past $9,200 with the Plan still applying coinsurance.

QUESTION · SUGGESTED FIX

Add an embedded individual OOPM equal to or below the ACA self-only limit and reconcile the two provisions.

C-08 Tier structure vs. two-network narrative

HIGH

APPEARS Schedule pp.4-14 (three benefit tiers with separate deductibles/OOPMs)

CONFLICTS Provider Network p.37 + OOP section p.16 (describe only 'In-Network' [ACME IA/OOA] and 'Out-of-Network' levels; 'separate in-network and out-of-network out-of-pocket maximums')

The Schedule prices every service across Tier 1/2/3, but the Provider Network and OOP sections describe a binary in/out-of-network world and binary accumulators. Nothing in the document defines which providers are Tier 2 (e.g., the carrier network?) or how three tiers map to two accumulation buckets.

EXAMPLE CLAIM

Any claim from a non-ACME, carrier-contracted provider: is it Tier 2? Does its deductible spend accumulate to the 'in-network' bucket? Does Tier 2 spend cross-accumulate with Tier 1?

QUESTION · SUGGESTED FIX

Define Tier 1/2/3 membership explicitly and rewrite the accumulation rules for three tiers (including the scattered 'After Tier 1 Deductible' rows).

C-09 Bariatric surgery cost share vs. HDHP structure

HIGH

APPEARS Schedule p.9: 'Bariatric Surgery - All Other Services: Paid By Plan 80%' (no deductible language); 'Informational Seminar: Paid By Plan After Deductible 100%'

CONFLICTS QHDHP declaration p.4 + IRS HDHP rules (only preventive care may be paid pre-deductible)

The 'All Other Services' bariatric row omits 'After Deductible,' implying first-dollar 80% coverage of surgery - which would disqualify the plan as an HSA-eligible HDHP. Meanwhile the low-cost informational seminar is paid 100% only AFTER deductible. The two rows read as if their deductible treatments were swapped.

EXAMPLE CLAIM

Bariatric surgical claim early in the plan year before deductible is met; also affects every enrollee's HSA eligibility if administered as written.

QUESTION · SUGGESTED FIX

Confirm intended design (almost certainly: seminar deductible-waived, surgery after deductible) and correct the schedule.

C-10 Foreign travel immunizations vs. HDHP qualification

HIGH

APPEARS Schedule p.10 & p.12: Foreign Travel Immunizations 'Paid By Plan After Deductible 100% (Deductible Waived)' Tiers 1-2

CONFLICTS QHDHP declaration p.4; Preventive/Routine Care glossary definition p.108 (QHDHP preventive = IRC 223(c)(2)(C))

Travel immunizations are not ACA/IRS-preventive. Paying them at 100% with the deductible waived under a purported Qualified HDHP contradicts the plan's own QHDHP definition and threatens every participant's HSA eligibility. (The 'After Deductible ... (Deductible Waived)' phrasing is also self-contradictory - see C-16.)

EXAMPLE CLAIM

Yellow fever/typhoid vaccine claim before deductible met; downstream: IRS challenge to HSA contributions for all enrollees.

QUESTION · SUGGESTED FIX

Either apply the deductible to travel immunizations or obtain tax counsel sign-off; fix the row.

C-11 Auto accident claims

HIGH

APPEARS — General Exclusions #9 'Auto Excess' (excludes any illness/injury for which medical payment is provided or PAYABLE under any automobile coverage)

CONFLICTS — Coordination of Benefits p.68 (Plan coordinates with motor-vehicle policies and 'will always be considered secondary')

The exclusion removes auto-accident charges from coverage to the extent payable under auto coverage; COB instead treats the Plan as a secondary payer that pays the balance. Under the exclusion the member absorbs the PIP-payable amount even if PIP is exhausted or disputed; under COB the Plan pays secondary.

EXAMPLE CLAIM

MVA claim where PIP limits ($10k in FL) are exhausted or the auto carrier disputes; ER + inpatient balances after PIP.

QUESTION · SUGGESTED FIX

Pick one mechanism. If COB-secondary is intended, narrow Exclusion #9 to amounts actually paid by the auto carrier.

C-12 Developmental / behavioral therapy

HIGH

APPEARS — Covered Benefits #8 (ASD: ABA, speech/OT/PT covered) + #77 (speech therapy at ACME/Wolfson for under-18 covers Developmental Delays, Learning Disabilities, behavioral problems, any 'developmental' diagnosis) + Schedule 'Learning Disability' row (Tier 1 80%)

CONFLICTS — General Exclusions #24 (excludes medical charges and OT/PT for Developmental Delays, intellectual disability, or behavioral therapy)

Exclusion #24 excludes the same category of services that #8, #77, and the Learning Disability schedule row cover. ABA is behavioral therapy; developmental speech diagnoses are Developmental Delays. There is no 'unless covered elsewhere' softener on #24.

EXAMPLE CLAIM

ABA therapy claims (97153-97158); OT/PT for a child with global developmental delay; speech therapy for developmental language disorder outside Wolfson.

QUESTION · SUGGESTED FIX

Add 'unless covered elsewhere in this SPD' to Exclusion #24 and define exactly which developmental services are in vs. out.

C-13 Speech therapy visit maximum

MEDIUM

APPEARS — Schedule p.13-14 (Speech: 25 visits/yr; 'Medical Necessity Will Be Reviewed After 25 Visits')

CONFLICTS — Covered Benefits #77 (25-visit maximum does NOT apply to Down Syndrome or autism diagnoses)

The Schedule states a flat 25-visit calendar-year maximum for speech therapy with review after 25. The narrative exempts Down Syndrome and autism from the maximum entirely. The schedule note ('reviewed after 25') also reads differently from a hard maximum.

EXAMPLE CLAIM

Speech therapy visit #26+ for an autistic child - denied under the schedule, payable under the narrative.

QUESTION · SUGGESTED FIX

Add the Down Syndrome/autism exemption to the schedule row; clarify whether 25 is a hard cap or a medical-necessity review trigger for all other diagnoses.

C-14 Wig / cranial prosthesis scope

LOW

APPEARS Schedule p.14 (cancer treatment AND 'Alopecia Areata' only)

CONFLICTS Covered Benefits #82 (cancer treatment or 'alopecia related to A MEDICAL CONDITION')

The schedule limits the wig benefit to alopecia areata specifically; the covered-benefit text extends it to alopecia related to any medical condition (e.g., lupus, thyroid disease, telogen effluvium from illness).

EXAMPLE CLAIM

$300 wig claim for hair loss from lupus or chemotherapy-unrelated medical alopecia other than areata.

QUESTION · SUGGESTED FIX

Conform the two provisions - either 'alopecia areata' or 'alopecia related to a medical condition' in both places.

C-15 Timely filing

MEDIUM

APPEARS General Exclusions #17 (claims received later than 12 months from date of service - no exceptions)

CONFLICTS Claims Procedures p.82 (12 months, but 3 years if Medicare/Medicaid paid primary in error; 6 years for VA hospitals)

The exclusion is absolute; the claims section carves exceptions for Medicare/Medicaid error and VA hospitals. An exclusion-based denial engine would reject claims the claims section deems timely.

EXAMPLE CLAIM

Claim resubmitted 20 months after DOS following a Medicare primary-payment recoupment.

QUESTION · SUGGESTED FIX

Add the exceptions to Exclusion #17 or cross-reference the Claims section.

C-16 'After Deductible ... (Deductible Waived)' rows

MEDIUM

APPEARS Schedule pp.5-13, ~15 rows (e.g., Breast Pumps, Routine Prenatal, Contraceptives-Women, Preventive Exams, Pap, PSA, Sterilizations-Women)

CONFLICTS Same rows - internal wording

Numerous rows read 'Paid By Plan After Deductible - 100% (Deductible Waived).' 'After deductible' and 'deductible waived' cannot both be true. Other preventive rows (mammograms, colonoscopies) correctly drop the 'After Deductible' lead-in, proving the inconsistency is drafting error rather than design.

EXAMPLE CLAIM

Every preventive/first-dollar claim - a literal parser (human or machine) must choose which phrase to honor; on an HDHP the choice changes member cost by the full deductible.

QUESTION · SUGGESTED FIX

Strip 'After Deductible' from every deductible-waived row.

C-17 Emergency definition

MEDIUM

APPEARS Glossary p.103 ('serious medical condition ... require immediate care ... to avoid jeopardy to the life and health')

CONFLICTS Claims Procedures p.81 (prudent-layperson standard: severe pain, impairment of bodily function, examples incl. chest pain, syncope, fever >=103)

Two different emergency standards coexist. The glossary standard is narrower (jeopardy to life and health); the claims section uses the broader prudent-layperson standard required by the ACA/No Surprises Act. Which definition gates the ER benefit row and the retrospective review of ER claims?

EXAMPLE CLAIM

ER visit for severe abdominal pain discharged with a non-emergent diagnosis - payable under prudent layperson, deniable under the glossary definition.

QUESTION · SUGGESTED FIX

Replace the glossary definition with the prudent-layperson standard used in the claims section (and required by law).

C-18 COBRA lapse date vs. end-of-month termination

MEDIUM

APPEARS Termination p.24 (employee coverage ends the LAST DAY OF THE MONTH employment ends)

CONFLICTS COBRA p.29 ('If the Qualified Beneficiary does not choose COBRA ... group health coverage will end on the DAY OF the Qualifying Event')

Coverage termination is end-of-month, but the COBRA section states coverage ends on the day of the qualifying event when COBRA is declined. For a June 10 termination, claims incurred June 11-30 are covered under one provision and not the other.

EXAMPLE CLAIM

Claims incurred between a mid-month termination date and month-end when COBRA is waived.

QUESTION · SUGGESTED FIX

Conform the COBRA text to the actual loss-of-coverage date (end of month).

C-19 Effective date of the document

LOW

APPEARS Cover page ('Restated 01-01-2025') + Amendment (eff. 1/1/2025)

CONFLICTS Introduction p.1 ('This document became effective on January 1, 2024')

The restated SPD says it became effective 1/1/2024 while the cover and amendment say 1/1/2025; the amendment footer separately references 'Plan Year 10-01-2024 to 10-01-2025' (the ERISA year). Date-of-service adjudication against 'the document in effect' is ambiguous for 2024 claims.

EXAMPLE CLAIM

Appeal of a 2024 date-of-service claim: which document version governs?

QUESTION · SUGGESTED FIX

Update the Introduction effective date to the restatement date and keep a version history.

C-20 Diagnostic mammogram payment rate

MEDIUM

APPEARS Schedule p.10 (Diagnostic Mammograms: 100% after deductible, Tiers 1-2; Tier 3 No Benefit)

CONFLICTS Schedule p.7 (Outpatient X-Ray/Diagnostic Testing & Advanced Imaging rows: 80%/60%; physician charges 80/60/60)

A diagnostic mammogram is outpatient diagnostic imaging. The mammogram-specific row pays 100% after deductible with Tier 3 No Benefit; the general imaging rows pay 80/60 with Tier 3 60% (physician). The same claim maps to two different rates depending on which row the adjudicator selects, especially for the professional component and for Tier 3.

EXAMPLE CLAIM

Diagnostic mammogram (77066) global or split-billed claim; any Tier 3 diagnostic mammogram professional charge.

QUESTION · SUGGESTED FIX

State that the specific mammogram row supersedes general imaging rows, incl. professional components and Tier 3 treatment.

C-21 Grandfathered contradiction: 'Learning Disability' coverage vs. education exclusions

MEDIUM

APPEARS Covered Benefits #39 (covers 'special education, remedial reading, school system testing' except when provided by a school)

CONFLICTS General Exclusions #26 (educational services) & #72 (services provided by a school) & #84 (vocational/educational services)

#39 affirmatively covers services that #26 and #84 exclude as educational in nature. The only reconciling carve in #26 is for clinical education by licensed professionals in disease self-management - which does not describe remedial reading or school-system testing.

EXAMPLE CLAIM

Claim for psychoeducational testing by a private psychologist; remedial reading program billed by a clinic.

QUESTION · SUGGESTED FIX

Clarify which educational-flavored services are payable under the Tier-1-only Learning Disability benefit and reconcile #26/#84.

C-22 Travel immunizations: medical vs. pharmacy benefit

LOW

APPEARS Schedule p.10/p.12 (Foreign Travel Immunizations covered 100%, Tiers 1-2)

CONFLICTS Rx Exclusions p.59 (excludes 'Vaccines ... not included in the Healthcare Reform Drug List')

The identical vaccine is covered at 100% when administered in a medical setting but excluded when dispensed/administered at a pharmacy, because travel vaccines are not on the ACA preventive list. Members steered to retail pharmacy vaccination (the cheaper site) are denied.

EXAMPLE CLAIM

Typhoid or yellow-fever vaccine administered at Walgreens vs. at a physician office.

QUESTION · SUGGESTED FIX

Align vaccine coverage across benefit silos or disclose the site-of-service difference explicitly.

AMBIGUITIES

28 ambiguities

Language that exists but is undefined or open to two readings, leaving the outcome to discretion.

7 HIGH · 15 MEDIUM · 6 LOW

A-01 Definition of Tier 2

HIGH

PLAN LANGUAGE — Schedule pp.4-14; Provider Network p.37; ACME CARE p.63 ('Managed Care [Carrier] Network Providers')

Tier 1 is presumably ACME Health System IA/OOA and Tier 3 out-of-network, but the SPD never says what Tier 2 is (the carrier's national PPO network? Options PPO is expressly excluded from 'Managed Care [Carrier] Network Providers'). Members and adjudicators cannot map a provider to a tier from this document.

EXAMPLE CLAIM

Every claim from a non-ACME contracted provider.

QUESTION · SUGGESTED FIX

Add a tier-definition table naming the network(s) behind each tier.

A-02 Cross-tier deductible and OOPM accumulation

HIGH

PLAN LANGUAGE — Schedule pp.4-14 ('After Tier 1 Deductible' notations on select Tier 2/Tier 3 rows: ambulance, ER, cataract Tier 2, DME Tier 2, hospice Tier 2, sleep studies Tier 2, independent lab Tiers 1-2, wigs)

Some Tier 2/3 rows are 'After Tier 1 Deductible,' implying a member must satisfy the Tier 1 deductible for a Tier 2 service - but the OOP section describes only binary in/out accumulation. Whether Tier 2 spend credits the Tier 1 deductible (and vice versa), and which OOPM caps a mixed-tier year, is undefined.

EXAMPLE CLAIM

Member with $4k of Tier 2 spend who then has a Tier 1 surgery; ambulance claim ('After Tier 1 Deductible' at all tiers) for a member who has only met the Tier 2 deductible.

QUESTION · SUGGESTED FIX

Publish an accumulation matrix: which buckets exist, what credits each, and which OOPM applies per tier.

A-03 Conventional (non-femto) cataract surgery

MEDIUM

PLAN LANGUAGE Schedule p.5 row is titled 'Cataract Surgery (Using Femto Laser)'; Covered Benefits #15 covers cataract/aphakia surgery generally

Only femto-laser cataract surgery has a schedule row (with Tier 3 No Benefit). Standard phacoemulsification is not named - it presumably falls to outpatient surgery rows or 'All Other Covered Expenses,' but a reader could equally conclude only femto technique is covered, or that the femto row's Tier 3 'No Benefit' applies to all cataract surgery.

EXAMPLE CLAIM

Conventional cataract extraction (66984) at a Tier 2 ASC; any Tier 3 cataract claim.

QUESTION · SUGGESTED FIX

Rename the row or add a row for conventional cataract surgery and state Tier 3 treatment.

A-04 ACME HealthPlace On Demand cost share

MEDIUM

PLAN LANGUAGE Schedule p.5 (single '80%' value printed under the Tier 2 column; Tier 1 and Tier 3 cells blank)

The telehealth-on-demand row shows one number positioned under Tier 2 with the other columns empty. It is unclear whether 80% applies to all tiers, only Tier 2, or whether the placement is a layout artifact. (A vendor-provided service arguably has no tier at all.)

EXAMPLE CLAIM

Any Telescope virtual visit claim.

QUESTION · SUGGESTED FIX

Restate the row with an explicit single-column benefit ('All tiers: 80% after deductible' or similar).

A-05 'Physician Office Visit' vs. 'Physician Office Services' rows

LOW

PLAN LANGUAGE Schedule p.10 (two adjacent rows, both 80/60/60; the first carries a carve-out list)

Two nearly identical rows exist with different names and no definition distinguishing a 'visit' from 'services.' Because the carve-out list attaches only to the first row, the scope of those carve-outs (e.g., do they apply to office-billed labs?) is indeterminate.

EXAMPLE CLAIM

Office claim with an E/M code plus in-office procedure - which row (and whose carve-outs) governs each line?

QUESTION · SUGGESTED FIX

Merge the rows or define each term and its claim mapping.

A-06 Hearing aids (conventional)

MEDIUM

PLAN LANGUAGE Hearing Aid Benefits p.60 (the carrier's hearing DISCOUNT program); Exclusion #38 (hearing aid purchase/fitting excluded 'unless covered elsewhere'); Schedule covers only IMPLANTABLE devices (Tier 1)

A section titled 'Hearing Aid Benefits' describes only discounted purchasing - not a plan-paid benefit. Exclusion #38's 'unless covered elsewhere' clause invites the argument that the p.60 section is that 'elsewhere.' Whether any plan dollars are payable toward a conventional hearing aid is unclear.

EXAMPLE CLAIM

Hearing aid claim (V5257) purchased through the carrier's hearing-discount program - member expects the 'benefit' section to mean coverage.

QUESTION · SUGGESTED FIX

Retitle the section as a discount program and state plainly that conventional hearing aids are not a covered expense (or add a benefit).

A-07 Dental implants after accidental injury

MEDIUM

PLAN LANGUAGE Covered Benefits #20 bullet 1 ('treatment of natural teeth and gums if an Injury is sustained in an Accident ..., or for treatment of cleft palate, excluding implants')

The clause 'excluding implants' sits at the end of a compound sentence covering both accident-related dental care and cleft palate. Whether implants are excluded only for cleft treatment or also for accident restoration is grammatically ambiguous.

EXAMPLE CLAIM

Implant claim (D6010) to replace a tooth avulsed in a fall, submitted within 12 months.

QUESTION · SUGGESTED FIX

Restructure the bullet so the implant exclusion's scope is explicit.

A-08 CGMs, insulin pumps, and 'diabetic supplies'

HIGH

PLAN LANGUAGE Exclusion #18 (CGMs and supplies excluded); Covered Benefits #21 (diabetes treatment, education, shoes, counseling covered); Rx Exclusions p.59 (DME excluded 'other than the diabetic supplies ... specifically stated as covered')

CGMs are excluded on the medical side, yet the Rx exclusions imply some 'diabetic supplies' are covered under pharmacy without listing them. Whether a pharmacy-dispensed CGM (Dexcom/Libre, routinely adjudicated as a pharmacy claim) is a covered 'diabetic supply' or an excluded CGM is unresolved. Insulin pumps are mentioned nowhere.

EXAMPLE CLAIM

Dexcom G7 sensors billed through the PBM; insulin pump (E0784) DME claim.

QUESTION · SUGGESTED FIX

List covered diabetic supplies explicitly and state CGM/pump treatment on both the medical and Rx sides.

A-09 HDHP pharmacy cost share (blank cells)

HIGH

PLAN LANGUAGE Rx table p.56 (HDHP column shows only Preventive Generics $0 and Specialty 20% after deductible; Generic/Preferred/Non-Preferred/GLP-1 cells blank in the HDHP column)

This SPD is the HDHP plan document, yet the pharmacy table leaves the HDHP cost share blank for ordinary generics, preferred brands, non-preferred brands, and GLP-1s. Whether HDHP members pay the Premium/Core copays after deductible, coinsurance, or something else is not stated.

EXAMPLE CLAIM

Any post-deductible retail fill of a generic or brand drug by an HDHP member; any GLP-1 fill (does the $200 copay and $20k lifetime max even apply to this plan?).

QUESTION · SUGGESTED FIX

Complete the HDHP column for every drug tier and state whether the GLP-1 benefit (and its $20,000 lifetime max) applies to Plan 006.

A-10 GLP-1 weight-loss drugs vs. weight-control exclusion

MEDIUM

PLAN LANGUAGE Rx table p.56 (GLP-1 Weight Loss Drugs covered, $20,000 lifetime max)

Medical Exclusion #86 excludes weight-control treatment 'whether or not prescribed by a Physician,' excepting only the listed Morbid Obesity services. The Rx benefit covers weight-loss GLP-1s. Because Rx benefits are 'covered under the Medical Plan' (p.56), the exclusion arguably reaches them; nothing reconciles the two. Eligibility criteria (BMI? morbid obesity only?) are also unstated.

EXAMPLE CLAIM

Zepbound/Wegovy prior-auth request for a member with BMI 32 and no comorbidities.

QUESTION · SUGGESTED FIX

State that Exclusion #86 does not apply to the Rx GLP-1 benefit and publish the clinical criteria.

A-11 Transplants outside Designated Transplant Facilities

HIGH

PLAN LANGUAGE Transplant Schedule p.15 + Transplant Benefits pp.53-55 (all provisions keyed to 'Designated Transplant Facility')

Every transplant provision assumes a Designated (transplant-network) facility. The SPD never states what happens at a non-designated facility: No Benefit? Standard tiered benefits? Reduced level? ('Benefits may also be subject to reduced levels as outlined in individual Plan provisions' - which are never supplied.) Only cornea is expressly routed to 'All Other Covered Expenses.'

EXAMPLE CLAIM

Kidney transplant at a Tier 1 ACME hospital that is not a designated transplant-network facility; out-of-state liver transplant at a non-designated center of the member's choice.

QUESTION · SUGGESTED FIX

Add a non-designated-facility benefit statement (even if 'No Benefit').

A-12 Donor coverage window

MEDIUM

PLAN LANGUAGE Transplant Benefits p.53 ('donor services for donor-related complications DURING THE TRANSPLANT PERIOD, per the transplant contract') vs. Transplant Exclusions p.55 (post-transplant donor complications excluded if donor not a Covered Person)

'Transplant period' is undefined, and the governing 'transplant contract' is not part of the SPD. The boundary between covered donor complications (during the period) and excluded ones (post-transplant) cannot be determined from the document.

EXAMPLE CLAIM

Non-covered living kidney donor readmitted with a surgical complication 45 days after harvest.

QUESTION · SUGGESTED FIX

Define 'transplant period' (e.g., through X days post-procurement) in the SPD.

A-13 Weekend admission exclusion

MEDIUM

PLAN LANGUAGE General Exclusions #85 (admissions after 3pm Friday / before noon Sunday excluded unless Emergency or childbirth-related)

The exclusion does not address medically necessary but non-'Emergency' weekend admissions: direct admissions from an ER after stabilization, scheduled chemotherapy starts, transfers, observation-to-inpatient conversions crossing the weekend window. Whether the exclusion voids the entire stay or only the weekend room-and-board days is also unstated.

EXAMPLE CLAIM

Saturday 5pm direct admission for IV antibiotics ordered from urgent care; Friday 6pm post-surgical admission following an ASC complication.

QUESTION · SUGGESTED FIX

Modernize or delete #85; at minimum define its scope (which charges, which days) and the 'Emergency' standard applied.

A-14 Marriage counseling vs. family psychotherapy

MEDIUM

PLAN LANGUAGE Exclusion #47 (marriage counseling) vs. Mental Health Benefits p.61 (outpatient therapy by Qualified Provider covered)

Family/couples psychotherapy billed with CPT 90847 for treatment of a member's diagnosed mental health disorder is standard care, but is superficially 'marriage counseling.' The SPD gives no rule for distinguishing excluded relationship counseling from covered conjoint psychotherapy.

EXAMPLE CLAIM

90847 claim where the identified patient has an ICD-10 F-code diagnosis and the spouse participates.

QUESTION · SUGGESTED FIX

State that family/conjoint therapy for a covered diagnosis is payable and the exclusion reaches only counseling without a treating diagnosis.

A-15 Prior authorization list terms

MEDIUM

PLAN LANGUAGE ACME CARE p.64 ('Echography (No Prior Authorization required for Tier 1)'; 'Percutaneous aerial ultrasound')

'Echography' (all ultrasounds?) requiring PA at Tiers 2-3 is an enormous, undefined scope. 'Percutaneous aerial ultrasound' is not a recognized procedure (likely a corrupted term - arterial? aerial?). Providers cannot reliably determine PA obligations, yet failure carries payment penalties.

EXAMPLE CLAIM

Routine OB ultrasound at a Tier 2 facility without PA; any claim denied for missing PA on 'percutaneous aerial ultrasound.'

QUESTION · SUGGESTED FIX

Replace with defined procedure categories/CPT ranges; correct the garbled term.

A-16 Morbid obesity revisions

MEDIUM

PLAN LANGUAGE Amendment (revisions 'covered under your standard medical benefits based on place of service' if ACME-approved) vs. Schedule p.9 (Morbid Obesity Treatment: Tier 2/3 No Benefit)

Original bariatric surgery is Tier 1-only, but approved revisions ride 'standard medical benefits based on place of service' - implying a revision could be paid at Tier 2 under inpatient/outpatient rows even though the underlying benefit is Tier 1-only. Which schedule rows and tier limits govern a revision is unclear.

EXAMPLE CLAIM

ACME-approved revision of a gastric sleeve performed at a Tier 2 hospital.

QUESTION · SUGGESTED FIX

State the tier availability and applicable schedule rows for approved revisions.

A-17 Observation status (72-hour rule)

MEDIUM

PLAN LANGUAGE Covered Benefits #33/#34 (observation >72 hours = Inpatient; <=72 hours = Outpatient); Glossary 'Inpatient' p.105

The 72-hour pivot is unusual (industry-typical is 48) and its mechanics are unstated: does hour 73 reclassify the entire stay retroactively to Inpatient (triggering the inpatient PA/notification requirement and different cost share)? Do the Tier 2 'No Benefit' outpatient-facility cells apply to observation at Tier 3? Is the facility's billed status (rev code 0762) or elapsed time controlling?

EXAMPLE CLAIM

76-hour observation stay at a Tier 2 hospital billed as observation; PA penalty exposure for a stay that 'became' inpatient at hour 73.

QUESTION · SUGGESTED FIX

Specify the reclassification mechanics, notification duty, and which schedule rows apply.

A-18 'Authorized signature' on complete claims

LOW

PLAN LANGUAGE Claims Procedures p.82 (a complete claim must include 'Authorized signature from the Covered Person' and 'Signature of provider')

Standard electronic claims (837P/837I) carry no signatures. Read literally, every EDI claim is incomplete and can be denied or aged past timely filing while 'incomplete.' The SPD does not say signature-on-file indicators satisfy the requirement.

EXAMPLE CLAIM

Any electronically submitted claim; member-submitted OON reimbursement without a provider signature.

QUESTION · SUGGESTED FIX

State that signature-on-file / electronic submission satisfies the signature elements.

A-19 Contested workers' compensation claims

HIGH

PLAN LANGUAGE Exclusion #88 (services required to be covered by WC excluded) + Subrogation pp.72-74 (contemplates plan payment and first-priority recovery from WC awards)

When a WC carrier denies compensability, the SPD does not say whether the Plan pays pending dispute (and recovers via subrogation, as pp.72-74 imply) or denies under #88 leaving the member uncovered during the contest.

EXAMPLE CLAIM

ER and surgery claims for a back injury the WC carrier denies as non-occupational while the employer's incident report says otherwise.

QUESTION · SUGGESTED FIX

Add a conditional-payment provision for disputed WC claims (pay-and-pursue) or state the denial posture explicitly.

A-20 Screening colonoscopy that becomes therapeutic

HIGH

PLAN LANGUAGE Schedule p.11 (Preventive colonoscopy from 45: 100% no deductible; Diagnostic colonoscopy: 100% after deductible)

The SPD does not say how a screening colonoscopy with polyp removal, or a colonoscopy following a positive Cologuard/FIT, is classified. Federal guidance treats both as preventive (no cost share), but the document's preventive/diagnostic split invites deductible application. Related: bowel prep, anesthesia, and pathology bundling are unaddressed.

EXAMPLE CLAIM

45-year-old's screening colonoscopy with polypectomy (45385) - preventive at 100% or diagnostic after a $3,000+ deductible?

QUESTION · SUGGESTED FIX

State that polyp removal during screening and post-positive-stool-test colonoscopies retain preventive status, including anesthesia/pathology.

A-21 BRCA genetic TESTING as preventive

MEDIUM

PLAN LANGUAGE Preventive care p.47 & women's list p.12 (covers BRCA 'genetic test COUNSELING' for high-risk women) vs. Covered Benefits #29 (genetic testing criteria with cost share)

The preventive list covers counseling only; USPSTF-mandated coverage extends to the BRCA test itself for indicated women at no cost share. As written, the test would route through #29 with deductible/coinsurance. Which pathway applies is unclear.

EXAMPLE CLAIM

BRCA1/2 panel for a woman with strong family history, ordered after covered counseling.

QUESTION · SUGGESTED FIX

State that indicated BRCA testing is preventive at 100% in-network.

A-22 Network abbreviations 'IA' and 'OOA'

LOW

PLAN LANGUAGE Provider Network p.37 ('ACME Health System IA, ACME Health System OOA')

The abbreviations are never expanded (presumably In-Area / Out-Of-Area). Members with out-of-area dependents (college students) cannot determine from the SPD which network - and therefore which tier - applies to them.

EXAMPLE CLAIM

Claims for a dependent attending school in another state seeing a carrier-contracted provider.

QUESTION · SUGGESTED FIX

Expand the abbreviations and explain the out-of-area benefit mechanics.

A-23 Home Health 'Durable Medical Pharmacy' / 'Medical Pharmacy'

MEDIUM

PLAN LANGUAGE Schedule p.6 (two rows: Home Health Care Durable Medical Pharmacy; Home Health Care Medical Pharmacy - both 80/80, Tier 3 No Benefit)

Neither term is defined anywhere in the SPD or glossary. Whether these mean home infusion drugs, DME-adjacent supplies, or something else - and how they differ from the Infusion and DME rows - cannot be determined.

EXAMPLE CLAIM

Home infusion antibiotic claim: Infusion row (80/60) or Home Health Medical Pharmacy row (80/80)?

QUESTION · SUGGESTED FIX

Define both terms and their claim mapping vs. the Infusion/DME rows.

A-24 Private Duty Nursing pointer

LOW

PLAN LANGUAGE Home Health Care p.52 ('Information regarding Private Duty Nursing can be found elsewhere in this SPD')

The only 'elsewhere' is Exclusion #63, which excludes PDN entirely, plus a glossary definition. The pointer reads as if a PDN benefit exists somewhere. Skilled-care hours 4+ per day fall between the HHC 4-hour visit cap and the PDN exclusion with no stated pathway.

EXAMPLE CLAIM

Member needing 6 hours/day of skilled nursing at home - HHC covers 4; the remainder is PDN and excluded.

QUESTION · SUGGESTED FIX

Change the pointer to state PDN is excluded (see Exclusion #63).

A-25 Panniculectomy vs. abdominoplasty boundary

LOW

PLAN LANGUAGE Schedule p.9 + Covered Benefits #54 (panniculectomy covered if medically necessary) vs. Exclusion #1 (abdominoplasty absolutely excluded)

The two procedures are commonly performed together and are clinically adjacent (15830 vs. 15847 add-on). The SPD gives no criteria for panniculectomy medical necessity and no rule for claims combining both, so line-splitting outcomes are unpredictable.

EXAMPLE CLAIM

Post-bariatric patient's 15830 + 15847 claim after massive weight loss with panniculitis.

QUESTION · SUGGESTED FIX

Publish panniculectomy MN criteria and combined-procedure adjudication rules.

A-26 Gender dysphoria benefits – age and criteria

MEDIUM

PLAN LANGUAGE Covered Benefits #28 (incl. puberty-suppressing medication; surgery list; cosmetic list)

No age limits, readiness criteria (e.g., WPATH), or PA requirements are stated for gender dysphoria services, even though puberty suppression by definition involves minors and bilateral mastectomy appears on the covered list while 'mastopexy' appears on the cosmetic list (frequently combined procedures). Hormone therapy 'dispensed from a pharmacy' is described in the medical benefit but administered by the PBM.

EXAMPLE CLAIM

GD surgery PA request for a 17-year-old; FtM chest surgery claim combining mastectomy and mastopexy codes; pharmacy hormone fill.

QUESTION · SUGGESTED FIX

State clinical criteria, age rules, PA requirements, and the medical-vs-Rx routing for hormones.

A-27 Rx deductible/OOPM tier mapping

MEDIUM

PLAN LANGUAGE Rx p.56 ('Deductibles apply before copay/coinsurance. Medical out-of-pocket maximums also apply.' HDHP note: '$3,000/$6,000 deductible combined with medical')

The plan has three medical deductibles and three OOPMs. The Rx section references 'the' deductible and 'medical out-of-pocket maximums' without saying which tier bucket pharmacy spend credits (presumably Tier 1) or whether the family aggregate rule applies to Rx accumulation.

EXAMPLE CLAIM

Family member's specialty fill when the family has met the Tier 2 but not Tier 1 deductible.

QUESTION · SUGGESTED FIX

State that Rx accumulates to the Tier 1 (in-network) deductible/OOPM and confirm the family-aggregate mechanics.

A-28 Preventive frequency and 'appropriate ages'

LOW

PLAN LANGUAGE Schedule pp.10-13 (exams/screenings 'at appropriate ages' with no stated frequency except mammogram/pap/PSA 1/yr)

'Appropriate ages' is undefined; annual-physical frequency limits, well-child schedules, and screening intervals (e.g., colonoscopy every 10 years?) are not stated. Whether a second physical in a calendar year, or an early repeat screening, is payable cannot be determined.

EXAMPLE CLAIM

Second preventive visit in one year after switching PCPs; screening colonoscopy 5 years after a normal one.

QUESTION · SUGGESTED FIX

Reference the USPSTF/HRSA/ACIP schedules as the frequency standard, or publish the plan's own limits.

SILENCES

25 silences

Foreseeable claims the document never addresses — no grant, no exclusion, no limit.

8 HIGH · 10 MEDIUM · 7 LOW

S-01 Ectopic pregnancy

MEDIUM

PLAN LANGUAGE Maternity #42 covers 'abdominal operation for INTRAUTERINE pregnancy or miscarriage'

Ectopic (extrauterine) pregnancy - among the most common surgical emergencies of early pregnancy - is not literally within the maternity grant and appears nowhere else. It would presumably pay under 'All Other Covered Expenses' or surgery rows, but the omission invites inconsistent mapping and cost-share disputes (maternity vs. surgical).

EXAMPLE CLAIM

Laparoscopic salpingectomy for ruptured ectopic (59151); methotrexate management of unruptured ectopic.

QUESTION · SUGGESTED FIX

Add ectopic pregnancy management to the maternity benefit.

S-02 Insulin pumps

HIGH

PLAN LANGUAGE Diabetes #21; DME #23; Exclusion #18 (CGMs only)

The SPD excludes CGMs by name but says nothing about insulin pumps or pump supplies - a high-cost, high-frequency diabetes claim. Silence next to an explicit CGM exclusion will be argued both ways.

EXAMPLE CLAIM

Insulin pump (E0784) and monthly infusion sets; hybrid closed-loop systems that integrate an excluded CGM.

QUESTION · SUGGESTED FIX

State pump coverage (and how integrated pump+CGM systems are handled).

S-03 Medication-assisted treatment (MAT) for opioid use disorder

HIGH

PLAN LANGUAGE SUD benefits p.62; Rx section

Buprenorphine/naloxone, methadone clinic services (bundled H0020), and naltrexone injections are unaddressed on both the medical and Rx sides. Methadone OTPs bill medical, not pharmacy; nothing maps them to a benefit row.

EXAMPLE CLAIM

Weekly OTP bundled claims; Sublocade (Q9991) office administration; Suboxone retail fills.

QUESTION · SUGGESTED FIX

Add MAT (including OTP services) to the SUD benefit and formulary documentation.

S-04 Autism ABA visit/hour limits and schedule row

HIGH

PLAN LANGUAGE Covered Benefits #8; Schedule (no ABA row)

ABA is covered by narrative but has no schedule row, no cost share, no hour/visit limits, and no stated PA requirement. It presumably falls to 'All Other Covered Expenses' (80/60/60), but ABA is delivered 10-40 hrs/week and the therapy-services 25-visit caps arguably reach it via 'habilitation (such as therapies).'

EXAMPLE CLAIM

97153 claims at 20 hrs/week - unlimited at 80%? Capped at 25 visits? PA required?

QUESTION · SUGGESTED FIX

Add an ABA schedule row with cost share, any limits, and PA requirements.

S-05 Hearing aids for children / bone-anchored devices

MEDIUM

PLAN LANGUAGE Hearing Services #30; Schedule p.6

Only 'implantable' devices are addressed. Bone-anchored hearing aids (BAHA - surgically implanted abutment with external processor), external processors and their replacements, and pediatric conventional aids are unaddressed. The external processor of a covered implant is neither clearly a covered device nor an excluded 'hearing aid.'

EXAMPLE CLAIM

Cochlear implant external processor replacement (L8619); BAHA claim (69714 + device).

QUESTION · SUGGESTED FIX

Define which device components are covered, including processor replacement cycles.

S-06 High-risk / early screening colonoscopy (under 45)

MEDIUM

PLAN LANGUAGE Schedule p.11 (preventive colonoscopy 'From Age 45')

Screening colonoscopy for members under 45 with family history or genetic risk (Lynch, FAP) is unaddressed - it is neither preventive (age floor) nor diagnostic (no symptoms). Claims will be inconsistently classified.

EXAMPLE CLAIM

38-year-old with first-degree relative dx at 42 - screening colonoscopy claim.

QUESTION · SUGGESTED FIX

State that risk-indicated earlier screening is covered and at what cost share.

S-07 Anesthesia and pathology with preventive endoscopy

MEDIUM

PLAN LANGUAGE Preventive colonoscopy rows p.11

Facility, anesthesia (00812), pathology (88305) and prep components of a screening colonoscopy are not addressed. Federal FAQs require them at no cost share when integral to the preventive service; the SPD's silence lets them route to standard 80/60 rows with deductible.

EXAMPLE CLAIM

Screening colonoscopy where the ASC and GI pay at 100% but anesthesia and path bill separately.

QUESTION · SUGGESTED FIX

State that integral components of a preventive service inherit preventive cost share.

S-08 Telemedicine (vendor-delivered) and behavioral telehealth

MEDIUM

PLAN LANGUAGE Glossary defines 'Telemedicine' (via a vendor) separately from 'Telehealth'; Schedule covers only 'Telehealth (Virtual Appointments With a PCP or Specialist)' and ACME HealthPlace

The glossary defines Telemedicine but no benefit provision uses it - vendor platforms (Teladoc, etc.) map to no row. Virtual behavioral health visits are also unaddressed (the telehealth row names PCP/Specialist only; MH parity questions follow).

EXAMPLE CLAIM

Teladoc dermatology visit; virtual psychotherapy (90837-95) with an out-of-state teletherapy group.

QUESTION · SUGGESTED FIX

Map vendor telemedicine and tele-behavioral-health to explicit rows (or exclude them explicitly).

S-09 Emergency air ambulance vs. non-emergency fixed-wing

LOW

PLAN LANGUAGE Ambulance #4 and NSA section pp.35-36

Emergency air ambulance is handled (NSA), and non-emergency medically necessary transport is covered 'to the nearest appropriate facility' - but medically necessary fixed-wing transport arranged for specialty care (e.g., transplant patient to the Designated Transplant Facility 600 miles away) sits between the transplant travel benefit (commercial airfare) and the ambulance benefit. Which pays, at what limit, is unaddressed.

EXAMPLE CLAIM

Air-medical transfer of a transplant candidate to the designated facility; neonatal fixed-wing transfer.

QUESTION · SUGGESTED FIX

Clarify the boundary between the ambulance benefit and transplant travel benefit.

S-10 Doula, lactation consultant network, childbirth education alternatives

LOW

PLAN LANGUAGE Maternity #42; breastfeeding #12; Exclusion #43 (Lamaze)

Doulas are unaddressed (not excluded, not covered). Lactation 'support and counseling by a trained provider' is covered but with no network/OON rule (ACA requires no-cost in-network; many lactation consultants are OON). Childbirth education is excluded only as 'Lamaze classes or other childbirth classes' - hospital-billed prenatal education is unclear.

EXAMPLE CLAIM

OON IBCLC lactation visit; doula claim submitted with a maternity global; hospital prenatal class fee.

QUESTION · SUGGESTED FIX

State doula treatment; state OON lactation adjudication; clarify the childbirth-class exclusion's reach.

S-11 Fertility preservation before gonadotoxic treatment (iatrogenic infertility)

MEDIUM

PLAN LANGUAGE Infertility #36; Exclusion #41 (freezing/storage of embryo, eggs, semen excluded)

Sperm/egg preservation before chemotherapy or radiation - standard-of-care for cancer patients and covered under many plans and state mandates - is not distinguished from elective fertility services. The blanket freezing/storage exclusion sweeps it in without ever considering the oncofertility scenario.

EXAMPLE CLAIM

Sperm cryopreservation for a 24-year-old starting chemo for Hodgkin lymphoma; oocyte retrieval before pelvic radiation.

QUESTION · SUGGESTED FIX

Decide and state whether iatrogenic-infertility preservation is covered notwithstanding Exclusion #41.

S-12 Out-of-network dialysis for ESRD members (network adequacy)

HIGH

PLAN LANGUAGE Schedule p.5 (Dialysis Facility: Tier 3 No Benefit); Centers of Excellence p.67 (KRS)

The SPD is silent on what happens when no Tier 1/Tier 2 dialysis facility is reasonably available (travel, rural, capacity) - there is no network-gap or access exception for a life-sustaining, thrice-weekly service, and no stated consequence for failing to contact KRS. MSP rules also scrutinize plans that disadvantage dialysis benefits.

EXAMPLE CLAIM

ESRD member relocating or traveling where only an OON (Tier 3) dialysis center exists - facility charges 'No Benefit.'

QUESTION · SUGGESTED FIX

Add a network-adequacy/gap exception for dialysis (and generally for Tier 3 'No Benefit' services when no network provider exists).

S-13 Network gap exception (general)

HIGH

PLAN LANGUAGE Provider Network pp.37-38 (exceptions listed: ambulance, inpatient physicians at Tier 1 hospitals, wigs; transitional care; continuity of care)

Beyond the three narrow exceptions and NSA scenarios, the SPD never addresses services with no participating provider (rare sub-specialists, pediatric subspecialties, geographic gaps). With many Tier 3 rows at 'No Benefit,' the absence of a gap-exception process is a recurring denial generator.

EXAMPLE CLAIM

Only pediatric geneticist within 200 miles is OON; member needs a service every Tier 1/2 provider declines.

QUESTION · SUGGESTED FIX

Add a documented gap-exception process paying in-network level when no network provider is reasonably available.

S-14 Growth hormone via pharmacy

MEDIUM

PLAN LANGUAGE Medical Exclusion #37 (growth hormones); Rx section (silent)

Growth hormone is excluded on the medical side but the pharmacy benefit - where GH is actually dispensed as a specialty drug - never mentions it. The Rx formulary controls in practice, but the SPD gives no answer, and the medical exclusion arguably reaches the whole Plan.

EXAMPLE CLAIM

Norditropin specialty fill for pediatric GH deficiency, prior-auth requested through the PBM.

QUESTION · SUGGESTED FIX

State GH treatment on the Rx side (excluded, or covered with PA criteria) consistent with the medical exclusion's intent.

S-15 Eating disorder treatment specifics

MEDIUM

PLAN LANGUAGE Mental Health p.61 (generic levels of care)

Anorexia/bulimia treatment - residential ED programs, meal-supervision partial hospitalization, and the interplay with the Nutrition Counseling exclusion carve-outs - is unaddressed. ED residential facilities often blur the 'therapeutic services primary' test used to exclude therapeutic boarding schools.

EXAMPLE CLAIM

Residential eating-disorder admission for an adolescent; dietitian visits within an ED treatment plan.

QUESTION · SUGGESTED FIX

Confirm ED residential/PHP coverage and dietitian services under the MH benefit.

S-16 Second bariatric procedure / weight regain

LOW

PLAN LANGUAGE Amendment + #45 (revisions covered if ACME-approved)

'Revisions' are addressed, but a second primary procedure after weight regain (sleeve-to-bypass conversion years later; band removal + new procedure) is not clearly a 'revision.' Whether the two-year enrollment/employment clock re-runs is also unstated.

EXAMPLE CLAIM

Conversion of failed lap band to gastric sleeve 6 years after the original surgery.

QUESTION · SUGGESTED FIX

Define 'revision' vs. new primary procedure and the eligibility clock for each.

S-17 Emergency care in a foreign country – cost share and tier

HIGH

PLAN LANGUAGE #43 (foreign services covered unless travel was for care); claims p.82 (reimbursement mechanics)

Foreign services are covered and reimbursement mechanics are given, but the SPD never states which TIER/cost share applies to foreign claims (no foreign provider is in any network - is everything Tier 3, where many rows are 'No Benefit'? Or does the NSA-style emergency rule apply?).

EXAMPLE CLAIM

Appendectomy in Mexico while on vacation - inpatient facility at Tier 3 is 'No Benefit' if foreign = OON.

QUESTION · SUGGESTED FIX

State that foreign emergency/urgent claims pay at the in-network (Tier 1) level, or define their tier explicitly.

S-18 Preventive vs. diagnostic 'conversion' rules generally

HIGH

PLAN LANGUAGE Preventive rows pp.10-13; Glossary 'Preventive / Routine Care' p.108 ('routine if there is no personal history of the Illness')

The SPD never addresses the recurring conversion scenarios: a preventive visit where a new problem is addressed (modifier -25 E/M added), surveillance screening after a personal history (post-polyp, post-cancer mammography - 'no personal history' language pushes these to diagnostic), or lab panels ordered at a physical. These drive the highest volume of member cost-share disputes on any plan.

EXAMPLE CLAIM

Annual physical where the PCP addresses new knee pain (99396 + 99213-25); annual mammogram for a breast-cancer survivor.

QUESTION · SUGGESTED FIX

Publish conversion rules: problem-addressed-at-preventive-visit billing, surveillance screening status, and preventive lab panels.

S-19 Compression garments post-mastectomy / lymphedema supplies

LOW

PLAN LANGUAGE WHCRA reconstruction #65 (covers 'complications of mastectomies, including lymphedemas'); Orthotics #52 (compression stockings)

Lymphedema treatment is promised at the diagnosis level, but compression sleeves/garments (not 'stockings'), pneumatic pumps, and ongoing garment replacement are unaddressed. Orthotics covers 'elastic compression stockings' only.

EXAMPLE CLAIM

Compression sleeve (S8420-series) and pneumatic compression pump (E0651) for post-mastectomy lymphedema.

QUESTION · SUGGESTED FIX

Enumerate lymphedema supplies and replacement frequency.

S-20 COVID-19 / vaccines administered at pharmacies generally

MEDIUM

PLAN LANGUAGE Preventive immunizations pp.10-12 (ACIP-recommended covered); Rx exclusions (vaccines not on Healthcare Reform list excluded)

ACIP vaccines administered at retail pharmacies (flu, shingles, COVID) - the dominant delivery channel - are not clearly mapped: the medical benefit covers immunizations at 100% but the pharmacy benefit excludes vaccines except the 'Healthcare Reform Drug List' (undefined in the SPD). Whether Shingrix at Walgreens processes at $0 is not determinable from the document.

EXAMPLE CLAIM

Shingrix administered at a network pharmacy, billed through the PBM.

QUESTION · SUGGESTED FIX

Define the Healthcare Reform Drug List's vaccine scope or route all ACIP vaccines to $0 at both sites.

S-21 Habilitative therapy for congenital conditions (non-ASD)

HIGH

PLAN LANGUAGE Therapy #77 (therapies 'ordered by a Physician'); Exclusion #24 (developmental delays); ASD #8

Habilitative PT/OT/speech for cerebral palsy, Down syndrome (outside the speech exemption), spina bifida, and genetic syndromes is unaddressed: not clearly 'developmental delay' (excluded), not ASD (covered), and the 25-visit caps' application to lifelong habilitative need is unstated.

EXAMPLE CLAIM

Ongoing PT for a 6-year-old with cerebral palsy after visit 25.

QUESTION · SUGGESTED FIX

State habilitative coverage by condition category and the visit-cap treatment for each.

S-22 Hospice benefit maximum

MEDIUM

PLAN LANGUAGE #32 ('up to the maximum hospice benefits available under the Plan'); Schedule p.6 (no hospice maximum shown)

The narrative caps hospice at a Plan maximum that is never stated anywhere - no day limit, dollar limit, or episode limit appears in the schedule. The referenced ceiling does not exist in the document.

EXAMPLE CLAIM

Hospice election continuing past 6 months with physician recertification - is there any limit?

QUESTION · SUGGESTED FIX

Either state the hospice maximum in the schedule or delete the reference to one.

S-23 Egg/sperm donor and gestational carrier medical costs for the INTENDED covered parent

LOW

PLAN LANGUAGE Exclusion #77 (surrogacy services excluded except a covered Employee/spouse acting AS surrogate)

Costs the covered intended parents incur that are not 'services provided in connection with a surrogate' - e.g., the covered member's own monitoring during a donor cycle - and newborn coverage when a child is born to a gestational carrier for a covered employee (child is the employee's legal child at birth) are unaddressed.

EXAMPLE CLAIM

Enrollment and nursery charges for a newborn via gestational carrier; covered member's labs during a donor-egg cycle.

QUESTION · SUGGESTED FIX

State newborn eligibility/nursery treatment for children born via surrogacy and the reach of Exclusion #77.

S-24 Consequence of failing to contact KRS / Centers of Excellence steering

LOW

PLAN LANGUAGE Centers of Excellence p.67 ('the Covered Person MUST contact ACME CARE' to use a KRS preferred provider)

The section imposes a 'must' with no stated consequence - no penalty, no benefit differential, no statement of what happens for dialysis outside KRS. Members cannot assess the stakes of the requirement.

EXAMPLE CLAIM

Member starts at a non-KRS in-network dialysis center without calling - any penalty?

QUESTION · SUGGESTED FIX

State the consequence (or remove 'must').

S-25

Claims incurred during the COBRA election window at a provider requiring payment

LOW

PLAN LANGUAGE COBRA p.29 (claims denied during election period reprocessed after election + payment)

Retroactive reinstatement is addressed, but the SPD is silent on prescription fills at point of sale during the gap (pharmacy claims reject in real time; retroactive Rx reprocessing through the transplant network is not described) and on PA obligations for services during the gap.

EXAMPLE CLAIM

Member needing a specialty fill 3 weeks into the COBRA election window before electing/paying.

QUESTION · SUGGESTED FIX

Describe retroactive Rx claim submission and PA handling during election gaps.