

I.B.U. of the Pacific National Health Benefit Trust

Transportation & Alternative Housing Benefits

Transportation Benefit

Transportation benefits are paid for travel within the Continental United States and Canada of the Covered Individual by professional ambulance service, railroad, or scheduled airline to and from a Hospital or Skilled Nursing Facility. These will be Covered Charges if the Covered Individual's Illness or Injury cannot be adequately treated at the location where the Illness or Injury occurs.

Alternative Housing Benefit

Alternative Housing benefits are paid for housing for a Covered Individual receiving special treatment that is not available at a local facility. The alternative housing benefit is available if the Covered Individual's medical condition prohibits traveling between home and the site of treatment. A physician must certify that the medical condition requires hospitalization, and the alternative housing benefit must be approved in advance by the Trust Office. The PPO Plan will pay the lesser of the single occupancy hotel rate or \$60 per day for up to seventy (70) days for each period of confinement. .

Benefit Requirements:

The attending doctor must certify that the necessary care is not available in the patient's home community. The patient must be placed under care as soon as possible after arrival at the designated location.

Limitations and Exclusions:

The Transportation benefit does not cover travel for an escort.

Check List:

Air or Railroad Transportation:

- Proof of purchase
- Itinerary (indicating travel dates)
- E-tickets or paper & Boarding Passes (must match itinerary and purchase price)

Alternative Housing:

- Hotel Bill and proof of payment

Insured Name: _____

Patient Name: _____

Group and Employee Number: _____

Address: _____

Phone: (____) _____

I AM MAKING APPLICATION FOR TRANSPORTATION BENEFITS FOR THE FOLLOWING DATES:

From _____ Through _____

I traveled from the location of _____ to _____ to obtain medical care. I request reimbursement for travel expenses, as indicated below:

Airfare or Railroad for Patient \$ _____

I AM MAKING APPLICATION FOR ALTERNATIVE HOUSING BENEFITS FOR THE FOLLOWING DATES:

From _____ Through _____

Calculation: _____ days X \$60/day (maximum of 70 days)
(# of days)

Total Cost \$ _____

*****PLEASE ATTACH ALL RECEIPTS NECESSARY TO CERTIFY THE DOLLAR AMOUNTS FOR WHICH YOU ARE REQUESTING REIMBURSEMENT*****

Member Signature Date

Phone Email

***Before benefits can be paid, this page must be completed
by the "Referring Doctor"*****

REFERRING DOCTOR'S CERTIFICATION

Insured Name: _____

Patient Name: _____

Group and Employee Number: _____

Diagnosis of Patient: _____

Care cannot be administered at this location. Patient must travel to:

I have referred patient to: _____
(name of doctor or medical facility)

Date(s) of scheduled treatment: _____

Name of referring doctor: _____
(Please print)

Address & Phone of referring doctor:

Signature of referring doctor: _____