Insurance Policy Guidelines

1. Coverage Overview

Our insurance plans provide comprehensive coverage for medical expenses including hospitalization, outpatient services, prescription drugs, preventive care, and specialist consultations. All plans follow the guidelines established by state and federal regulations.

2. Pre-Authorization Requirements

The following procedures require pre-authorization before services are rendered:

• Major surgical procedures (excluding emergency)

• MRI and CT scans

• Hospitalization (planned admissions)

• Specialty medications and biologics

• Durable medical equipment over $1,000

• Home health care services

• Physical therapy (beyond initial 6 visits)

3. Network Provider Requirements

To receive maximum benefits, members must use in-network providers. Out-of-network services may result in higher out-of-pocket costs or claim denials. Emergency services are covered regardless of network status.

4. Medical Necessity Criteria

All services must be medically necessary to be covered. Medical necessity means healthcare services that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is:

• In accordance with generally accepted standards of medical practice

• Clinically appropriate in terms of type, frequency, extent, site, and duration

• Not primarily for the convenience of the patient, physician, or other healthcare provider

• Not more costly than alternative services that are at least as likely to produce equivalent results

5. Common Exclusions

The following services are typically not covered under standard policies:

- Cosmetic procedures (unless medically necessary)
- Experimental or investigational treatments
- Services not prescribed by a licensed provider
- Self-inflicted injuries (certain circumstances)
- Services outside policy effective dates