Pennsylvania State Employees Credit Union

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QHDHP PPO

GROUP PREFERRED PROVIDER BENEFITS BOOKLET

Administered by:
Capital Blue Cross and Capital Advantage Assurance Company®,
A Subsidiary of Capital Blue Cross
2500 Elmerton Avenue
Harrisburg, PA 17110

Capital

NONDISCRIMINATION AND FOREIGN LANGUAGE ASSISTANCE NOTICE

Capital Blue Cross and its family of companies comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Capital Blue Cross does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Capital Blue Cross provides free aids and services to people with disabilities or whose primary language is not English, such as:

- ✓ Qualified sign language interpreters.
- ✓ Written information in other formats (large print, audio, accessible electronic format, other formats).
- ✓ Qualified interpreters, and information written in other languages.

If you need these services, call 800.962.2242 (TTY: 711).

If you believe that Capital Blue Cross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in person or by mail, fax, or email at:

Capital Blue Cross
PO Box 779880, Harrisburg, PA 17177-9880
800.417.7842 (TTY: 711), fax: 855.990.9001
CRC@capbluecross.com

If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW., Room 509F, HHH Building
Washington, D.C. 20201
Toll-free: 800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at https://www.hhs.gov/ocr/office/file/index.html.

Language assistance

To talk to an interpreter in your language at no cost, call 800.962.2242 (TTY: 711).

Para hablar con un intérprete de forma gratuita, llame al 800.962.2242 (TTY: 711).

欲免费用本国语言洽询传译员，请拨电话 800.962.2242 (TTY: 711).

Để nói chuyện với thông dịch viên bằng ngôn ngữ của quý vị không phải mất phí, xin gọi 800.962.2242 (TTY: 711).

Для бесплатного разговора с переводчиком на своем языке, позвоните по тел.: 800.962.2242 (TTY: 711).

Fa koschdefrei schwetze mit me dolmetscher in deinre Schrooch, ruf 800.962.2242 uff (TTY: 711).

무료 전화 통역 서비스 800.962.2242 (TTY: 711).

Per parlare con un interprete nella vostra lingua gratis, chiami 800.962.2242 (TTY: 711).

للتحدث مجانًا إلى مترجم للغتك، يرجى الاتصال بـ 800.962.2242 (الهاتف النصي: 711)

Pour parler à un interpréter dans votre langue sans charges, téléphoner à 800.962.2242 (TTY: 711).

Um in Ihrer Sprache gebührenfrei mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800.962.2242 an (TTY: 711).

 દુભાષીયા જોડે વાત કરવા, 800.962.2242 (TTY: 711) પર ફોન કરો.

Aby porozmawiac z tlumaczem w jezyku polskim, prosze zadzwonic na numer darmowy telefonu 800.962.2242 (TTY: 711).

Pou pale avèk yon entèprèt nan lang ou grastis, rele nan 800.962.2242 (TTY: 711).

ដើម្បីនិយាយជាមួយអ្នកបកប្រែផ្ទាល់មាត់ជាភាសារបស់អ្នកដោយមិនគិតថ្លៃ សូមហៅទៅកាន់ 800.962.2242 (TTY: 711).

Para falar com um intérprete em seu idioma de graça, ligue para 800.962.2242 (TTY: 711).

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Table of Contents

Table of Contents

WELCOME

Thank you for choosing healthcare and *prescription drug coverage* from the Capital Blue Cross family of companies. We are eager for this opportunity to help you and your family on your health and wellness journey.

This *Benefits Booklet* (also known as "Certificate of *Coverage*") is provided to you as part of the *group contract* entered into between the *contract holder* and us. It explains the *benefits* provided to you under your group health plan. It also defines terms important for your understanding, itemizes what your plan pays for and how, and explains how you can make the most of this *coverage*. We have also included our contact information so you can reach us when you have questions or concerns.

There are five sections in the *Benefits Booklet* that we would like to call out to help you to better understand your *coverage.* You should take extra time to review the following sections:

1. **How to Access Benefits**, serves as a guide to using and making the most of this *coverage*.
2. **Summary of Cost Sharing and Benefits**, provides a summary of your *benefits* and any *benefit* limitations under your plan.
3. **Medical Benefit and Prescription Drug Exclusions**, lists the services not covered under your plan.
4. **Claims Reimbursement**, offers important information on how to file a claim for *benefits*.
5. **Appeal Procedures,** details the appeal process so you know how to file an appeal, if needed.

This *Benefits Booklet* also includes the following, important materials:

- **A Schedule of Preventive Care Services** – This table shows guidelines for preventive care benefits.
- **The Preauthorization Program** – This program outlines services we need to review to determine if the services are *medically necessary*.

Let's Get Started

We want this *Benefits Booklet* to be easy to read and understand. Here are some of our language and format choices to help:

- When we say "you" or "your," we mean you, the subscriber. We may also say "you" or "your" to mean the member, which is anyone covered under your plan ("**dependents**").
- When we say "we," "us," or "our," we mean Capital Advantage Assurance Company.
- When we use a defined term in a section, we will use *italics* to alert you to look the word up, if you want or need to, under ***Definitions***.
- We will use **boldface font** to call out section titles, like ***How to Contact Us***, so you can go to that section to learn more.

Of course, any time you have questions or concerns about your *coverage*, we encourage you to call Member Services. You will find their number on the back of your *identification (ID) card*.

IMPORTANT NOTICES

There are a few important points that you need to know about your *coverage* before you continue reading the remainder of this *Benefits Booklet*:

- This plan may not cover all your healthcare and prescription drug expenses. You should read this *Benefits Booklet* carefully to determine which healthcare and *prescription drug* services are provided as *benefits* under your *coverage*.
- To receive certain *benefits* and pay the least for your healthcare and *prescription drugs*, use *in-network providers*.
- *Your benefits* may be subject to *cost sharing amounts,* including *copayments*, *deductibles*, and *coinsurance*. Refer to the **Summary of Cost Sharing and Benefits** section of this *Benefits Booklet* for specifics.
- *Benefits* are subject to review for *medical necessity* and may be subject to clinical management or utilization management. These programs help us make sure you receive the quality of care you need at the best price. Refer to the ***Clinical Management for Medical Benefits*** and ***Pharmaceutical Utilization Management*** sections for more details.
- When applicable, if you fail to follow *Capital's* clinical management requirements, we may reduce the level of payment for *benefits* or deny *coverage*, even if the *benefits* are *medically necessary*. Refer to the **Clinical Management Programs for Medical Benefits** section for the specific requirements applicable to your *coverage*.
- We base our *medical necessity* determinations on whether a healthcare service or *prescription drug* is appropriate and is a *benefit* under this *coverage*. We do not reward individuals or providers for denying *coverage*. And we don't provide them financial incentives to encourage you to use fewer covered services.
- We may contract with other companies to provide certain services, including administrative services, relating to this *coverage*.
- This *Benefits Booklet* replaces any other *Benefits Booklet*, *Certificates of Coverage,* or Certificate of Insurance we may have issued to you previously under your *coverage* with the Capital Blue Cross family of companies.
- The Summary of Benefits and *Coverage* (SBC) required by *PPACA* will be provided to you by the *contract holder*. The SBC contains only a partial description of the *benefits*, limitations, and exclusions under this *coverage*. It is not intended to be a complete list or complete description of available *benefits*. If the SBC and *Benefits Booklet* do not agree*,* the terms and conditions of this *coverage* shall be governed solely by the *group contract* issued to the *contract holder*.
- The *group contract* is nonparticipating in any divisible surplus of premium.
- *Capital* does not assume any financial risk or obligation with respect to *benefits* or claims for such *benefits*.
- The *group contract* is available for inspection at the office of the *contract holder* during regular business hours.

HOW TO CONTACT US

We are committed to providing excellent service to you. We offer you a variety of ways to connect with us to answer your questions, confirm your *benefits* and *coverage*, and more.

Online

Be sure to sign up for a secure account at CapitalBlueCross.com. With it, you can find your benefits, claims, and cost share balances. You can locate doctors, hospitals, and treatment costs; submit a request for preauthorization; change personal information; or request ID cards.

Member Services

Member Services representatives can answer your questions, confirm your benefits and *coverage*, and help you find in-network providers. They can help with questions about preauthorization for medical services or prior authorization for pharmaceuticals. Member Services can also help answer your questions about how to access providers who accommodate your physical disabilities or other special needs. This may include providing interpreting services in your preferred language or translating documents upon request. Language assistance is also available to disabled individuals. Information in Braille, large print or other alternate formats are available upon request at no charge.

Call	**800.962.2242 or TTY users, 711** M-F 8 a.m. to 6 p.m.
Email	Complete the Contact Us form at **CapitalBlueCross.com**.
Write	Capital Blue Cross PO Box 779519 Harrisburg, PA 17177-9519
FAX	**717.541.6915**
Walk In	2500 Elmerton Avenue Harrisburg, PA 17177 M-F 8 a.m. to 4:30 p.m.
Visit a Capital Blue Cross Connect health and wellness center	Go to **CapitalBlueCrossConnect.com** or call **855.505.BLUE (2583)** to make an appointment or just stop in. M-F 9 a.m. to 6 p.m., Sat. 9 a.m. to 1 p.m. **Promenade Shops at Saucon Valley** 2845 Center Valley Parkway Suite 404/409 Center Valley, PA 18034 **Patrick O'Donnell Pavilion** **WellSpan Health Campus** 12 St. Paul Drive Chambersburg, PA 17201 **Hampden Marketplace** 4500 Marketplace Way Enola, PA 17025 **Capital Blue Cross** 1221 Hamilton Street Allentown, PA 18102 **Apple Hill Medical Center** 25 Monument Rd., Suite 220A York, PA 17402

DEFINITIONS

The terms below have the following meanings whenever italicized in your Benefits Booklet or the *group contract*:

Allowed Amount: The maximum charge or payment level that we pay for to you under your *coverage*.

- For *in-network providers*, the allowed amount is the amount provided for in the contract between the *provider* and us, unless otherwise specified in this *Benefits Booklet*.
- For *out-of-network providers*, the allowed amount is the lesser of the *provider's* billed charge or the amount reflected in the *fee schedule*, unless otherwise specified in this *Benefits Booklet*. However, for *out-of-network providers* performing either (1) *emergency services* in the emergency department of a hospital (or *independent freestanding emergency department*), (2) *non-emergency services* at certain *in-network facilities* (namely, *hospitals*, *hospital* outpatient departments, critical access hospitals, or *ambulatory surgical facilities*), or (3) air ambulance services, the *allowed amount* is the *recognized amount*.
- For *in-network pharmacies*, the allowed amount is the lesser of either the *in-network pharmacy's* actual charge or the amount agreed to between *the pharmacy benefits manager (PBM)* and us.
- For *out-of-network pharmacies*, the allowed amount is the lesser of the *out-of-network pharmacy's* actual charge or the in-network pharmacy level.

When you get healthcare services from *professional* or *facility providers* outside of our geographic area through the *BlueCard Program*, the allowed amount is the lower of the *provider* billed charges for *covered services* or the price that the Host Plan charges us.

Ambulatory Surgical Facility: A *facility provider* licensed and approved by the state in which it provides covered healthcare services or as otherwise approved by us and which meets the following criteria:

- Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an *outpatient* basis.
- Provides treatment by or under the supervision of *physicians* when the patient is in the facility.
- Does not provide *inpatient* accommodations.
- Is not, other than incidentally, a facility used as an office or clinic for the private practice of a *physician*.

Ancillary Charge(s): The difference in cost you must pay if you or your *provider* choose a *brand drug* when a generic drug is available. *Ancillary charges* do not apply to the *deductible* or *out-of-pocket maximum*.

Annual Enrollment: The specified time period each year during which you can sign up for or make changes to *coverage*.

Applied Behavior Analysis (ABA): The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

Authorized Representative: One of the following:

- A person, including a *provider*, to whom a *member* has given express written consent to represent the *member* in a complaint, grievance, adverse benefit determination, internal appeal or external review process.
- A person authorized by law to provide substituted consent for a covered person or enrollee; or
- A family member or *provider* involved in providing health care to a *member* if the *member* is incapacitated or unable to provide consent due to a medical emergency or as necessary to prevent a serious and imminent threat to the health or safety of the covered person or enrollee.

Autism Service Provider: A person, entity or group licensed or certified by the applicable state authority providing treatment for *autism spectrum disorders* within the scope of their license or certification.

Autism Spectrum Disorders: Any of the disorders defined as an autism spectrum disorder by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or its successor.

Behavior Specialist: An individual licensed or certified by the applicable state authority who designs, implements or evaluates a behavior modification intervention component of a treatment plan, including those based on *applied behavior analysis*, to produce socially significant improvements in human behavior or to prevent loss of attained skill or function, through skill acquisition and the reduction of problematic behavior.

Benefit Period: The specified period of time during which charges for *benefits* must be incurred to be eligible for payment by us. A charge for *benefits* is incurred on the date you received the service or supply. The benefit period does not include any part of a year during which you have no *coverage* under the *group contract*, or any part of a year before the date of this *Benefits Booklet* or a similar provision takes effect. **The benefit period for this *coverage* begins January 1st and ends December 31st.**

Benefit Period Maximum: The limit of *coverage* for *benefit(s)* under the *group contract* within a *benefit period*. Such limits may be in the form of visits, days, or dollars. Benefit period maximums are described in the **Summary of Cost Sharing and Benefits** section.

Benefits: Those *medically necessary* healthcare services, *prescription drugs*, supplies, equipment and facility charges covered under, and in accordance with, this *coverage*.

Benefits Booklet (Certificate of Coverage): This document, issued to subscribers as part of the group contract entered into by the contract holder and us. It explains the terms of this *coverage*, including the benefits available to members and information on how this *coverage* is administered.

Birth Defect: Also known as congenital anomalies, congenital disorders or congenital malformations, can be defined as structural or functional abnormalities, including metabolic disorders, which are present from birth (whether evident at birth or become manifest later in life) and can be caused by single gene defects, chromosomal disorders, multifactorial inheritance, environmental teratogens or micronutrient deficiencies.

Birthing Facility: A licensed *facility provider* primarily organized and staffed to provide maternity care by a licensed certified nurse midwife.

BlueCard® Program: A program that allows you to access covered healthcare services from *Host Blue in-network providers* of a Blue Cross and/or Blue Shield Licensee (Blue Plan) located outside the *service area*. The local Blue Plan servicing the geographic area where the covered healthcare service is provided is referred to as the “Host Blue.”

Brand Drug: A *prescription drug* sold under its proprietary name or name(s) by one or more companies. A brand drug may or may not have a *generic drug* equivalent available.

Brand Nonpreferred Drug: A medication reviewed by our Pharmacy and Therapeutics committee and found not to have significant therapeutic advantage or overall value over alternative *generic drugs*, *brand preferred drugs* or *over-the-counter* medications that treat the same condition, factoring in safety, efficacy and cost.

Brand Preferred Drug: A medication that has been reviewed and approved by our Pharmacy and Therapeutics committee and found to have a therapeutic advantage or overall value over brand nonpreferred that treat the same condition, factoring in safety, efficacy, and cost.

Capital: Capital Blue Cross and Capital Advantage Assurance Company, the entities administering this *coverage*, as indicated on the cover page of this *Benefits Booklet*.

Certified Registered Nurse: A *certified registered nurse* anesthetist, *certified registered nurse* practitioner, certified enterostomal therapy nurse, certified community health nurse, certified psychiatric mental health nurse, or certified clinical nurse specialist, certified by the State Board of Nursing or a national nursing organization recognized by the State Board of Nursing. This excludes any noncertified registered professional nurses employed by a healthcare facility, as defined in the Health Care Facilities Act, or by an anesthesiology group.

Clinical Trial (Approved): A Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to prevention, detection, or treatment of cancer or other life-threatening disease or condition and meets the following criteria:

- The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  1. The National Institutes of Health (NIH)
  2. Centers for Disease Control and Prevention (CDC)
  3. Agency for Healthcare Research and Quality (AHRQ)
  4. Centers for Medicare and Medicaid Services (CMS)
  5. A cooperative group or center of any of the entities described in 1 through 4 above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA)
  6. A qualified nongovernmental research entity identified in the guidelines issued by the NIH for center support grants
  7. The VA, the DOD, or the Department of Energy when the study or investigation has been reviewed and approved through a system of peer review that meets the following criteria:
     a. The Secretary of Health and Human Services determines to be comparable to the system of peer review of studies and investigations used by the NIH, and
     b. Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- The study or investigation is a drug that is exempt from having such an investigational new drug application.

Coinsurance: The percentage of the *allowed amount* you pay for certain benefits *Coinsurance* percentages, if any, are identified in the **Summary of Cost Sharing and Benefits** section or in the applicable rider to this *Benefits Booklet*.

Compound Drug: A product prepared by a *pharmacist* from a *prescription drug order* that results from the combining, mixing, or altering of two or more ingredients, excluding flavorings, to create a customized drug.

Contract Holder: The organization or firm, usually an employer, union, or association, that contracts with us to provide or administer the *coverage* offered under your group health plan.

Copayment: A fixed amount you pay for certain benefits at the time of the service. Copayments, if any, are identified in the **Summary of Cost Sharing and Benefits** section or in the applicable rider to this *Benefits Booklet*.

Cosmetic Procedure: An elective procedure performed primarily to restore a person's appearance by surgically altering a physical characteristic that does not prohibit normal function, but is unpleasant or unsightly.

Cost Sharing Amount: The amount of covered services that you must pay. We subtract this amount from the *allowed amount* when we make payment to the *provider* for *benefits*. Cost sharing amounts include *copayments*, *deductibles*, and *coinsurance*.

Coverage: The program offered and/or administered by us which provides *benefits* for *members* covered under the *group contract*.

Covered Drugs: Unless specifically excluded, all *prescription drugs,* preventive drugs mandated by law, and any diabetic supplies that are dispensed pursuant to a valid *prescription order* in each case for your *outpatient* use.

Custodial Care: Care provided primarily for your maintenance or which is designed essentially to assist you in meeting the activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or condition. Custodial care includes but is not limited to help in walking, bathing, dressing, feeding, preparation of special diets, and supervision over self-administration of medications, which do not require the technical skills or professional training of medical or nursing personnel to be performed safely and effectively.

Deductible: The amount of the *allowed amount* that you and your dependents, if any, must meet each *benefit period* before *benefits* are covered under the *group contract*. Deductibles are described in the **Summary of Cost Sharing and Benefits** section.

Dependent: Any member of a *subscriber's* immediate family or a *subscriber's* domestic partner who satisfies the applicable eligibility criteria, who enrolled under the *group contract* by submitting an *enrollment application* to us and for whom such *enrollment application* has been accepted by us.

Effective Date of Coverage: The date your *coverage* under the *group contract* begins as shown on our records.

Emergency Medical Services (EMS) Agency: An entity that engages in the business or service of providing emergency medical services to patients by operating any of the following:

- An ambulance
- An advanced life support squad vehicle
- A basic life support squad vehicle
- A quick response service
- A special operations EMS service including, but not limited to the following:

  - A tactical EMS service
  - A wilderness EMS service
  - An urban search and rescue EMS service
- A vehicle or service that provides emergency medical services outside of a healthcare facility

Emergency Services: Any healthcare services provided to a *member* after the onset of a medical condition, including a mental health condition or substance use disorder, that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the *member*, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.
- Other serious medical consequences.
- Transportation, treatment, and related *emergency services* provided by a licensed *emergency medical services agency* if the condition is as described in this definition.

Emergency services are not subject to *preauthorization* and are available twenty-four (24) hours a day, seven (7) days a week.

Enrollment Application: The properly completed written or electronic application for membership submitted on a form provided by or approved by us, together with any amendments or modifications.

Facility Providers include:

- Ambulance Service *Provider*
- *Ambulatory Surgical Facility*
- *Birthing Facility*
- Durable Medical Equipment Supplier
- Facility/Hospital-owned Laboratory
- Freestanding Outpatient/Diagnostic Facility
- *Freestanding Dialysis Treatment Facility*
- Freestanding Ambulatory Care Facility
- *Home Health Care Agency*
- *Hospice*
- *Hospital*
- *Infusion Therapy Provider*
- *Long-Term Acute Care Hospital*
- Orthotics Supplier
- Prosthetics Supplier
- *Psychiatric Hospital*
- *Rehabilitation Hospital*
- *Residential Treatment Facility*
- Retail Clinic
- *Skilled Nursing Facility*
- *Substance Use Disorder Treatment Facility*
- Urgent Care Center

Fee Schedule: The predetermined fee maximums that we will pay, subject to applicable law, for services performed by *out-of-network providers*, which are provided as *benefits* under this *coverage*. The fee schedule may be amended from time to time and may be adjusted based upon factors, including but not limited to, geographic location and *provider* types.

Formulary: A continually updated list of *prescription drugs.* These drugs represent the current clinical judgment of *physicians* and other experts in the treatment of disease and preservation of health.

Freestanding Dialysis Treatment Facility: A licensed *facility provider* primarily engaged in providing dialysis treatment, maintenance or training on an *outpatient* or home care basis.

Freestanding Outpatient Facility: A licensed *facility provider* primarily engaged in providing *outpatient* diagnostic and/or therapeutic services by or under the supervision of *physicians*.

Functional Impairment: A condition that describes a state in which an individual is physically limited in the performance of basic daily activities.

Generic Drug (Preferred and Nonpreferred): A *prescription drug*, whether identified by its chemical, proprietary, or nonproprietary name that is accepted by the FDA as therapeutically equivalent and interchangeable with the *brand drug* having an identical amount of the same active ingredient.

Group Application: The properly completed written and executed or electronic application for *coverage* the *contract holder* submits on a form provided by or approved by us, together with any amendments or modifications thereto.

Group Effective Date: The date specified in the *group policy/contract* as the original date that the *group contract* became effective.

Group Enrollment Period: A period of time established by the *contract holder* and us from time to time, but no less frequently than once in any 12 consecutive months, during which eligible persons may enroll for *coverage*.

Group Policy/Contract: The legal agreement between the *contract holder* and us for administration and/or *coverage* of *benefits*.

Hearing Aid: Any device that does not produce as its output an electrical signal that directly stimulates the auditory nerve. Examples of hearing aids are devices that produce air-conducted sound into the external auditory canal, or devices that produce sound by vibrating the cochlear fluid through stimulation of the round window. Devices such as cochlear implants, which produce as their output an electrical signal that directly stimulates the auditory nerve, are not considered to be hearing aids.

Home Delivery Dispensing: The dispensing of maintenance *prescription drugs* through the designated *home delivery pharmacy* in quantities up to a 90-day supply per *prescription order*.

Home Delivery Pharmacy: A duly licensed mail service *pharmacy or pharmacies*, designated by us, where *prescription orders* are received through the mail or other means and from which *prescription drugs* are shipped to *members* via the United States Postal Service, United Parcel Service, or other delivery service.

Home Health Care Agency: A licensed *facility provider* that provides skilled nursing and other services on an intermittent basis in the *member's* home; and is responsible for supervising the delivery of such services under a plan prescribed by the attending *physician*.

Hospice: A licensed *facility provider* primarily engaged in providing palliative care to terminally ill *members* and their families with such services being centrally coordinated through an interdisciplinary team directed by a *physician*.

Hospital: A *facility provider* that meets the following criteria:

- Is licensed by the state in which it is located.
- Provides 24-hour nursing services by *certified registered nurse*s on duty or on call.
- Provides services under the supervision of a staff of one or more *physicians* to diagnose and treat ill or injured bed patients hospitalized for surgical, medical or psychiatric conditions.
- Is certified by the Joint Commission on the Accreditation of Healthcare Organizations, an equivalent body, or as accepted by us.

Hospital does not include residential or nonresidential treatment facilities; nursing homes; *skilled nursing facilities*; facilities that are primarily providing custodial, domiciliary, or convalescent care; or *ambulatory surgical facilities*.

Host Blue: A local Blue Cross and/or Blue Shield Licensee serving a geographic area other than our service area that has contractual agreements with providers in that geographic area, which participate in the *BlueCard program*, regarding claim filing or payment for covered healthcare services rendered to our *members* who use services of such *providers* when traveling outside of our service area.

Identification (ID) Card: The card issued to the *member* that evidences *coverage* under the terms of the *group contract*.

Immediate Family: The *subscriber's* or *member's* spouse, domestic partner, parent, step-parent, brother, sister, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law, son-in-law, child, step-child, grandparent, or grandchild.

Independent Freestanding Emergency Department: A health care facility that is geographically separate, distinct, and licensed separately from a *hospital* under applicable state law, and provides any *emergency services*.

Infusion Therapy Provider: An entity that meets the necessary licensing requirements and is legally authorized to provide home infusion/IV therapy services.

In-Network Pharmacy: A *pharmacy* or other *prescription drug* provider approved by us, licensed where required, engaged by us or our *PBM* to provide *benefits* to you. The status of a *pharmacy* as an in-network *pharmacy* may change from time to time. It is your responsibility to verify the current status of a *pharmacy*.

In-Network Provider(s): A *pharmacy*, *professional provider*, *facility provider*, or any other eligible healthcare *provider* or practitioner that is approved by us and, where licensure is required, is licensed in the applicable state and provides covered services and has entered into a *provider* agreement with or is otherwise engaged by us to provide *benefits* to you and who satisfies our credentialing and privileging criteria. The status of a *provider* as an in-network *provider* may change from time to time. It is your responsibility to verify the current status of a *provider*.

Inpatient: When you are admitted as a patient and spend greater than 23 hours in a *hospital*, *rehabilitation hospital*, *skilled nursing facility,* or *residential treatment facility* and a room and board charge is made. This term may also describe the services rendered to you while admitted.

Intensive Outpatient Treatment program (IOP): An intensive part-time specialized outpatient program that provides *substance use disorder* treatment services and support programs for relapse prevention which is typically two to three hours per day, and three days per week.

Investigational: For this *group contract*, a drug, treatment, device, or procedure is investigational if any of the following apply:

- It cannot be lawfully marketed without the approval of the FDA and final approval has not been granted at the time of its use or proposed use;
- For a period of up to six (6) months following FDA approval, unless otherwise provided in our applicable medical policies.
- It is the subject of a current investigational new drug or new device application on file with the FDA.
- The predominant opinion among experts as expressed in medical literature is that usage should be substantially confined to research settings.
- The predominant opinion among experts as expressed in medical literature is that further research is needed to define safety, toxicity, effectiveness or effectiveness compared with other approved alternatives.
- It is not investigational in itself but would not be *medically necessary* except for its use with a drug, device, treatment, or procedure that is investigational.

In determining whether a drug, treatment, device, or procedure is investigational, the following information may be considered:

- Your medical records.
- The protocol(s) pursuant to which the treatment or procedure is to be delivered.
- Any consent document you have signed or will be asked to sign, in order to undergo the treatment or procedure.
- The referred medical or scientific literature regarding the treatment or procedure at issue as applied to the injury or illness at issue.
- Regulations and other official actions and publications issued by the federal government.
- The opinion of a third-party medical expert in the field, obtained by us, with respect to whether a treatment or procedure is investigational.

Licensed Practical Nurse (LPN): A nurse who has graduated from a formal practical or vocational nursing educations program and licensed by the appropriate state authority.

Maintenance Drugs: Drugs that are *prescription drugs* commonly used to treat conditions that are chronic or long-term. These conditions usually require regular use of medications.

Medicaid: Hospital or medical insurance *benefits* financed by the United States government under Title XIX of the Social Security Act of 1965 and its related regulations, each as amended.

Medical Necessity (Medically Necessary): Means the following:

- Services or supplies that a *physician* exercising prudent clinical judgment would provide to a *member* for the diagnosis and/or direct care and treatment of the *member's* medical condition, disease, illness, or injury that are necessary.
- In accordance with generally accepted standards of good medical practice.
- Clinically appropriate for the *member's* condition, disease, illness, or injury.
- Not primarily for the convenience of the *member* and/or the *member's* family, *physician*, or other healthcare *provider*.
- Not costlier than alternative services or supplies at least as likely to produce equivalent results for the *member's* condition, disease, illness or injury.

For this definition, “generally accepted standards of good medical practice” means standards based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national *physician* specialty society recommendations and the views of *physicians* practicing in relevant clinical areas and any other clinically relevant factors. The fact that a *provider* may prescribe, recommend, order, or approve a service or supply does not make it *medically necessary* or a covered *benefit*.

Medicare: The programs of healthcare for the aged and disabled established by Title XVIII of the Social Security Act of 1965 and its related regulations, each as amended.

Medication Assisted Treatment (MAT): The use of FDA approved medications, in combination with counseling and behavioral therapies, for the treatment of substance use disorders.

Medication Synchronization: The coordination of *prescription drug* filling or refilling by a pharmacy or dispensing *physician* for a *member* taking two or more maintenance medications for the purpose of improving medication adherence.

Member: A *subscriber*, *dependent* or “Qualified Beneficiary” (as defined under *COBRA*) enrolled for *coverage* and entitled to receive covered services under the *group contract* in accordance with its terms and conditions. For purposes of the appeal processes, the term includes parents of a minor member as well as designees or legal representatives who are entitled or authorized to act on behalf of the member. The term member is sometimes identified with the pronouns “you” and “your” in this *Benefits Booklet.*

Mental Illness/Disorder: A health condition characterized by alterations in thinking, mood, or behavior (or some combination thereof), that are all mediated by the brain and associated with distress and/or impaired functioning.

Negotiated Arrangement (a.k.a., Negotiated National Account Arrangement): An agreement negotiated between a Control/Home Licensee and one or more Par/Host Licensees for any National Account not delivered through the *BlueCard Program.*

Opioid Treatment Program (OTP): A program that provides opioid use disorder treatment services and may include medication-assisted treatment, counseling, drug testing, and individual and group therapy. Counseling and therapy services are covered in person and by virtual delivery (using 2-way audio/video communication technology.

Out-of-Network Pharmacy: A *pharmacy* that is not under contract with, directly or indirectly, us or our *PBM*.

Out-of-Network Provider(s): A *provider* that is not under contract with us or a *provider* who is not a *BlueCard in-network provider*.

Out-of-Pocket Maximum: A specified limit to the *cost sharing amount* that you or your dependents may incur for covered services in a *benefit period*. The amount of, and types of *cost sharing* applied to, the out-of-pocket maximum is described in the **Summary of Cost Sharing and Benefits** section.

Outpatient: A *member* who receives services or supplies while not an *inpatient*. This term may also describe the services rendered to such a *member*.

Over-the-Counter (OTC): A drug defined by the FDA as safe and effective for use by the general public without seeking treatment by a health professional and for which a prescription is not legally required.

Partial Hospitalization: The provision of planned and regularly scheduled medical, nursing, counseling, or therapeutic services in a *hospital* or non-*hospital* facility licensed as a mental health or *substance use disorder* treatment program by the Pennsylvania Department of Health, designed for a patient or client who would benefit from more intensive services than are offered in *outpatient* treatment but who does not require *inpatient* care. To qualify, the partial hospitalization services must be provided for a minimum of four hours, with a maximum of 12 hours per day without incurring a charge for an overnight stay.

Pharmacy: A pharmacy or other appropriate *prescription drug* provider that is licensed in the state in which it practices or is located, provides covered services, and performs services within the scope of their licensure.

Pharmacy Benefit Manager (PBM): The pharmacy benefit manager under contract with us to assist in the administration of the drug *benefits* under the *group contract*.

Physician: A person who is a Doctor of Medicine (M.D.) or a Doctor of Osteopathic Medicine (D.O.), licensed, and legally entitled to practice medicine in all its branches, and/or perform *surgery* and prescribe drugs.

PPACA: The Patient Protection and Affordable Care Act of 2010 and its related regulations, as amended. It is often called the Affordable Care Act (ACA),

Preauthorization: An authorization (or approval) from us or our designee that results from a process used to determine *member* eligibility at the time of the request, and the *medical necessity* of the proposed medical services before delivery of services. Preauthorization is required for the procedures identified in the **Preauthorization Program**.

Prescription Drug: Any FDA-approved medication that, by federal or state law, may not be dispensed without a *prescription order*.

Prescription Order: The request for a *prescription drug* issued by a *provider*.

Preventive Drug Coverage (PPACA): Certain categories of *over-the-counter* and *prescription drugs* for which *coverage* is mandated by law as included in preventive care services *coverage* based on recommendations from the U.S. Preventive Services Task Force as well as the Institute of Medicine.

Prior Authorization: A *prescription drug* authorization (or approval) from us or our designee that results from a process used to determine *benefit coverage* and *medical necessity* based on clinical practice guidelines, with a requirement that specific criteria are met.

Professional Provider: A person or entity licensed and approved to supply healthcare services, support, or supplies. Includes any of the following:

- Audiologist
- *Autism Service Provider*
- *Behavior Specialist*
- *Certified Registered Nurse* Anesthetist
- *Certified Registered Nurse* Midwife
- *Certified Registered Nurse* Practitioner
- Chiropractor
- Licensed Social Worker
- Occupational Therapist
- Oral Surgeon
- Physical Therapist
- Physician’s Assistant
- Podiatrist
- Psychologist

- Clinical or Physician Laboratory
- Doctor of Medicine (M.D.)
- Doctor of Osteopathy (D.O.)
- Licensed Dietitian Nutritionist
- Respiratory Therapist
- Social Worker/Other Masters Prepared Therapist
- Speech Language Pathologist

Provider: A *hospital*, *physician*, *pharmacy*, person or practitioner licensed (where required) and performing services within the scope of such licensure, and as identified in this *Benefits Booklet*. Providers include *in-network providers* and *out-of-network providers*.

Provider Incentive: An additional amount of compensation paid to a healthcare *provider* by a Blue Cross and/or Blue Shield Plan, based on the *provider's* compliance with agreed-upon procedural and/or outcome measures for a particular population of covered persons.

Psychiatric Hospital: A licensed facility *provider* primarily engaged in providing diagnostic and therapeutic services for behavioral *healthcare*. Such services are provided by or under the supervision of an organized staff of *physicians*.

Recognized Amount: The amount used to calculate member *cost-share amounts* for claims meeting surprise-billing criteria under the No Surprises Act. The recognized amount is the lesser of the *out-of-network provider's* billed charge or our median contracted rate for *in-network providers* for the same or similar item or service received in the same or similar specialty in the same geographic region, calculated in accordance with applicable law.

Reconstructive Surgery: A procedure performed to improve or correct a *functional impairment*, restore a bodily function or correct deformity resulting from *birth defect,* medical condition or disease*,* or accidental injury. The fact that a *member* might suffer psychological consequences from a deformity does not, qualify surgery, in the absence of bodily *functional impairment*, as being *reconstructive surgery*.

Rehabilitation Hospital: A licensed facility *provider* primarily engaged in providing skilled rehabilitation services for injured or disabled individuals to restore function following an illness or accidental injury. Skilled rehabilitation services consist of the combined use of medical and vocational services to enable *members* disabled by disease or injury to achieve the highest possible level of functional ability. Skilled rehabilitation services are provided by or under the supervision of an organized staff of *physicians*.

Remote Patient Monitoring: A type of service in which mobile medical technology for remote monitoring uses a wireless transmission of biometric data from anywhere the patient may be, directly to the doctor or care team member for the purpose of identifying clinical interventional needs when vital readings exceed patient specific norms to close gaps in medical care for high-risk populations.

Residential Treatment Facility (RTF): A licensed non-hospital *facility provider* that provides *residential treatment*.

Residential Treatment: A 24-hour level of care providing active treatment and close monitoring of behavioral and clinical interventions and activities related to psychiatric treatment, eating disorders, and substance use disorders. Residential treatment offers an organized set of services, including diagnostic, medical management and monitoring, and therapeutic services, as well as daily living skill development on a short-term basis. The following are required for residential treatment:

- State licensure as a residential treatment (nonhospital) facility;
- 24-hour registered nurse supervision;
- Primary focus on short-term stabilization, rehabilitation or crisis services;
- *Medical necessity* determination for this level of care;
- The development and implementation of a comprehensive and individualized treatment plan for each member through a multidisciplinary team approach which incorporates active treatment; and
- The provision of individual, group and family counseling and other services/interventions in accordance with the developed plan.

Retail Dispensing: The dispensing of *prescription drugs* on-site at a *retail pharmacy* in quantities up to a 30-day supply per *prescription order*.

Retail Pharmacy: Any *pharmacy* licensed to sell and dispense *prescription drugs* excluding a *home delivery pharmacy* and excluding a *pharmacy* that dispenses *prescription drugs* solely via the internet.

Retiree: A former employee of the *contract holder* who meets the *contract holder's* definition of a retired employee and to whom the *contract holder* offers *coverage* under the *group contract*, if any. The *contract holder* must designate and we must agree that one or more classes of retired former employees of the *contract holder* are eligible to receive *coverage* for *benefits* under the *group contract* in order for a person to qualify as a retiree.

Routine Costs Associated with Approved Clinical Trials: Routine costs include all the following:

- Covered services under this *Benefits Booklet* that typically would be provided absent an *approved clinical trial*.
- Services and supplies required solely for the provision of the *investigational* drug, biological product, device, medical treatment or procedure.
- The clinically appropriate monitoring of the effects of the drug, biological product, device, medical treatment or procedure required for the prevention of complications.
- The services and supplies required for the diagnosis or treatment of complications.

Service Area: The 21 Pennsylvania counties in which we offer *coverage*: Adams, Berks, Centre, Columbia, Cumberland, Dauphin, Franklin, Fulton, Juniata, Lancaster, Lebanon, Lehigh, Mifflin, Montour, Northampton, Northumberland, Perry, Schuylkill, Snyder, Union, and York.

Skilled Nursing Facility: A licensed *provider* primarily engaged in providing daily *skilled nursing services* and related skilled services to *members* requiring 24-hour skilled nursing services but not requiring confinement in an acute care general *hospital*. Such care is provided by or under the supervision of *physicians*. A skilled nursing facility is not, other than incidentally, a place that provides either of the following:

- Minimal care, *custodial care*, ambulatory care, or part-time care services.
- Care or treatment of mental illness or substance use disorder.

Skilled Nursing Services: Services that must be provided by a registered nurse, or a licensed practical (vocational) nurse under the supervision of a registered nurse, to be safe and effective. In determining whether a service requires the skills of a nurse, consider both the inherent complexity of the service, the condition of the patient, and accepted standards of medical and nursing practice.

Specialized Care Unit: A designated unit within an acute care *hospital* that has concentrated all facilities, equipment, and supportive services for the provision of an intensive level of care for critically ill patients, including neonatal intensive care and cardiac intensive care that is not critical care.

Specialty Medication Preferred Network: Specialty pharmacies contracted with and designated by us to dispense *specialty prescription drugs*.

Specialty Pharmacy: A *retail pharmacy* contracted with and designated by us to dispense specialty oral and injectable *prescription drugs*. A specialty *pharmacy* may receive *prescription orders* through the mail or other means and may ship *specialty prescription drugs* to *members* via the United States Postal Service, United Parcel Service, or other delivery service.

Specialty Prescription Drugs: Biotech and other self-administered *prescription drugs* covered under a *prescription drug* benefit typically used in the treatment of complex and potentially life-threatening illnesses that typically require special handling and storage.

Step Therapy: A course of treatment in which certain designated drugs or treatment protocols must be either contraindicated, or used and found to be ineffective, prior to approval of coverage of other designated drugs or treatment protocols. The term does not include requests for coverage of nonformulary drugs.

Subscriber: A person whose employment or other status, except for family dependency, is the basis for eligibility for enrollment for *coverage* under the *group contract*, who enrolled under the *group contract* by submitting an *enrollment application* to us, and for whom such *enrollment application* has been accepted by us. Subscriber may include, without limitation, a *retiree*. A subscriber is also a *member*.

Substance Use Disorder: *Substance use disorder* is the use of alcohol or other drugs at dosages that place a *member's* social, economic, psychological, and physical welfare in potential hazard, or endanger public health, safety, or welfare. *Benefits* for the treatment of *substance use* disorder includes detoxification and rehabilitation.

Substance Use Disorder Treatment Facility: A licensed *provider* which primarily provides inpatient detoxification and/or rehabilitation treatment for *substance use disorder*. This facility must also meet all applicable standards set by the state in which healthcare services are received.

Surgery: The performance of operative procedures, consistent with medical standards of practice, which physically changes some body structure or organ and includes usual and related pre-operative and post-operative care.

Telehealth: *Medically necessary* services provided to you by an *eligible provider* in which the method of care delivery involves interaction between you and the *provider* using a secure, interactive real-time, audio and/or video telecommunications system or other remote, real-time monitoring technology for the purpose of providing covered services for the evaluation and treatment of conditions that do not require a direct hands-on provider examination.

Urgent Care: Medical care for an unexpected illness or injury that does not require *emergency services* but which may need prompt medical attention to minimize severity and prevent complications.

Value-Based Program (VBP): An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local *providers* that is evaluated against cost and quality metrics/factors and is reflected in *provider* payment.

HOW TO ACCESS BENEFITS

ID Card

Your *ID card* is the key to accessing the *benefits* provided under this *coverage* with us.

You should show your ID card and any other ID cards for other *coverage*, each time you seek medical services and obtain *prescription drugs* and related services. *Providers* and pharmacists use the information from your ID card to submit claims for processing and payment.

IMPORTANT INFORMATION ABOUT YOUR ID CARD:

- ***Preauthorization***: This term alerts *providers* that this element of your *coverage* is present. Refer to the **Preauthorization Program** attachment to this *Benefits Booklet* for more information.
- **Suitcase Symbol**: This symbol shows *providers* that your *coverage* includes BlueCard® and Blue Cross Blue Shield Global® Core. With both programs, you have access to *BlueCard in-network providers* nationwide and worldwide.
- ***Copayments****:* Healthcare *providers* use this information to determine the *copayment* they may collect from you at the time a service is rendered.

On the back of your ID *card*, you will find important additional information on the following:

- Member Services' telephone number
- *Preauthorization* instructions and telephone number.
- General instructions for filing claims.

Please call Member Services if any information on your ID *card* is incorrect or if you have questions. Remember to destroy old ID cards and use only the most recent *ID* card.

Obtaining Benefits for Healthcare Services

We classify providers (doctors, clinics, hospitals, and so on) as either "in-network" or "out-of-network." (You may have also heard the term "participating" or "nonparticipating." These terms mean the same thing.) The provider you select is — without limitation — in charge of your care, but your costs will generally be less if you choose an in-network provider.

Stay current about your providers. To confirm your providers are in network, go to CapitalBlueCross.com or call Member Services. You will find their number on the back of your ID card.

NOTE: Some *benefits* are covered only when you obtain services from an *in-network provider*.

Services Provided by In-Network Providers

An *in-network provider* is a healthcare *facility provider* or a *professional provider* who is properly licensed, where required, and has a contract **with us** to provide *benefits* under this *coverage*. Because *in-network providers* have agreed to accept our payment for covered *benefits* along with any applicable *cost sharing amounts* that you are obligated to pay under the terms of this *coverage* as payment in full, you can maximize your *coverage* and minimize your out-of-pocket expenses by visiting an *in-network provider*.

All *in-network providers* must seek payment for healthcare services, other than *cost sharing amounts*, directly from us. ***In-network providers* may not seek payment from you for services that qualify as *benefits*.** However, an *in-network provider* may seek payment from you for noncovered services, including specifically excluded services (e.g. cosmetic procedures, etc.), or services in excess of *benefit lifetime maximums* and *benefit period maximums*. The *in-network provider* must inform you before performing the noncovered services that you may be liable to pay for these services, and you must agree to accept this liability.

The status of a *provider* as an *in-network provider* may change from time to time. It is the *member's* responsibility to verify a *provider's* current network status. A list of *in-network providers* is available 24-hours a day on our website at CapitalBlueCross.com. This information includes:

- **Name, address, telephone numbers**
- **Professional qualifications**
- **Specialty**
- **Medical school attended**
- **Residency completion**
- **Board certification status**

Services Provided by Out-of-Network Providers

An *out-of-network provider* is a *provider* who does not contract with us or with another *Host Blue* to provide *benefits* to you.

Out-of-network services may mean higher *cost sharing* for you since *out-of-network providers* are not obligated to accept our payment as payment in full. As a result, you may be responsible for the difference, except where prohibited by law, between the amount we allowed for that service (i.e., *allowed amount*) and the *provider's* charge. This difference between the *provider's* charge for a service and the *allowed amount* is called the balance billing charge, which can be significant. In some instances, our contracted vendor may be able to negotiate a rate with the *provider*. If the *provider* accepts this negotiated rate, we pay the *provider* directly and they will not bill you for the balance of the charge. If the *provider* does not accept a negotiated rate, the claim payment will go directly to you and you are responsible for paying the *provider*. In these instances, the *provider* may bill you for the balance of the charge. Information on balance billing charges can be found in the **Cost Sharing Descriptions** section of this *Benefits Booklet*. Additionally, certain out-of-network services may not be covered benefits. Information on whether *benefits* are provided when performed by an *out-of-network provider* and the applicable level of payment for such *benefits* is noted in the **Summary of Cost Sharing and Benefits** section of this *Benefits Booklet.*

Note: When you receive emergency services from an *out-of-network provider*, the in-network level of coverage applies. You will be responsible for any applicable *cost-sharing amounts* such as *deductibles*, *coinsurance*, and *copayments*. In situations where you cannot reasonably see an *in-network provider* for emergency services, you are not liable for a greater out-of-pocket expense than if you saw an *in-network provider*. Out-of-network healthcare providers administering emergency services are prohibited from balance billing *members*.

In addition, for *out-of-network providers* performing: (1) *emergency services* in the emergency department of a hospital (or *independent freestanding emergency department*), (2) nonemergency services at certain *in-network facilities* (namely, *hospitals*, *hospital* outpatient departments, critical access hospitals, or *ambulatory surgical facilities*), or (3) air ambulance services, you will be subject to

in-network cost sharing, calculated based on the *recognized amount*, and the provider generally will be prohibited from balance billing you (except where the *out-of-network provider* satisfies advance patient notice and consent requirements).

After Normal Business Hours

Contact your *provider* if you need medical services after normal business hours. The *provider's* answering service may take your call. If so, the answering service will contact your *provider* or the *provider* on call, who will contact you as soon as possible. After normal business hours, calls should be limited to medical problems requiring immediate attention. However, do not postpone calling your *provider's* office if you believe you need medical attention.

Emergency Services

An *emergency service* is any healthcare service provided to you after the onset of a medical condition, including a mental health condition or substance use disorder, that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing your health, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.
- Other serious medical consequences.

Examples of conditions requiring *emergency services* are excessive bleeding; broken bones; serious burns; sudden onset of severe chest pain; sudden onset of acute abdominal pains; poisoning; unconsciousness; convulsions; and choking. In these circumstances, 911 services are appropriate and do not require *Preauthorization*.

Transportation, treatment, and related *emergency services* provided by a licensed *emergency medical services agency* are *benefits* if the condition qualifies as an *emergency service*.

In a true emergency, the first concern is to obtain necessary medical treatment; so you should seek care from the nearest appropriate *facility provider.*

Out-of-Area Services

Overview

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside of our *service area*, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside our *service area*, you will receive it from one of two kinds of *providers.* Most providers ("*in-network providers*") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some providers ("*out-of-network providers*") do not contract with the Host Blue. We explain below how we pay both kinds of providers.

Inter-Plan Arrangements Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all Dental Care Benefits, except when paid as medical claims/*benefits*, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by us to provide the specific service or services.

BlueCard® Program

Under the *BlueCard Program*, when you receive covered healthcare services within the geographic area served by a Host Blue, we will remain responsible for doing what we agreed to in the *group contract*. However, the Host Blue is responsible for contracting with and generally handling all interactions with its in-network *providers*.

When you access covered healthcare services outside *Capital's service area* and the claim is processed through the *BlueCard Program*, the amount you pay for covered healthcare services is calculated based on the lower of either of the following:

- The billed covered charges for your covered services.
- The negotiated price that the Host Blue makes available to us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare *provider*. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare *provider* or *provider* group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare *providers* after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price we used for your claim because they will not be applied after a claim has already been paid.

Out-of-Network Healthcare Providers Outside Capital's Service Area

Member Liability Calculation – When covered healthcare services are provided outside of our *service area* by out-of-network *providers*, the amount you pay for such services will normally be based on either the Host Blue's out-of-network *provider* local payment or the pricing arrangements required by applicable law. In these situations, you may be responsible for the difference between the amount that the out-of-network *provider* bills and the payment we will make for the covered healthcare services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services, certain services provided by out-of-network providers at in-network facilities, and out-of-network air ambulance services.

Exceptions – In certain situations, we may use other payment methods, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our *service area*, or a special negotiated payment, to determine the amount we will pay for services provided by out-of-network healthcare *providers*. In these situations, you may be liable for the difference between the amount that the out-of-network *provider* bills and the payment *we* will make for the covered services as set forth in this paragraph.

Special Cases: Value-Based Programs

BlueCard Program

If you receive covered healthcare services under a *Value-Based Program* inside a Host Blue's service area, you will not be responsible for paying any of the *provider incentives*, risk-sharing, and/or care coordinator fees that are a part of such an arrangement, except when a Host Blue passes these fees to us through average pricing or fee schedule adjustments. Additional information is available upon request.

Value-Based Programs – *Negotiated (Non-BlueCard Program) Arrangements*

If we have entered into a *negotiated arrangement* with a Host Blue to provide Value-Based Programs to contract holder on your behalf, we will follow the same procedures for *Value-Based Programs* administration and care coordinator fees as noted above for the BlueCard Program.

Blue Cross Blue Shield Global Core

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of the Blue Cross Blue Shield Global Core when accessing covered healthcare services. The Blue Cross Blue Shield Global Core is unlike the *BlueCard Program* available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the service center at **800.810.BLUE** (2583) or call collect at **804.673.1177**, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a *physician* appointment or hospitalization, if necessary.

Inpatient Services

In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient services, except for the *cost sharing amounts* (*deductibles, coinsurance*, etc.). In such cases, the hospital will submit the claims to the service center to begin claims processing. However, if you pay in full at the time of service, you must submit a claim to receive reimbursement for covered healthcare services. **You must contact us to obtain precertification for nonemergency inpatient services.**

Outpatient Services

Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered healthcare services.

Submitting a Blue Cross Blue Shield Global Core Claim

When you pay for covered healthcare services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of the claim. The claim form is available from us, the service center or online at www.bcbsglobalcore.com. If you need assistance with a claim submission, call the service center at **800.810.BLUE** (2583) or call collect at **804.673.1177**, 24 hours a day, seven days a week.

Continuity of Care

Transitional Period for New Members

New *members* may continue an ongoing course of treatment with an *out-of-network provider* for a transitional period of up to 60 days from the effective date of the *coverage* when approved by us in advance of receiving services. We, in consultation with the *member* and the healthcare provider, may extend this transitional period if determined to be clinically appropriate. If the new *member* is in the second or third trimester of pregnancy, the transitional period will be extended to postpartum care related to the delivery. *Members* wishing to receive continuing care from an *out-of-network provider* for a transitional period must obtain *preauthorization* for the requested services from us. All terms and conditions of this *Benefits Booklet*, including *preauthorization* requirements, will apply during any transitional period. Additionally, the *out-of-network provider* must agree to accept our reimbursement as payment in full.

Transitional Period for Group Contract or In-Network Provider Terminations

In the event of termination of an *in-network provider* contract, except in the case where an *in-network provider* has been terminated for cause, you may continue active treatment with the *in-network provider*, at your option and at in-network *cost sharing amounts*, for a transitional period of up to 90 days from the date of the termination of the *group contract* or *in-network provider*'s termination. For purposes of this continuity of care section, active treatment means:

- an ongoing course of treatment for a serious and complex condition, defined as one of the following: an acute illness that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (including but not limited to chemotherapy, radiation therapy, or post-operative visits); a chronic illness or condition that is life threatening, degenerative, potentially disabling or congenital; or chronic illness that requires specialized medical care over a prolonged period of time;
- a course of institutional or inpatient care from the provider;
- scheduled for nonelective surgery from the *provider*, including postoperative care related to the surgery;
- an individual who is pregnant and undergoing a course of treatment for the pregnancy from the *provider*;
- receiving treatment for a terminal illness (as determined under section 1861(dd)(3)(A) of the Social Security Act) from such *provider*; or
- an ongoing course of treatment for a health condition for which a treating *provider* attests that discontinuing care by that *provider* would worsen the condition or interfere with anticipated outcomes.

After consultation with you and your *provider*, we may provide the transitional period if it is clinically appropriate. All terms and conditions of this *coverage* and the *group contract*, including preauthorization requirements, will apply during any transitional period. Decisions on continuity of care requests are subject to our internal and external grievance and appeal processes.

Obtaining Benefits for Prescription Drugs

The Formulary

Your prescription plan uses our *Advantage*, *formulary* which provides you access to quality, affordable medications and provides providers with a reference list of preferred medications for cost-effective prescribing. The *formulary* is updated by our Pharmacy and Therapeutics committee on a quarterly

basis or when new generic or brand name medications become available and as discontinued drugs are removed from the marketplace.

The *formulary* provides you access to all covered drugs, whether they are designated *generic preferred*, *generic nonpreferred*, *brand preferred*, or *brand nonpreferred*. Under this *formulary* system, you are encouraged to use *generic or brand preferred drugs* that typically carry a lower copayment/coinsurance than nonpreferred brand drugs.

You can review the formulary at CapitalBlueCross.com or request a current copy by calling Member Services. You will find their number on the back of your ID card.

Obtaining Benefits for Covered Drugs and Related Services

Depending on your *coverage*, the level of payment for *benefits* is affected by whether you choose an *in-network pharmacy*.

Retail Pharmacy. You can choose any *retail pharmacy* for your *prescription drugs*, although your costs will usually be less when you get your *prescription drugs* from an *in-network retail pharmacy*. You have the option to visit an *out-of-network retail pharmacy*, but it generally will cost you more.

Home Delivery Pharmacy. You must use the *home delivery pharmacy* designated by us to receive *benefits* under this *coverage*.

Specialty Pharmacy. If you use select *specialty prescription drugs* as referenced on the *formulary* you must use the *specialty medication preferred network* designated by us to receive *benefits* under this *coverage*.

Prescription Drugs and Related Services Provided by In-Network Pharmacies

An *in-network pharmacy* is a *pharmacy* or other *prescription drug provider* that is approved by us, where required, is licensed in the Commonwealth of Pennsylvania (or such other jurisdiction approved by us), and has entered into a *provider* agreement with or is otherwise engaged by us or the *PBM* to provide *benefits* to you.

Because *in-network pharmacies* agree to accept our payment for covered *benefits* — together with any applicable *cost sharing amounts* that you are obligated to pay under the terms of this *coverage* — as payment in full, you can maximize your *coverage* and minimize your out-of-pocket expenses by using an *in-network pharmacy*.

All *in-network pharmacies* must seek payment, other than *cost sharing amounts*, from us through the *PBM*. ***In-network pharmacies* may not seek payment from you for *prescription drugs* and/or services that qualify as *benefits*.** However, an *in-network pharmacy* may seek payment from you for noncovered *prescription drugs* and services, including specifically excluded *prescription drugs* and services, or services in excess of quantity/day supply maximums. The *in-network pharmacy* must inform you prior to providing the noncovered *prescription drugs* and/or services that you may be liable to pay for these *prescription drugs* and/or services, and you must agree to accept this liability.

The status of a *pharmacy* as an *in-network pharmacy* may change from time to time. It is your responsibility to verify the current network status of a *pharmacy*. To find an *in-network pharmacy*, you can go to CapitalBlueCross.com or call Member Services. You will find their number on the back of your *ID card*.

Prescription Drugs and Related Services Provided by Out-of-Network Pharmacies

An *out-of-network pharmacy* is a *pharmacy* that does not contract, directly or indirectly, with us or the *PBM* to provide *benefits* to you.

Prescription drugs and/or services provided by *out-of-network pharmacies* may require you to pay higher *cost sharing amounts* or may not be covered. If such *prescription drugs* and/or services are covered, *benefits* will be reimbursed based on the *allowed amount* applicable to this *coverage* with us.

You may be responsible for the difference between the *out-of-network pharmacy's* charge for a *prescription drug* and/or service and the *allowed amount* for that *prescription drug* and/or service. This difference between the *pharmacy's* charge for a *prescription drug* and/or service and the *allowed amount* is called the balance billing charge. There can be a significant difference between what we pay for a prescription drug and/or service and what the *pharmacy* charged. In addition, all payments are made directly to the *subscriber*. Additional information on balance billing charges can be found in the **Cost Sharing Descriptions** section.

Retail Dispensing Benefits

To receive retail dispensing benefits, *you* should present your *ID card* to the *in-network pharmacy*. For *covered drugs* obtained from an in-network retail pharmacy, the in-network pharmacy will supply *covered drugs* up to the applicable day supply limit and will not charge you or collect from you any amount, except for any applicable *cost sharing* amounts. For *covered drugs* dispensed by an *out-of-network pharmacy*, or for *covered drugs* purchased without the *ID card*, to be reimbursed, you must submit a claim for payment by using a prescription drug claim form that you can access at CapitalBlueCross.com.

Refills may be dispensed under the *group contract* subject to federal and state law limitations, and only in accordance with the number of refills designated on the original *prescription order*. Refills may not be dispensed more than one year after the date of the original *prescription order*. When a *prescription order* is written for a *covered drug* that has previously been dispensed to you or a *prescription order* is presented for a refill, the *covered drug* will be dispensed only at such time when you have used 75 % of the previous supply dispensed through *retail dispensing* in accordance with the associated *prescription order*. (Extended release opioid medications will only be dispensed if you have used 83% of the previous supply.) Prescription eye drops will be dispensed only if you have used 70% of the previous supply.

We and the *PBM* are each authorized by you to make payments directly to a state or federal governmental agency or its designee whenever we or the *PBM* are required by law or regulation to make payment to such entity.

90DayMyWay Program

Your coverage includes the 90DayMyWay program, which allows the initial 30-day dispensing of covered Maintenance Drugs plus one additional 30-day refill through Retail Dispensing. For as long as you are enrolled in this product, subsequent refills of Maintenance Drugs in 90-day supplies are covered only through Home Delivery Dispensing or by obtaining a 90-day supply through a participating retail pharmacy. A maintenance medication is taken regularly for chronic conditions or long-term therapy (e.g., medications for managing high blood pressure, asthma or high cholesterol

Home Delivery Dispensing Benefits

You can fill *covered drugs*, subject to any applicable *cost sharing amount*, through the designated *home delivery pharmacy* in quantities up to a 90-day supply.

To order by mail, send the following items to the designated *home delivery pharmacy*:

- A completed home delivery registration and prescription order form.
- The method of payment for applicable *copayment* and/or *coinsurance.*
- The prescription order.

You can find the home delivery order forms by:

- Going to CapitalBlueCross.com
- Calling Member Services at the phone number listed on your *ID card.*
- Using the subsequent order forms supplied with the delivery of the home delivery prescription.

Refills are subject to federal and state law limits, and the number of refills designated on the original *prescription order*. A *prescription order* is only good for one year after the date of the original *prescription order*. You must use 60 % of your previous supply before a prescription can be refilled. (Extended release opioid medications will only be dispensed if you have used 83% of the previous supply.) Allow up to 14 days for delivery and have at least two weeks of medication on hand when ordering any refills.

Certain *prescription drugs* are not available for *home delivery dispensing* due to safety and quality concerns. These *prescription drugs* are available through *retail dispensing* or specialty pharmacy dispensing only. If you have questions on the availability of a drug through home delivery, call the telephone number on the back of your *ID card*.

Specialty Prescription Drug Benefits

Specialty prescription drugs are specialty oral and other self-administered *prescription drugs* typically used in the treatment of complex and potentially life-threatening illnesses. These medications usually require special handling and storage.

If you require select *specialty prescription drugs,* you must use the specialty medication preferred network designated by us in order to receive benefits under this *coverage*. Specialty medications are limited to a 30-day supply.

Certain *specialty prescription drugs* are limited distribution drugs (LDD). LDDs are specialty medications that the manufacturer limits distribution to only a few pharmacies. Specialty LDDs that are not available through the specialty medication preferred network will be available through the pharmacy identified by the manufacturer.

To see the most current list of *specialty prescription drugs*, view your *formulary* at CapitalBlueCross.com, or request a current copy of the formulary by calling Member Services. You will find the number on the back of your *ID card.*

For additional information or to begin service, call **800.803.2523**, TTY: **800.955.8770** or have your provider fax the prescription to **888.302.1028**.

Requests for Exceptions to the Formulary (Nonformulary Exception)

Standard Nonformulary Exception

If you are prescribed a drug that is not on the *formulary* (or is nonpreferred), you have two options:

You may ask us for a list of similar drugs that are on the *formulary* and ask your provider to prescribe a drug on the list if appropriate.

You, your representative or your provider may also ask us to make an exception to cover a drug that is not on the *formulary*. This request is known as a nonformulary exception request. If we grant a request to cover a nonformulary drug, you may not request a higher level of *coverage*. A request for a nonformulary exception should be made by calling the Member Services number listed on the back of your *ID card* or writing our Pharmacy Benefit Manager (PBM) at:

Pharmacy Services
Clinical Review Department
2900 Ames Crossing Road
Eagan, MN 55121

A request for an exception may be approved if alternative drugs or a lower tier drug included on the formulary would not be as effective in treating your condition or would cause you to have adverse medical effects.

A request for a nonformulary drug exception should include a statement by your prescribing *provider* supporting the request. We will make a decision granting or denying the request no later than 72 hours from receipt of the request as long as there is sufficient information to process the request. If additional information is needed to process the request, the decision will be made no later than 72 hours from when sufficient information is received.

If we grant the exception request, the nonformulary drug will be covered for the duration of the prescription, including any refills.

Expedited NonFormulary Exception

You or your *provider* may request an expedited nonformulary exception determination if:

(1) Your life, health or ability to regain maximum function could be seriously harmed by waiting up to 72 hours for a decision or

(2) You are undergoing a current course of treatment using a nonformulary drug.

In such cases, we will make a decision no later than 24 hours after receiving the expedited exception request as long as there is sufficient information to process the request. If additional information is required, the decision will be made no later than 24 hours from when sufficient information is received. A request for either a standard or an expedited exception determination should be made by calling the Member Services number on the back of your ID card.

Appealing a Standard or Expedited NonFormulary Exception Denial

If we deny your standard or expedited nonformulary exception request, you, or your authorized representative may appeal the denial (i.e., request an internal appeal) by calling us at the following number:

855.500.CARE (2273)

Or writing to us at:

Appeals & Grievances Resolution Unit

Capital Blue Cross
PO Box 779518
Harrisburg, PA 17177-9518

In reviewing the internal appeal request, *Capital* will utilize health care professionals with the proper medical training and experience for the appeal matter, and involved in, or the subordinates of those who were involved in, the nonformulary drug exception denial.

For appeals of a standard nonformulary drug exception denial, we will make a decision no later than 30 days from the receipt of your appeal request.

You or your authorized representative may request an expedited nonformulary exception appeal if (1) your life, health or ability to regain maximum function could be seriously harmed by waiting up to 30 days for an appeal decision, or (2) you are undergoing a current course of treatment using a nonformulary drug. For an expedited nonformulary drug exception denial appeal, we will make a decision no later than 72 hours after receiving the appeal request.

Review of an Exception Denial by an Independent Review Organization (IRO)

If we deny your standard or expedited nonformulary exception appeal, you or your authorized representative may ask for a second review of the decision and request that it be reviewed by an IRO.

For more information on the independent external review process, you can visit the Pennsylvania Insurance Department's website at:

www.insurance.pa.gov/externalreview

To submit a request for either standard or expedited independent external review, you must submit a copy of your adverse benefit determination or final adverse benefit determination notice and a completed independent external review request form to:

Mail: Pennsylvania Insurance Department
Attn: Bureau of Managed Care
1311 Strawberry Square
Harrisburg, PA 17120

Fax: 717-231-7960

Email: RA-IN-ExternalReview@pa.gov

Phone: Consumer Services
1-877-881-6388

As expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the date of receipt of the request for an expedited external review, as long as there is sufficient information to process the review, the assigned IRO shall provide notice of the IRO's decision to uphold or reverse the adverse benefit determination or the final adverse benefit determination.

If the notice provided is not in writing, within 48 hours of the date of providing that notice, the assigned IRO shall provide written notice of the IRO's decision to uphold or reverse the adverse benefit determination or the final adverse benefit.

SUMMARY OF COST SHARING AND BENEFITS

The following tables provide a summary of the applicable *cost sharing amounts* and *benefits* provided under this *coverage.*

The *benefits* listed in this section are covered when *medically necessary* and preauthorized (when required) in accordance with our medical *c*linical management and/or pharmaceutical utilization management policies and procedures.

It is important to remember that this *coverage* is subject to the exclusions, conditions, and limitations as described in this *Benefits Booklet*. Please see the **Cost Sharing Descriptions**, **Benefit Descriptions**, and **Exclusions** sections for a specific description of the *benefits* and *benefit* limitations provided under this *coverage*.

The *benefit period* for this *coverage* can be found in the **Benefit Period Addendum** of this *Benefits Booklet*.

SUMMARY OF COST SHARING AND MEDICAL BENEFITS ***** You will be responsible for paying the deductible, copayments, and coinsurance percentage reflected in this chart. Out-of-network providers may balance bill you, which would be additional costs to you over and above any deductible, copayments and coinsurance, except as required by law for emergency services, air ambulance services, and other services received in certain in-network facilities. *****			
	Amounts You Are Responsible For:		**Limits, Maximums, and Other Important Information**
	In-Network Providers	**Out-of-Network Providers**	
DEDUCTIBLE (PER BENEFIT PERIOD)			
Deductible **(Per Benefit Period)** For family coverage, the entire family coverage deductible must be met each benefit period before benefits are paid for any member.	$1,650 single coverage [1] $3,300 family coverage[1] Combined with prescription drug deductible.	$3,000 single coverage $6,000 family coverage	In-network deductible is waived for the following outpatient services, when billed with the indicated diagnoses: • Blood pressure monitor with hypertension diagnosis • Retinopathy screening with diabetes diagnosis • Peak flow meter with asthma diagnosis • International Normalized Ratio (INR) testing with liver disease or bleeding disorder diagnosis • Low-density Lipoprotein (LDL) testing with heart disease diagnosis.

[1] Includes out-of-network emergency services, air ambulance services, and subject to limited provider advance notice and consent requirements, other (non-emergency) provider services received in certain in-network facilities.

SUMMARY OF COST SHARING AND MEDICAL BENEFITS ***** You will be responsible for paying the deductible, copayments, and coinsurance percentage reflected in this chart. Out-of-network providers may balance bill you, which would be additional costs to you over and above any deductible, copayments and coinsurance, except as required by law for emergency services, air ambulance services, and other services received in certain in-network facilities. *****			
	Amounts You Are Responsible For:		**Limits, Maximums, and Other Important Information**
	In-Network Providers	**Out-of-Network Providers**	
OUT-OF-POCKET MAXIMUM			
Out-of-Pocket Maximum When you reach your out-of-pocket maximum, we pay all subsequent claims during the remainder of the benefit period at 100% of the allowed amount, except that coinsurance continues to apply for out-of-network facility providers	$6,750 per member $13,500 per family The in-network out-of-pocket maximum includes all deductible, copayments, and coinsurance for benefits received from in-network providers.[1] This out-of-pocket maximum amount is combined with, and not in addition to, the out-of-pocket maximum amount reflected in the Summary of Cost Sharing – Prescription Drug Benefits. This combined out-of-pocket maximum amount can be satisfied with eligible amounts incurred for medical benefits, prescription drug benefits, or a combination of the two.	$6,750 per member $13,500per family Only coinsurance for out-of-network professional providers applies to the out-of-network, out-of-pocket maximum. The following expenses do not apply to the out-of-network out-of-pocket maximum: • Deductible • Copayments • Facility provider coinsurance	The following expenses do not apply to either the in-network or out-of-network out-of-pocket maximum: • Expenses incurred for payment of a benefit after any applicable benefit maximum has been exhausted • Charges exceeding the allowed amount
ACUTE CARE HOSPITAL ROOM AND BOARD AND ASSOCIATED CHARGES			
Acute Care Hospital	Covered in full after deductible [2]	50% coinsurance after deductible	
Long Term Acute Care Hospital	Covered in full after deductible [2]	Not covered	
ACUTE INPATIENT REHABILITATION			
Benefits	Covered in full after deductible [3]	50% coinsurance after deductible	60 days per benefit period Limits not applicable to mental health and substance use disorder services.

[2] includes out-of-network emergency services, and unless provider advance notice and consent requirements are met, certain post-stabilization services resulting from an emergency, and services provided by an out-of-network provider at certain in-network facilities.

[3] Includes services provided by an out-of-network provider at certain in-network facilities.

SUMMARY OF COST SHARING AND MEDICAL BENEFITS *** You will be responsible for paying the deductible, copayments, and coinsurance percentage reflected in this chart. Out-of-network providers may balance bill you, which would be additional costs to you over and above any deductible, copayments and coinsurance, except as required by law for emergency services, air ambulance services, and other services received in certain in-network facilities. ***			
	Amounts You Are Responsible For:		Limits, Maximums, and Other Important Information
	In-Network Providers	Out-of-Network Providers	
ALLERGY SERVICES			
Benefits	Covered in full after deductible	30% coinsurance after deductible	
BLOOD AND ADMINISTRATION			
Benefits	Covered in full after deductible	30% coinsurance, after deductible	
DIABETIC SERVICES, SUPPLIES & EDUCATION			
Benefits	Covered in full after deductible	30% coinsurance after deductible	
DIAGNOSTIC SERVICES			
Laboratory Tests	Covered in full after deductible when performed at an independent laboratory or drawn at a physician's office and sent to an independent lab. Covered in full after deductible when performed at a Facility/Hospital owned laboratory	30% coinsurance after deductible	
All other Medical Tests	Covered in full after deductible	30% coinsurance after deductible	
Radiology Tests (Outpatient Facility only)	Covered in full after deductible for high tech imaging (MRI, MRA, CT scan, PET scan, SPECT scan and cardiac nuclear medicine procedures.)Covered in full after deductible for radiology tests other than high-tech radiology tests.	30% coinsurance after deductible	
DIALYSIS TREATMENT			
Benefits	Covered in full after deductible	30% coinsurance after deductible Not covered for freestanding dialysis facilities	

SUMMARY OF COST SHARING AND MEDICAL BENEFITS ***** You will be responsible for paying the deductible, copayments, and coinsurance percentage reflected in this chart. Out-of-network providers may balance bill you, which would be additional costs to you over and above any deductible, copayments and coinsurance, except as required by law for emergency services, air ambulance services, and other services received in certain in-network facilities. *****			
	Amounts You Are Responsible For:		**Limits, Maximums, and Other Important Information**
	In-Network Providers	**Out-of-Network Providers**	
DURABLE MEDICAL EQUIPMENT (DME) AND SUPPLIES			
Benefits	Covered in full after deductible	30% coinsurance after deductible	
EMERGENCY AND URGENT CARE SERVICES			
Emergency Services	$100 copayment per visit after deductible; copayment waived if admitted **Note: Your cost share is the same regardless of whether an in-network provider or an out-of-network provider delivers the emergency services.**		Out-of-network emergency service providers are prohibited from balance billing members, with certain exceptions. **Refer to Emergency and Urgent Care Services benefit description for more details.**
Urgent Care Services	$50 copayment per visit after deductible	30% *coinsurance* after *deductible*	Out-of-network emergency service providers are prohibited from balance billing members, with certain exceptions. **Refer to Emergency and Urgent Care Services benefit description for more details.**
ENTERAL NUTRITION			
Benefits	Covered in full after *deductible*	30% coinsurance after deductible	
FERTILITY SERVICES			
Benefits	Covered in full after *deductible*	30% coinsurance after deductible	
GYNECOLOGICAL SERVICES			
Screening Gynecological Exam	Covered in full deductible waived	30% coinsurance, deductible waived	
Screening Pap Smear	Covered in full deductible waived	30% coinsurance, deductible waived	
HOME HEALTHCARE SERVICES			
Benefits	Covered in full after *deductible*	30% coinsurance after deductible	90 visits per benefit period Visit limits not applicable to mental health and substance use disorder services

SUMMARY OF COST SHARING AND MEDICAL BENEFITS ***** You will be responsible for paying the deductible, copayments, and coinsurance percentage reflected in this chart. Out-of-network providers may balance bill you, which would be additional costs to you over and above any deductible, copayments and coinsurance, except as required by law for emergency services, air ambulance services, and other services received in certain in-network facilities. *****			
	Amounts You Are Responsible For:		**Limits, Maximums, and Other Important Information**
	In-Network Providers	**Out-of-Network Providers**	
HOSPICE CARE			
Benefits Benefits (includes Residential Hospice Care)	Covered in full after *deductible*	30% coinsurance after deductible	
IMMUNIZATIONS AND INJECTIONS (NONPREVENTIVE)			
Benefits	Covered in full after *deductible*	30% coinsurance after deductible	
INFUSION THERAPY			
Benefits	Covered in full after *deductible*	30% coinsurance after deductible	
INTERRUPTION OF PREGNANCY			
Benefits	Covered in full after *deductible*	30% coinsurance after deductible	
MAMMOGRAMS			
Screening Mammogram	Covered in full deductible waived	30% coinsurance deductible waived	
Diagnostic Mammogram	Covered in full after *deductible*	30% coinsurance after deductible	
MATERNITY SERVICES (NONPREVENTIVE)			
Benefits for Prenatal Services, Delivery and Postpartum Services (Non-Preventive)	Covered in full after *deductible*	50% coinsurance after deductible	
MEDICAL TRANSPORT			
Emergency Ambulance	Covered in full after deductible **Note: Cost share is the same regardless of whether an In-network Provider or an Out-of-network Provider delivers the emergency services.**		Out-of-network air emergency service providers are prohibited from balance billing members.
Nonemergency Ambulance	Covered in full after deductible	30% coinsurance after deductible	Out-of-network air emergency service providers are prohibited from balance billing members.
MENTAL HEALTH SERVICES			
Inpatient Services	Covered in full after deductible[2]	50% coinsurance after deductible	

SUMMARY OF COST SHARING AND MEDICAL BENEFITS ***** You will be responsible for paying the deductible, copayments, and coinsurance percentage reflected in this chart. Out-of-network providers may balance bill you, which would be additional costs to you over and above any deductible, copayments and coinsurance, except as required by law for emergency services, air ambulance services, and other services received in certain in-network facilities. *****			
	Amounts You Are Responsible For:		**Limits, Maximums, and Other Important Information**
	In-Network Providers	**Out-of-Network Providers**	
Partial Hospitalization	Covered in full after deductible[3]	50% coinsurance after deductible	
Outpatient Services	$20 copayment per visit after deductible when provided by a Family Practitioner, General Practitioner, Internist, or Pediatrician $30 copayment per visit after deductible for all other professional providers.[3]	30% coinsurance after deductible	
NEWBORN CARE			
Benefits	Covered in full after deductible	30% coinsurance after deductible	
NUTRITION THERAPY (COUNSELING AND EDUCATION)			
Benefits	Covered in full after deductible	30% coinsurance after deductible	20 visits for nonpreventive obesity counseling per benefit period 20 visits for chronic management conditions per benefit period2 visits per benefit period for nonpreventive obesity services Visit limits not applicable to mental health and substance use disorder services
OFFICE VISITS, CONSULTATIONS, CLINICS, TELEHEALTH AND VIRTUALCARE			
Inpatient Consultations	Covered in full after deductible	30% coinsurance after deductible	
Outpatient Office Visit, and Consultations, and Telehealth Visits	$20 copayment per visit after deductible, when provided by a Family Practitioner, General Practitioner, Internist, or Pediatrician $30 copayment per visit after deductible, for all other professional providers	30% coinsurance after deductible	Includes in-person and telehealth visits.

SUMMARY OF COST SHARING AND MEDICAL BENEFITS

***** You will be responsible for paying the deductible, copayments, and coinsurance percentage reflected in this chart. Out-of-network providers may balance bill you, which would be additional costs to you over and above any deductible, copayments and coinsurance, except as required by law for emergency services, air ambulance services, and other services received in certain in-network facilities. *****

	Amounts You Are Responsible For:		Limits, Maximums, and Other Important Information
	In-Network Providers	**Out-of-Network Providers**	
VirtualCare Visits delivered via the Capital Blue Cross VirtualCare platform	$5 copayment per visit after deductible when provided by a Family Practitioner, General Practitioner, Internist, or Pediatrician. $30 copayment per visit after deductible for all other professional providers.	Not covered	Service provided by a contracted vendor and delivered via the Capital Blue Cross VirtualCare platform
ORTHOTIC DEVICES			
Benefits	Covered in full after deductible	30% coinsurance after deductible	
PREVENTIVE CARE SERVICES			
Pediatric Preventive Care	Covered in full deductible waived	30% coinsurance, deductible waived for Pennsylvania mandated childhood immunizations	(Includes physical examinations, childhood immunizations and tests)
Adult Preventive Care	Covered in full deductible waived	30% coinsurance after deductible	(Includes physical examinations, immunizations and tests as well as specific women's preventive services as required by law)
PROSTHETIC APPLIANCES			
Prosthetic Appliances (other than wigs)	Covered in full after deductible	30% coinsurance after deductible	
Wigs	Covered in full after deductible		$300 benefit lifetime maximum
SKILLED NURSING FACILITY			
Benefits	Covered in full after deductible	50% coinsurance after deductible	100 days per benefit period Limits not applicable to mental health and substance use disorder services
SUBSTANCE USE DISORDER SERVICES			
Detoxification – Inpatient	Covered in full after deductible [2]	50% coinsurance after deductible	
Rehabilitation – Inpatient	Covered in full after deductible [3]	50% coinsurance after deductible	

SUMMARY OF COST SHARING AND MEDICAL BENEFITS ***** You will be responsible for paying the deductible, copayments, and coinsurance percentage reflected in this chart. Out-of-network providers may balance bill you, which would be additional costs to you over and above any deductible, copayments and coinsurance, except as required by law for emergency services, air ambulance services, and other services received in certain in-network facilities. *****			
	Amounts You Are Responsible For:		**Limits, Maximums, and Other Important Information**
	In-Network Providers	**Out-of-Network Providers**	
Rehabilitation – Outpatient	$20 copayment per visit after deductible when provided by a Family Practitioner, General Practitioner, Internist, or Pediatrician $30 copayment per visit after deductible for all other professional providers. [3] Partial Hospitalization – Covered in full after deductible [3]	30% coinsurance after deductible	
SURGERY			
Outpatient Surgery Facility	Covered in full after deductible at an Acute Care Hospital facility. Covered in fullafter deductible at an Ambulatory Surgical Facility.	30% coinsurance after deductible at an Acute Care Hospital facility Not covered at an out-of-network Ambulatory Surgical Facility.	
Professional Surgery Services including Anesthesia	Covered in full after deductible [3]	30% coinsurance after deductible	(Includes Inpatient and Outpatient professional surgical services)
THERAPY SERVICES			
Acupuncture	$30 copayment per visit after deductible	30% coinsurance after deductible	15 visits per benefit period Visit limits not applicable to mental health and substance use disorder services
Cardiac Rehabilitation Therapy	Covered in full after deductible	30% coinsurance after deductible	
Chemotherapy	Covered in full after deductible	30% coinsurance after deductible	
Manipulation Therapy	$30 copayment per visit after *deductible*	30% coinsurance after deductible	20 visits per benefit period Visit limits not applicable to mental health and substance use disorder services

SUMMARY OF COST SHARING AND MEDICAL BENEFITS ***** You will be responsible for paying the deductible, copayments, and coinsurance percentage reflected in this chart. Out-of-network providers may balance bill you, which would be additional costs to you over and above any deductible, copayments and coinsurance, except as required by law for emergency services, air ambulance services, and other services received in certain in-network facilities. *****			
	Amounts You Are Responsible For:		**Limits, Maximums, and Other Important Information**
	In-Network Providers	**Out-of-Network Providers**	
Occupational Therapy (includes Rehabilitative/Habilitative)	$30 copayment per visit after *deductible*	30% coinsurance after deductible	30 visits per benefit period combined for Physical Therapy and Occupational Therapy, Rehabilitative and Habilitative Visit limits not applicable to mental health and substance use disorder services
Physical Therapy (includes Rehabilitative/Habilitative)	$30 copayment per visit after *deductible*	30% coinsurance after deductible	30 visits per benefit period combined for Physical Therapy and Occupational Therapy, Rehabilitative and Habilitative Visit limits not applicable to mental health and substance use disorder services
Radiation Therapy	Covered in full after deductible	30% coinsurance after deductible	
Respiratory/Pulmonary Rehabilitation Therapy	$30 copayment per visit after deductible	30% coinsurance after deductible	30 rehabilitative visits per benefit period Visit limits not applicable to mental health and substance use disorder services
Speech Therapy (includes Rehabilitative/Habilitative)	$30 copayment per visit after deductible	30% coinsurance after deductible	30 visits per benefit period combined for Speech Therapy rehabilitative and habilitative services Visit limits not applicable to mental health and substance use disorder services
TRANSPLANT SERVICES			
Evaluation, Acquisition and Transplantation	Covered in full after deductible	30% coinsurance after deductible	
Blue Distinction Centers for Transplant (BDCT) Travel Expenses	Covered in full after deductible	Not covered	$10,000 per transplant episode

SUMMARY OF COST SHARING AND MEDICAL BENEFITS

***** You will be responsible for paying the deductible, copayments, and coinsurance percentage reflected in this chart. Out-of-network providers may balance bill you, which would be additional costs to you over and above any deductible, copayments and coinsurance, except as required by law for emergency services, air ambulance services, and other services received in certain in-network facilities. *****

	Amounts You Are Responsible For:		Limits, Maximums, and Other Important Information
	In-Network Providers	**Out-of-Network Providers**	
OTHER SERVICES			
Contraceptives	Covered in full deductible waived	30% coinsurance after deductible	Limited to coverage for those prescribed contraceptive products, services, or devices as mandated by PPACA, including but not limited to contraceptive implants such as intrauterine devices (IUD).
Diagnostic Hearing Screening	Covered in full after deductible	30% coinsurance after deductible	
Foot Care	Covered in full after deductible	30% coinsurance after deductible	Refer to Foot Care benefit description
Orthodontic Treatment of Congenital Cleft Palates	Covered in full after deductible	30% coinsurance after deductible	
Routine Costs Associated with Clinical Trials (Approved)	Covered in full after deductible	30% coinsurance after deductible	
Vision Care for Illness or Accidental Injury	Covered in full after deductible	30% coinsurance after deductible	

SUMMARY OF COST SHARING – PRESCRIPTION DRUG BENEFITS

You are responsible for paying your **deductible** and any **copayments** and **coinsurance** reflected in this chart

	Amounts You Are Responsible For:		
	Retail	**Home Delivery**	**Specialty Pharmacy**
Copayments			
• Generic Preferred Drug	$5 copayment after deductible	$10 copayment after deductible	Not applicable
• Generic Nonpreferred Drug	$5 copayment after deductible	$10 copayment after deductible	Not applicable
• Brand Preferred Drug	$35 copayment after deductible	$70 copayment after deductible	Not applicable

• Brand Nonpreferred Drug	$50 copayment after deductible	$100 copayment after deductible	Not applicable
Copayments for Contraceptives (Self-Administered) • Generic Preferred Drug*	Not applicable	Not applicable	Not covered
• Generic Nonpreferred Drug*	Not applicable	Not applicable	Not covered
• Brand Preferred Drug	$35 copayment after deductible	$70 copayment after deductible	Not covered
• Brand Nonpreferred Drug** For contraceptive therapeutic categories with no generic option, an available FDA approved brand drug as determined by Capital may be purchased at no cost share to you. **Coverage of a Brand Nonpreferred contraceptive at $0 cost share can be requested by you through the prior authorization process as described in the Pharmaceutical Utilization Management section	$50 copayment after deductible	$100 copayment after deductible	Not covered
Healthy Rewards Drugs** • *Generic Drug*	Not Applicable	Not Applicable	Not Applicable
• *Brand Preferred Drug*	$35 *copayment*	$70 *copayment*	Not Applicable
• *Brand Preferred Insulin and Diabetic Supplies*	$17.50 copayment	$35 copayment	Not Applicable
• *Brand Nonpreferred Drug*	$50 *copayment*	$100 *copayment*	Not Applicable
Deductible For family coverage, the entire family deductible must be met every benefit period before benefits are paid for any member.			
In-network Providers	$1,650 single coverage $3,300 family coverage This in-network provider deductible amount is combined with, and not in addition to, the in-network provider deductible amount reflected in the Summary of Cost Sharing – Medical Benefits. This combined deductible amount can be satisfied with eligible amounts incurred for medical benefits, prescription drug benefits, or a combination of the two.		
Out-of-network Providers	Not applicable		
Coinsurance			
• Generic Preferred Drug	Not applicable	Not applicable	2% coinsurance (minimum of $50 to a maximum of $150)

• Generic Nonpreferred Drug	Not applicable	Not applicable	2% coinsurance (minimum of $50 to a maximum of $150)
• Brand Preferred Drug	Not applicable	Not applicable	2% coinsurance (minimum of $50 to a maximum of $150)
• Brand Nonpreferred Drug	Not applicable	Not applicable	2% coinsurance (minimum of $50 to a maximum of $150)
• **PPACA Preventive Drug Coverage** (other than Prescription Contraceptives)	No cost share	No cost share	No cost share
• **QHDHP Preventive Drug Coverage*** • *For a complete list, members can access the QHDHP Preventive Medication list at CapitalBlueCross.com.	See above for copayment, deductible waived	See above for copayment, deductible waived	See above for copayment, deductible waived
Out-of-Pocket Maximum			
In-Network Providers	$6,750 per member $13,500 per family This in-network provider out-of-pocket maximum amount is combined with, and not in addition to, the in-network provider out-of-pocket maximum amount reflected in the Summary of Cost Sharing – Medical Benefits. This combined out-of-pocket maximum amount can be satisfied with eligible amounts incurred for medical benefits, prescription drug benefits, or a combination of the two.		
Out-of-Network Providers	Not applicable		
	The following expenses do not apply to the out-of-pocket maximum: • Amounts paid by you to an out-of-network pharmacy that is more than the amount we paid to you for covered drugs. • Amounts you paid for a brand drug that are more than our allowed amount (ancillary charge) when a generic drug is available, and the provider has not indicated "Brand Medically Necessary" (or substantially similar language). • Charges exceeding the allowed amount.		
Benefit Period Maximum	Not applicable		
Benefit Lifetime Maximum	Not applicable		
†We do not apply manufacturer cost share assistance program payments (e.g., manufacturer discount plans or coupons) to your deductible or out-of-pocket maximum.			

SUMMARY OF RESTRICTIONS PRESCRIPTION DRUG BENEFITS			
	Retail	**Home Delivery**	**Specialty Pharmacy**
Days' Supply	Up to 30 days	Up to 90 days	Up to 30 days
Pharmacy Network	Broad Plus		
Formulary	Advantage		
Ample Days' Supply Limit	Prescription drug refills will be dispensed only if you have used 60% of the previous supply dispensed through the designated Home Delivery Pharmacy or 75% of the previous supply dispensed through a Retail Pharmacy or Specialty Pharmacy. Extended release opioid medications will only be dispensed if you have used 83% of the previous supply.) Prescription eye drops may be dispersed only if you have used 70% of the previous supply		
Drug Quantity Management (Quantity Level Limits)	Prescription drugs that have quantity level limits are noted in the formulary. The quantity level limits set the maximum allowable quantity of a prescription drug that may be dispensed per prescription order, per date of service, or per month. If your prescription is written for more than an allowed quantity, the pharmacy will only fill up to the allowed amount.		
Prior Authorization	To be eligible as a covered drug, select prescription drugs require prior authorization before the prescription drug is dispensed by the pharmacy		
Step Therapy	This program encourages the use of covered drugs that should be tried first before coverage is available for other therapies		
Extended Supply Network	Not Applicable		
Specialty Medication Preferred Network	For most Specialty Medications, coverage is available only when dispensed by a specialty medication vendor contracted with us.		
Restrictive Generic Substitution	If a generic drug is available and you request the brand-name drug, you must pay the cost difference between the brand-name drug and its generic cost (*ancillary charge*). You also must pay the applicable brand copayment or coinsurance, up to the original cost of the brand-name drug. If your provider indicates "dispensed as written" or "DAW", you pay the applicable copayment or coinsurance for the brand product and need not pay the *ancillary charge.*		
90DayMyWay Program	The initial 30-day dispensing of covered Maintenance Drugs plus one additional 30-day refill are available through Retail Dispensing. For as long as you are enrolled in this product, subsequent refills of the maintenance medication are covered only through Home Delivery Dispensing or by obtaining a 90-day supply through a participating retail pharmacy.		
Medication Synchronization	If you take 2 or more maintenance medications, you may obtain partial supply of each medication up to 3 times a year at *retail pharmacies* or through Home Delivery for medication synchronization purposes		

SUMMARY OF BENEFITS-PRESCRIPTION DRUGS

This list is a summary of the most frequently used prescription drug therapeutic classes. It is not a complete list of prescription drugs. You should refer to the formulary on CapitalBlueCross.com for the most up to date prescription drug information.

Prescription Drug Category	**Retail** Up to a 30-day supply	**Home Delivery** Up to a 90 day supply	**Specialty Pharmacy** Up to a 30 day supply
Acne Products	Covered	Covered	Not covered
Anti-Flu Therapy	Covered	Not covered	Not covered
Compound Drugs (not including OTC*)	Covered	Not covered	Not covered
Contraceptives (Self-Administered)	Covered	Covered	Not covered
Diabetic Supplies	Covered	Covered	Not covered
Fertility (except as mandated by law)	Not covered	Not covered	Not covered
Nicotine Cessation Drugs **	Covered	Covered	Not covered
Over-the-Counter (OTC*) Products (except as mandated by law)	Not covered	Not covered	Not covered
Sexual Dysfunction Drugs	Covered	Covered	Not covered
Specialty Drugs (Self-Administered)	Not covered	Not covered	Covered
Weight Loss Drugs	Covered	Covered	Not covered
Vitamins	Covered	Covered	Not covered

*Over-the-counter OTC drugs require a prescription and must be dispensed by a pharmacy for *coverage*.

**We cover FDA approved nicotine cessation medications (both prescription and over-the-counter) at no cost share for a 90-day treatment (up to two attempts per benefit period). The medication must be prescribed by a healthcare provider and does not require prior authorization.

COST SHARING DESCRIPTIONS

This section of the *Benefits Booklet* describes the *cost sharing* that may be required under your *coverage* with *Capital*.

Because *cost sharing amounts* vary depending on your specific *coverage*, it is important that you refer to the **Summary of Cost Sharing and Benefits** section. That section shows the services that are covered and the applicable *cost sharing* amounts (***copayments, deductibles***, and ***coinsurance***) for each benefit.

Application of Cost Sharing

The *allowed amount* is the amount upon which your *cost sharing* amount (other than a copayment) is based, and in many cases, the maximum amount that we will pay for *benefits* under this *coverage*. Before we make payment, any applicable *cost sharing amount* is subtracted from the *allowed amount*.

Payment for healthcare *benefits* may be subject to any of the following cost sharing:

- Deductibles
- Copayments
- Coinsurance

In addition, you are responsible for paying (except where prohibited by law) any:

- Balance billing charges, which are amounts due to an *out-of-network provider* that exceed the *allowed amount*.
- Services for *benefits* not provided under your *coverage*, regardless of the *provider's* network status.

Under certain circumstances, if we pay the healthcare *provider* amounts that are your responsibility, such as *deductible*, *copayments* or *coinsurance*, we may collect such amounts directly from you. You agree that we have the right to collect such amounts from you.

Payment for *prescription drug benefits* may be subject to any of the following *cost sharing amounts*:

- Copayments
- Deductibles
- Coinsurance

In addition, you are responsible for paying any of the following:

- *Ancillary charges*, as described in the **Restrictive Generic Substitution** section.
- Balance billing charges, which you pay to an *out-of-network pharmacy* that exceed the *allowed amount*.
- Services for *benefits* not provided under your *coverage*, regardless of the *pharmacy's* network status.

Cost sharing for facility services: sometimes *members* may receive services in which there are separate charges for the professional and facility services (e.g. laboratory tests, diagnostic tests, outpatient procedures). In such situations, you are responsible for the applicable *cost sharing amount* (*copayment*, *coinsurance*, or *deductible*) for each service until the *member out-of-pocket maximum* has been reached.

Copayment

A *copayment* is a fixed dollar amount that you must pay directly to the *provider* or *pharmacy* for certain *benefits* at the time of services. *Copayment* amounts may vary, depending on the type of healthcare service or *prescription drug* for which *benefits* are being provided and/or the type of *provider* performing the service.

Refer to the **Summary of Cost Sharing and Benefits** section to determine if any *copayments* apply to your *coverage*.

Deductible

A *deductible* is a dollar amount that an individual *member* or a *subscriber's* entire family must incur before *benefits* are paid under this *coverage*. The *allowed amount* that we otherwise would have paid for *benefits* is the amount applied to the *deductible*. Depending on the *member's coverage*, there may be a *deductible* amount applicable only to *benefits* received for services provided by *in-network providers* and a separate *deductible* amount applicable only to *benefits* received for services provided by *out-of-network providers*.

For each *deductible* amount (in-network and out-of-network) that apply to this *coverage*, one of two *deductible* amounts will apply: a single *coverage deductible* or a family *coverage deductible*. If only the *subscriber* is covered under the *group contract*, then the *subscriber* must satisfy the single *coverage deductible* applicable to this *coverage* every *benefit period* before *benefits* are paid. When the *subscriber* and one or more *dependents* are covered under the *group contract*, the entire family *coverage deductible* applicable to this *coverage* must be met every *benefit period* before *benefits* are paid. In calculating the family *coverage deductible*, *Capital* will apply the amounts satisfied by each *member* towards the family *coverage deductible*.

Coinsurance

Coinsurance is the percentage of the *allowed amount* payable for a *benefit* that you are obligated to pay. Depending on your *coverage*, the *coinsurance* may be calculated as two separate percentages: one for *benefits* received for services provided by *in-network providers*; and one for *benefits* for services provided by *out-of-network providers*.

A claim for an *out-of-network provider* is calculated differently than a claim for an *in-network provider*.

Refer to the **Summary of Cost Sharing and Benefits** section to determine if *coinsurance* applies to your *coverage*.

Out-of-Pocket Maximum

The *out-of-pocket maximum* is the highest *cost sharing amount* that an individual *member* or a *subscriber's* entire family may be required to pay during a *benefit period*. Depending on the *subscriber's coverage*, there may be an *out-of-pocket maximum* amount for *in-network providers* and a separate *out-of-pocket maximum* amount for *out-of-network providers*.

If only the *subscriber* is covered under the *group contract*, then the single *coverage out-of-pocket maximum* applies. Once the *subscriber* has met the single *out-of-pocket maximum*, *cost sharing* is no longer applied for any claims for *benefits* through the end of the *benefit period*. If the *subscriber* and

one or more *dependents* are covered under the *group contract* (i.e. family *coverage*), then the *out-of-pocket maximum* can be met in one of two ways:

- Once any *member* on the family plan has met the single *out-of-pocket maximum*, that *member's* claims will no longer incur any *cost sharing* through the end of the *benefit period*.
- In calculating the family *out-of-pocket maximum*, we will apply the amounts satisfied by all *members* toward the family *coverage out-of-pocket maximum*. Once the family has met the family *out-of-pocket maximum*, then all claims for the family will no longer incur any *cost sharing* through the end of the of *benefit period.*

The in-network *out-of-pocket maximum* amount can be satisfied with eligible amounts incurred for medical *benefits*, prescription drug *benefits* or a combination of all *in-network benefits* (and certain *out-of-network benefits* in limited circumstances, where required by law).

Refer to the **Summary of Cost Sharing and Benefits** section to determine the *out-of-pocket maximums* that apply to your *coverage*.

Benefit Period Maximum

A *benefit period maximum* is the limit of *coverage* placed on a specific *benefit(s)* provided under this *coverage* within a *benefit period*. Such limits on *benefits* may be in the form of visits, days, or dollar limits; and there may be more than one limit on a specific *benefit*. This *coverage* has no dollar limits on Essential Health Benefits, as that term is defined by *PPACA*.

Refer to the **Summary of Cost Sharing and Benefits** section to determine if any *benefit period maximums* apply to your *coverage*.

Benefit Lifetime Maximum

A *benefit lifetime maximum* is the maximum amount for a specific *benefit(s)* payable by us during the duration of your *coverage* under the *group contract* or other *group contracts* from the Capital Blue Cross family of companies. This *coverage* has no *benefit lifetime maximums* on Essential Health Benefits, as that term is defined by *PPACA*.

Refer to the **Summary of Cost Sharing and Benefits** section to determine if any *benefit lifetime maximums* apply to your *coverage*.

Balance Billing Charges

Providers have an amount that they bill for the services or supplies furnished to *members*. This amount is called the *provider's* billed charge. There may be a difference between the *provider's* billed charge and the *allowed amount.*

How the interaction between the *allowed amount* and the *provider's* billed charge affects the payment for *benefits* and the amount you will be responsible for paying a *provider* varies depending on whether the *provider* is an *in-network provider* or an *out-of-network provider*.

- For *in-network providers*, the *allowed amount* for a *benefit* is set by the *provider's* contract with us. These contracts also include language whereby the *provider* agrees to accept the amount paid by us, minus any *cost sharing amount* due from you, as payment in full.
- For *out-of-network providers*, because the *out-of-network provider* does not have a contract with us or our *PBM*, the *provider* has not agreed to accept the *allowed amount* as payment in full. However, in some instances, our contracted vendor may be able to negotiate a rate with the *provider*. If the

provider accepts the negotiated rate, we will pay the *provider* directly and they will not bill you for the balance of the charge. If the *provider* does not accept a negotiated rate, the claim payment will go directly to you and you are responsible for paying the *provider*. In these instances, the *provider* may bill you for the balance of the charge.

Out-of-network providers performing either (1) *emergency services* in the emergency department of a *hospital* (or *independent freestanding emergency department*), (2) non-emergency services at certain in-network facilities (namely, *hospitals*, *hospital* outpatient departments, critical access hospitals, or *ambulatory surgical facilities*), or (3) air ambulance services are prohibited from balance billing you, with certain exceptions. In these instances, we will pay the provider directly.

Except as noted above, you may be responsible for paying the difference between the *provider's* billed charge and the *allowed amount,* in addition to any applicable *cost sharing amount*. Unless otherwise agreed to by us, or required by law, we will pay you for services performed by an *out-of-network provider*. You are responsible for paying the provider.

Out-of-Network Emergency Providers Notice and Consent Exception

The exception permits *out-of-network emergency providers* performing certain post-stabilization services, and *out-of-network providers* at certain *in-network facilities* (except for those performing *ancillary services*), to balance bill if they give you written notice and obtain your written consent at least 72 hours prior to receiving the services – or on the date the appointment is scheduled, if less than 72 hours before you receive the services (but in no event less than 3 hours before you receive the services) – that includes the following:

- The *provider's* out-of-network status
- Notice that your consent to receive the items or services from the *out-of-network provider* is optional, and you may instead seek care from an *in-network provider* and be subject to in-network *cost sharing*
- Information about *preauthorization* or care management limitations
- An estimate of charges

If an *out-of-network provider* satisfies this exception, you will be subject to *cost sharing amounts* at the applicable *out-of-network* level or rate, in addition to being subject to balance billing.

The exception cannot be used in instances where the *out-of-network provider* is the only *provider* at the in-network *facility* who can perform the service (i.e., you cannot choose someone in-network) or when the result of unforeseen, urgent medical needs.

Providers furnishing certain services are excluded and cannot balance bill you with or without consent regardless of their specialty. (Those services can be defined as: emergency medicine, anesthesiology, pathology, radiology, neonatology, items and services provided by assistant surgeons, hospitalists, and intensivists, as well as diagnostic services (including radiology and laboratory services.

BENEFITS DESCRIPTIONS

Subject to the terms, conditions, definitions and exclusions specified in this *Benefits Booklet* and subject to the payment of the applicable *cost sharing amounts*, if any, you shall be entitled to receive *coverage* for the *benefits* listed below. Services will be covered by us only if: a) they are *medically necessary,* b) they are preauthorized (if required) by us or our designee, and c) if you are actively enrolled at the time of the services.

It is important to refer to the Summary of Cost Sharing and Benefits section to determine whether a healthcare service, a *prescription drug*, and/or a therapeutic class of *prescription drugs* described in this section is a covered *benefit*. Also reference the Summary of Cost Sharing and Benefits section to determine the *cost sharing* amounts you are responsible for paying to *providers* or *pharmacies*, and to determine whether any *benefit* limitations/maximums apply to this *coverage*.

Certain healthcare services require *preauthorization* by us or our designee. Please see the **Preauthorization Program** attachment for the services that require *preauthorization*. Certain *prescription drugs* require *prior authorization* or enhanced *prior authorization,* or are limited to specific quantities by us or our designee.

This *coverage* provides all Essential Health Benefits, as defined by *PPACA.*

Acute Care Hospital Room and Board and Associated Charges

Benefits for room and board in an acute care hospital include bed, board and general nursing services when you occupy any of the following:

- A semi-private room (two or more beds).
- A bed in a *specialized care unit*.
- A private room, if *medically necessary* or if no semi-private accommodations are available. A private room is not *medically necessary* when used solely for your comfort or convenience.

Benefits for associated services include, but are not limited to the following:

- Drugs and medicines provided for use while an *inpatient.*
- Use of operating or treatment rooms and equipment.
- Oxygen and administration of oxygen.
- Medical and surgical dressings, casts and splints.

Long-Term Acute Care Hospital (LTACH)

LTACH is an acute care *hospital* designed to provide specialized acute care for medically stable, but complex, patients who require long periods of hospitalization (average 25 days) and who would require high-intensity services. LTACHs are a "hospital within a hospital" because they generally are located within a short-term acute care hospital. In Pennsylvania, the Pennsylvania Department of Health licenses LTACHs as an acute care facility.

Benefits for *LTACHs hospitals* include services provided when you are acutely ill and would otherwise require an extended stay in an acute care setting.

Acute Inpatient Rehabilitation

Benefits for acute *inpatient* rehabilitation provided in a *rehabilitation hospital* include services provided when you require an intensive level of skilled *inpatient* rehabilitation services on a daily basis and these skilled rehabilitation services are provided in accordance with a *physician's* order. We must agree with the *physician's* certification that the care and the *inpatient* setting are both *medically necessary*.

Allergy Services

Benefits for allergy services include testing, immunotherapy, and allergy serums.

Testing

Benefits for tests used in the diagnosis of allergy to a particular substance include direct skin testing (percutaneous, intracutaneous, intradermal) as well as in vitro techniques (i.e., RAST, MAST, FAST).

Immunotherapy

Immunotherapy refers to the treatment of disease by stimulating the body's own immune system and involves injections over a period of time in order to reduce the potential for allergic reactions.

Benefits for immunotherapy include therapy provided to individuals with a demonstrated hypersensitivity that cannot be managed by avoidance or environmental controls.

However, certain methods of treatment, which are *investigational*, as well as items that are for personal convenience (for example, pillows, mattress casing, air filters) are not covered.

Allergy Serums

Benefits for allergy serums include the immunizing agent (serum) used in immunotherapy injections as long as the immunotherapy itself is covered.

Autism Spectrum Disorders Services

Benefits are provided for the diagnostic assessment and treatment of *autism spectrum disorders* for *members* subject to the applicable *cost sharing amount* specified for the type of service provided (e.g., therapy services, diagnostic services, etc.) as set forth in the **Summary of Cost Sharing and Benefits** section of this contract. However, any visit limits listed in the **Summary of Cost Sharing and Benefits** section for the service will not apply when received for an *autism spectrum disorder* diagnosis.

Diagnostic Assessment

Diagnostic assessment of *autism spectrum disorders* consists of *medically necessary* assessments, evaluations or tests performed by a licensed physician, licensed physician assistant, licensed psychologist or certified registered nurse practitioner to diagnose whether an individual has *autism spectrum disorders*.

Treatment

Coverage for the treatment of *autism spectrum disorders* may include any of the following *medically necessary* services:

- Rehabilitative and Habilitative care - professional services and treatment programs, including *applied behavior analysis*, provided by an *autism service provider* to produce socially significant improvements in human behavior or to prevent loss of attained skill or function.
- Therapeutic care - services provided by a speech language pathologist, occupational therapist or physical therapist
- Psychiatric care - direct or consultative services provided by a physician who specializes in psychiatry.
- Psychological care - direct or consultative services provided by a psychologist.
- *Prescription drugs* for the treatment of *autism spectrum disorders* that are prescribed by a licensed *physician*, licensed *physician* assistant or *certified registered nurse* practitioner, as well as any assessment, evaluation or test prescribed or ordered by a licensed *physician*, licensed *physician* assistant or *certified registered nurse* practitioner to determine the need or effectiveness of such drugs.

Blood and Blood Administration

Benefits for blood and blood administration include whole blood, the administration of blood, blood processing and blood derivatives used to treat specific medical conditions.

Diabetic Services, Supplies and Education

Unless otherwise covered under a *prescription drug* program, *benefits* for diabetic drugs and supplies include drugs, including insulin, equipment, agents, and orthotics used for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and noninsulin-using diabetes when prescribed by a *provider* legally authorized to prescribe such items. Diabetic supplies do not include batteries, alcohol swabs, preps or gauze.

Equipment, agents, and orthotics include the following:

- Injectable aids (e.g., syringes).
- Pharmacological agents for controlling blood sugar
- Blood glucose monitors and related supplies
- Insulin infusion devices
- Orthotics (e.g., diabetic shoes and foot orthotics mandated by Pennsylvania state law are covered).

Diabetes Education

Benefits for diabetes self-management training and education include participation in a diabetes self-management training and education program approved by the American Diabetes Association or American Association of Diabetes Educators under the supervision of a licensed healthcare professional with expertise in diabetes, and subject to the criteria determined by us. These criteria are based on certification programs for diabetes education developed by the American Diabetes Association or American Association of Diabetes Educators.

Diagnostic Services

Diagnostic services are procedures ordered by a *physician* because of specific symptoms to determine a definitive condition or disease, not for screening purposes. *Benefits* for diagnostic services include,

but are not limited to radiology tests, laboratory tests, and medical tests. Some high-risk conditions may result in a service being considered diagnostic, rather than screening.

Laboratory Tests

Benefits for laboratory tests include diagnostic pathology and laboratory tests for the diagnosis or treatment of a disease or condition.

In certain situations, an additional *cost sharing amount* may be associated with a lab service performed by a *provider* that is not an independent laboratory. An independent laboratory is one that performs clinical pathology procedures and is not affiliated or associated with a *hospital, physician or facility provider*. For a list of independent laboratories, as well as how to access them, go to CapitalBlueCross.com or call Member Services. You will find their number on the back of your *ID card.*

Medical Tests

Benefits for diagnostic medical tests include EKGs, EEGs, and other diagnostic medical procedures performed for the purpose of diagnosing or treating a disease or condition.

Inpatient admissions that are primarily for diagnostic purposes are not covered.

Radiology Tests

Benefits for radiology tests include X-rays, MRIs (Magnetic Resonance Imaging), CT scans, Ultrasounds, Echography, and other radiological services performed for the purpose of diagnosing a condition due to an illness or injury.

Other Diagnostic Tests and Services

Benefits for other diagnostic tests and services include Positron Emission Tomography (PET scan), Computerized Axial Tomography (CAT scan), Magnetic Resonance Angiography (MRA), and Single Photon Emission Computed Tomography (SPECT scan).

Dialysis Treatment

Benefits for dialysis include the *inpatient* or *outpatient* treatment of acute renal failure or chronic renal insufficiency for removal of waste materials from the body.

Durable Medical Equipment (DME) and Supplies

Durable medical equipment consists of items described as follows:

- Primarily and customarily used to serve a medical purpose.
- Not useful to a person in the absence of illness or injury.
- Ordered by a *professional provider* within the scope of their license.
- Appropriate for use in the home.
- Reusable.
- Can withstand repeated use.

Examples of covered DME are wheelchairs, canes, walkers, and nebulizers when shown to be *medically necessary*.

Examples of noncovered DME include, but are not limited to, iPads, home computers, laptops, and wearable activity or health monitors. Enteral pumps are only a covered DME when the enteral nutrition is considered *medically necessary.*

Benefits for DME may include wheelchair *coverage* for primary use outside the home (e.g. work or school) when *medically necessary*, reasonable repairs, adjustments and certain supplies that are necessary to use and maintain the DME in operating condition. Repair costs cannot exceed the purchase price of the DME. Routine periodic maintenance (e.g., testing, cleaning, regulating and checking of equipment) for which the owner or vendor is generally responsible is not covered.

DME may be rented or purchased based on:

- *Member's* condition at diagnosis.
- *Member's* prognosis.
- Anticipated time frame for use.
- Total costs.

Reimbursement on a rental DME cannot exceed the lesser of the established fee schedule price, billed amount, usual or customary purchase price of the equipment. When you purchase a DME, the previous allowances for its rental will be deducted from the amount allowed for its purchase.

Except in circumstances of risk of disability or death, there are generally no *benefits* for replacement DME when repairs are due to equipment misuse and/or abuse or for replacement of lost or stolen items. Replacement due to change in employment, school or home settings are not eligible unless *medically necessary* due to change in health condition.

Medical supplies are medical goods that **support** the provision of therapeutic and diagnostic services but cannot withstand repeated use and are disposable or expendable in nature. *Benefits* for medical supplies include items such as hoses, tubes and mouthpieces that are *medically necessary* for proper functioning of covered DME.

Emergency and Urgent Care Services

Emergency Services

An *emergency service* is any healthcare service provided to you after the onset of a medical condition, including a mental health condition or substance use disorder, that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any one of the following:

- Placing your health, or with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.
- Other serious medical consequences.

Benefits for *emergency services* include the initial evaluation, treatment and related services, such as diagnostic procedures provided on the same day as the initial treatment.

Outpatient surgery resulting from an emergency room visit (including sutures) is reimbursed at the level of payment for *outpatient surgery* benefits.

Inpatient hospital stays as a result of an emergency are reimbursed at the level of payment for *inpatient benefits*. Observation status is not considered *inpatient* admission. Emergency room *cost sharing amounts* will apply to observational care unless the *member* is admitted *inpatient*. Consultations received in the emergency room are subject to the applicable *outpatient* consultation *copayment*.

When *emergency services* are provided by *out-of-network providers*, *benefits* will be provided at the *in-network provider level*. *Members* will be responsible for any applicable *cost sharing amounts* such as *deductibles*, *coinsurance*, and *copayments*. and will not be liable for a greater out-of-pocket expense than if they had been attended to by an *in-network provider*.

When *emergency services* are provided for the administration of the rabies vaccine series at the initial visit/injection, only one emergency copayment will apply. Additional non-emergency cost share may apply for any subsequent vaccine injections.

Benefits for emergency dental accident services include only treatment required to stabilize you *immediately* following an accidental injury, which includes injuries caused by a mental condition or an act of domestic violence. Treatment of accidental injuries resulting from chewing or biting is not covered.

Upon reviewing the emergency room records, if we determine that the services provided do not qualify as *emergency services*, those nonemergency services may not be covered or may be reduced according to the limitations of this *coverage*.

Urgent Care Services

Benefits for services performed in an urgent care center include those that, in the judgment of the *provider*, are not life-threatening and urgent. These services can be treated on other than an inpatient hospital basis and are performed at a freestanding urgent care center by a duly licensed associated *physician* or allied health professional practicing within the scope of his/her licensure and specialty. *Urgent care services* are performed in an ambulatory medical clinic that is open to the public for walk-in, unscheduled visits during all open hours, and offer significant extended hours, which may include evenings, holidays and weekends.

Enteral Nutrition

Enteral nutrition involves the use of special formulas and medical foods that are administered by mouth or through a tube placed in the gastrointestinal tract. *Benefits* for enteral nutrition include enteral nutrition products (i.e. special formulas and medical food, as defined by the U.S. Food and Drug Administration), as well as *medically necessary* enteral feeding equipment (e.g. pumps, tubing, etc.).

Benefits for enteral nutrition products are covered if the enteral nutrition product provides 50% or more of total nutritional intake.

Regardless of the percentage nutritional intake, *benefits* for enteral nutrition products for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria are covered. Similarly, *benefits* for amino acid-based enteral nutrition products are covered for documented food protein allergies, food protein-induced enterocolitis syndrome, eosinophilic disorders, and short-bowel syndrome.

Benefits for *medically necessary* enteral feeding equipment for feeding through a tube are included for individuals with functioning gastrointestinal tracts, but for whom oral feeding is impossible or severely limited.

Fertility Services

Benefits include testing to diagnose the causes of infertility and treatments and procedures for infertility. *Benefits* do not include artificial insemination services or other treatments or procedures leading to or in connection with assisted fertilization such as, but not limited to, in vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), and zygote intra-fallopian transfer (ZIFT).

Gynecological Services

Screening Gynecological Exam

A screening gynecological exam is a preventive service performed by a gynecologist, primary care *physician*, or other qualified healthcare *provider*. The exam generally includes a pelvic examination, a Pap smear, a breast examination, a rectal examination and a review of the patient's past health, menstrual cycle and childbearing history. *Benefits* for screening gynecological exams are covered under the **Preventive Care Services** section and are highlighted in the **Schedule of Preventive Care Services** attachment to this *Benefits Booklet.*

Screening Papanicolaou Smear

A Papanicolaou (Pap) Smear is a laboratory study used to detect cancer. The Pap test has been used most often in the diagnosis and prevention of cervical cancers. *Benefits* for Pap Smears are covered under the **Preventive Care Services** section and are highlighted on the **Schedule of Preventive Care Services** attachment.

Diagnostic pap smears are covered under the **Diagnostic Services** section and may be subject to *cost sharing amounts*.

Home Healthcare Services

Home healthcare is *medically necessary* skilled care provided to a homebound patient for the treatment of an acute illness, an acute exacerbation of a chronic illness, or to provide rehabilitative services.

Benefits for home healthcare services provided to a homebound patient can include all the following:

- Professional services when provided by appropriately licensed and certified individuals.
- Physical therapy, occupational therapy and speech therapy.
- Medical and surgical supplies provided by the *home health care agency*.
- Medical social service consultation.

No home healthcare *benefits* are provided for any of the following:

- Drugs provided by the *home health care agency* with the exception of intravenous drugs administered under a treatment plan we approved.
- Food or home delivered meals.
- Homemaker services such as shopping, cleaning, and laundry.
- Maintenance therapy.
- Custodial care.

Home Healthcare Visits Related to Mastectomies

Benefits for home healthcare visits related to mastectomies include one home healthcare visit, as determined by *your physician*, received within 48 hours after discharge, if such discharge occurs within 48 hours after an admission for a mastectomy.

Home Healthcare Visits Related to Maternity

Benefits for home healthcare visits related to maternity include one home healthcare visit within 48 hours after discharge when the discharge occurs prior to 48 hours of *inpatient* care following a normal vaginal delivery or prior to 96 hours of *inpatient* care following a cesarean delivery. Home healthcare visits can include, but are not limited to parent education, assistance and training in breast and bottle feeding, infant screening and clinical tests, and the performance of any necessary maternal and neonatal physical assessments. A licensed healthcare *provider* whose scope of practice includes postpartum care must make such home healthcare visits. At the mother's sole discretion, the home healthcare visit may occur at the facility of the *provider*. Home healthcare visits following an *inpatient* stay for maternity services are not subject to *copayments*, *deductibles*, or *coinsurance*, if applicable to this *coverage.*

Hospice Care

Hospice care involves palliative care to terminally ill *members* and their families with such services being centrally coordinated through a multi-disciplinary *hospice* team directed by a *physician*. Most *hospice* care is provided in the *member's* home or facility that the *member* has designated as home. (i.e. assisted living facility, nursing home, etc.)

The *hospice provider* must bill all eligible *hospice* services.

Benefits for *hospice* care include the following services provided to you by a *hospice provider* responsible for your overall care:

- Professional services provided by a registered nurse or *licensed practical nurse.*
- Medical and surgical supplies and durable medical equipment.
- Prescribed drugs related to the *hospice* diagnosis (drugs and biologicals).
- Oxygen and its administration.
- Therapies (physical therapy, occupational therapy, speech therapy).
- Medical social service consultations.
- Dietitian services.
- Home health aide services.
- Family counseling services.
- Respite care.
- Continuous home care provided only during a period of crisis in which a patient requires continuous care, which is primarily nursing care, to achieve palliation or management of acute medical symptoms.
- *Inpatient* services of an acute medical nature arranged through the *hospice provider* in a hospital or skilled setting to address short-term pain and/or symptom control that cannot be managed in other settings.

Residential hospice care involves palliative care provided in a *hospice* facility for the express or implied purpose of providing end-of-life care for the terminally ill patient who is unable to remain in the home

and requires facility placement to provide for routine activities of daily living (ADLs) as well as specialized *hospice* care on a 24-hour-per-day basis.

Benefits for residential hospice care include the following services provided to a member by a hospice provider responsible for the member's overall care:

- Room and board in a *hospice* facility that meets our criteria for residential hospice care
- Professional services provided by a registered nurse or *licensed practical nurse*
- Medical and surgical supplies and durable medical equipment
- Prescribed drugs related to the *hospice* diagnosis (drugs and biologicals)
- Oxygen and its administration
- Therapies (physical therapy, occupational therapy, speech therapy)
- Medical social service consultations
- Dietitian services
- Family counseling services

No *hospice* care *benefits* are provided for the following:

- Volunteers
- Pastoral services
- Homemaker services
- Food or home delivered meals

The *member* is not eligible to receive further *hospice* care *benefits* if the *member* or the *member*'s authorized representative elects to institute curative treatment or extraordinary measures to sustain life.

Immunizations and Injections (Nonpreventive)

Benefits for immunizations and injections include certain immunizations for individuals determined to be at high risk. We follow guidelines set by the Center for Disease Control in determining high-risk individuals. Immunizations for travel or for employment are not covered except as required by *PPACA*

Injectables that are primarily "self-administered" are not covered under your medical *benefit* under any circumstances, even if you are unable to self-administer. In the event you are unable to self-administer an injectable medication, only the charges for the administration of the injectable will be covered when administered and reported by an eligible *provider* in an office, *hospital outpatient*, or home setting. You can view the list of medications that we consider to be primarily self-administered by accessing the Self-Administered Medications Policy at CapitalBlueCross.com.

Infusion Therapy

Infusion therapy involves the enteral, parenteral, or other instillation and administration of pharmaceuticals, biologicals and fluids. Infusion is used for a broad range of therapies such as antibiotics, chemotherapy, gene therapy, cellular therapy, pain management, and hydration.

A home *infusion therapy* provider typically provides services in the home, but a patient is not required to be homebound.

Benefits for infusion therapy include the procurement and preparation of the pharmaceuticals, biologicals and fluids; accompanying medications and solutions; supplies and equipment used to

administer the infusions; and inpatient and outpatient care required to administer and monitor the infusions.

Interruption of Pregnancy

Benefits for an interruption of pregnancy include, to the extent permitted by state law, procedures for termination of a pregnancy performed through a medical or surgical procedure, including the administration of medication in a *provider's* office. Termination of the pregnancy may be nonelective or elective.

Mammograms

A mammogram is an X-ray image examination of the breast(s) used to detect tumors and cysts, and to help differentiate benign and malignant disease.

Screening Mammogram

A screening mammogram is furnished to an individual without signs or symptoms of breast disease, for the purpose of early detection of breast cancer. *Benefits* for screening mammograms are covered under the **Preventive Care Services** section and are highlighted in the **Schedule of Preventive Care Services** attachment to this *Benefits Booklet.*

Diagnostic Mammogram

A diagnostic mammogram is intended to provide specific evaluation of patients with a detected breast abnormality. *Benefits* for diagnostic mammograms may be subject to *cost sharing amounts*.

Maternity Services(Nonpreventive)

Benefits for maternity services include prenatal, delivery and postpartum services provided to female *members* who are pregnant.

Prenatal Services

Benefits for prenatal services include an initial examination, tests, and a series of follow-up exams to monitor the health of the mother and fetus. Prenatal services continue up to the date of delivery.

Delivery

Benefits for deliveries include facility and professional services for vaginal and cesarean section deliveries.

Group health plans and health insurance issuers offering group health insurance *coverage* generally may not restrict *benefits* for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending *provider* (e.g., *physician*, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, plans and issuers may not set the level of *benefits* or *out-of-pocket* costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, require that a *physician* or other healthcare *provider* obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain *providers* or *facilities*, or to reduce *out-of-pocket* costs, you may be required to obtain preauthorization. For information on preauthorization, see the Preauthorization Program attachment to this *Benefits Booklet*.

Postpartum Services

Benefits for postpartum services include post-delivery *hospital* services and office visits.

Medical Transport

Benefits for medical transport services include the use of specially designed and equipped vehicles to transport ill or injured patients. Medical transport services may involve ground or air transports in both emergency and nonemergency situations.

Air ambulance transportation is covered only when the transport is *medically necessary* or the point of pickup is not accessible by land, and the transport is to an acute care hospital (whether for initial transport or subsequent transfer to another facility for special care). Out-of-network air emergency providers are prohibited from balance billing you.

Emergency Ambulance

Benefits for emergency ambulance services include transportation to an acute care hospital when the circumstances leading up to the ambulance services qualify as *emergency services* and the patient is transported to the nearest acute care *hospital* with appropriate facilities for treatment of the injury or illness involved.

Nonemergency Ambulance

Benefits for nonemergency ambulance services include services only for inter-facility transportation if the circumstances leading up to the ambulance services do not qualify as *emergency services*, but are *medically necessary*. Inter-facility transportation means transportation between *hospitals* or between a *hospital* and a *skilled nursing facility*.

Transportation by way of wheelchair vans, stretcher vans, or other transportation modalities where advanced or basic life support is unnecessary are not covered. In addition, membership fees are excluded from *coverage*.

Mental Health Services

Benefits for mental health services include services for *mental illness* diagnoses. S*ubstance use disorder* treatment is defined under a separate *benefit*.

Inpatient Services

Benefits for *inpatient* mental health services include bed, board and general *inpatient* nursing services when provided for the treatment of *mental illness*. Services provided by a *professional provider* to you as an *inpatient* for mental health are also covered. *Benefits* include treatment received at a *residential treatment facility* when preauthorized and *medically necessary*.

Partial Hospitalization

Benefits for *partial hospitalization* mental health services include the *outpatient* treatment of a *mental illness* in a planned therapeutic program during the day only or during the night only.

The *partial hospitalization* program must be approved by us or our designee. *Partial hospitalization* mental *health* is not covered for halfway houses.

Outpatient Services

Benefits for *outpatient* mental *health* services include the *outpatient* treatment of *mental illness* by a *hospital*, a *physician,* intensive outpatient treatment program (IOP), or another eligible *provider*.

Attention deficit/hyperactivity disorder (ADHD) is classified as a mental health condition. Treatments for ADHD are eligible under mental health *benefits*.

Newborn Care

Benefits for newborn care include routine nursery care; prematurity services, preventive healthcare services, and services to treat an injury or illness, including care and treatment of medically diagnosed congenital defects and birth abnormalities. Refer to the **Membership Status** section for limitations on newborn care *coverage*.

For the first 31 days following birth, any costs for *benefits* provided to your newborn child will be applied toward your *cost sharing amounts*. Separate *cost sharing amounts* will not apply to the newborn child unless and until the child is separately enrolled as a dependent in accordance with the terms of this *Benefits Booklet.*

Nutrition Therapy (Counseling and Education)

Benefits for nutrition therapy include counseling and education for the treatment of diagnoses in which dietary modification is *medically necessary.* Services can include but are not limited to the treatment of diabetes, heart disease, and obesity.

Benefits for self-management education and education relating to diet are covered when prescribed and include the following:

- Visits upon obtaining a diagnosis of a medical condition in which nutrition therapy is *medically necessary*.
- Visits when a licensed *physician* identifies or diagnoses a significant change in your symptoms or conditions that necessitates changes in your self-management, or when a new medication or therapeutic process relating to your treatment and/or management of the medical condition has been identified as *medically necessary* by a licensed *physician*.

Office Visits, Consultations, Clinics, Telehealth Visits and VirtualCare

You can have an office visit with an eligible *provider* in any of the following ways:

- *Telehealth* (audio and/or video)
- Provider office
- Hospital
- Retail clinic

Visits

Inpatient – *Benefits* for *inpatient* evaluation and management include medical care services provided by a *physician* or other *professional provider* when you are admitted as a *hospital inpatient*. Medical care includes *inpatient* visits and intensive care.

Outpatient – *Benefits* for *outpatient* evaluation and management include *outpatient* visits provided by a *physician* or other *professional provider* for the prevention, diagnosis, and treatment of an injury or illness.

In certain situations, a facility fee may be associated with an *outpatient* visit to a *professional provider* where the *provider* bills separately for the *member's* use of that facility. *Members* should consult with the *provider* of the service to determine whether a facility fee may apply to that *provider*. An additional *cost sharing amount* may apply to the facility fee.

Consultations

Consultations are distinguished from evaluation and management services because these services are provided by a *physician* whose opinion or advice is usually requested by another *physician* regarding a specific problem.

Inpatient – *Benefits* for *inpatient* consultations include initial and follow-up *inpatient* consultation services rendered to you by another *physician* at the request of the attending *physician*.

Coverage for consultations does not include the following:

- Staff consultations required by *hospital* rules and regulations.
- Staff consultations related to teaching interns and resident medical education programs.

Outpatient – *Benefits* for *outpatient* consultations include *outpatient* office consultation visits.

Retail Clinic Services

Benefits for services performed in a retail clinic include those that, in the judgment of the *provider*, can be treated by a duly licensed or certified associated *physician* or allied health professional practicing within the scope of his/her licensure, certification or specialty. Retail clinic services are performed in an ambulatory medical clinic that provides a limited scope of services for preventive care or the treatment of minor injuries and illnesses. The clinic is open to the public for walk-in, unscheduled visits during all open hours, and offers significant extended hours, which may include evenings, holidays and weekends.

Telehealth Visits

Your cost sharing for *telehealth* services is the same as for in-person visits with that provider. Not all services are eligible for *telehealth coverage*.

For more information on the types of providers approved for *telehealth*, visit CapitalBlueCross.com.

Telehealth coverage does not include the following:

- Email communications for reporting or discussions of laboratory or other diagnostic and screening results
- Nurse call centers/advice centers
- Services involving remote invasive treatment and/or diagnostic testing

- Group counseling

Capital Blue Cross VirtualCare

Capital Blue Cross VirtualCare offers *medically necessary* services to a member where the interaction between the member and the provider is through a secure, interactive real-time, audio and video telecommunications system on a secure platform hosted by our contracted vendor.

Through our VirtualCare platform, accessible via an application or website, you can access virtual visits through our contracted vendor. Available providers include *physicians, certified registered nurse practitioners* (CRNPs), physician assistants (PAs), within the specialties of family medicine, pediatrics, internal medicine, and psychiatrists and other eligible providers who are licensed psychologists, social workers, behavioral specialists, marriage counselors, certified psychiatric nurses and family therapists.

Capital Blue Cross VirtualCare *benefits* are limited to the following *medically necessary* services:

- Diagnosis and management of acute minor illness that do not typically require direct hands-on *provider* examination.
- Individual behavioral health diagnosis, counseling, and treatment. (*Benefits* do not include group counseling.)
- Treatment for general wellness concerns.
- Treatment for nicotine cessation.

Capital Blue Cross VirtualCare *coverage* does not include:

- E-mail communications for reporting or discussions of laboratory or other diagnostic and screening results.
- Nurse call centers/advice centers.
- Services involving remote invasive treatment and/or diagnostic testing.
- Group counseling.

For information on accessing Capital Blue Cross VirtualCare, visit CapitalBlueCross.com.

Orthotic Devices

An orthotic device is a rigid or semi-rigid support. It restricts or eliminates motion of a weak or diseased body part. *Benefits* for orthotic devices include the purchase, fitting, necessary adjustment, repairs, and replacement of orthotic devices. Examples of orthotic devices are diabetic shoes; braces for arms, legs, and back; splints; and trusses.

Diabetic shoes and foot orthotics mandated by Pennsylvania state law are covered. Orthopedic shoes and other supportive devices of the feet are covered only when they are an integral part of a leg brace. Otherwise, foot orthotics and other supportive devices for the feet are not covered.

Preventive Care Services

Benefits for preventive care are highlighted in the **Schedule of Preventive Care Services** attachment to this *Benefits Booklet*. These guidelines are periodically updated to reflect current recommendations from organizations such as the American Academy of Pediatrics (AAP), U.S. Preventive Service Task Force (USPSTF), and Advisory Committee on Immunization Practices (ACIP). This document is not intended to be a complete list of preventive care services and is subject to change.

Pediatric

Benefits for pediatric preventive care include routine physical examinations, childhood immunizations, and tests. For more information, refer to the **Schedule of Preventive Care Services** attachment.

Adult

Benefits for adult preventive care include routine physical examinations, immunizations, and tests. *Benefits* also include specific women's preventive services as mandated by law. For more information, refer to the **Schedule of Preventive Care Services** attachment.

Services that need to be performed more frequently than stated in the **Schedule of Preventive Care Services** attachment due to high-risk situations are covered when the diagnosis and procedures are otherwise covered. We follow guidelines set by the Center for Disease Control in determining high-risk individuals. These services are subject to all applicable *cost sharing amounts*.

Prosthetic Appliances

Prosthetic appliances replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body part that is lost or impaired as a result of disease, injury or congenital deficit regardless of whether they are surgically implanted or worn outside the body. The surgical implantation or attachment of covered prosthetics is considered *medically necessary*, regardless of whether the covered prosthetic is functional (i.e., irrespective of whether the prosthetic improves or restores a bodily function.)

Benefits for prosthetics include the purchase, fitting, necessary adjustment, repairs, and replacements after normal wear and tear of the most cost-effective prosthetic devices and supplies. Repair costs cannot exceed the purchase price of a prosthetic device. Prosthetics are limited to the most cost-effective *medically necessary* device required to restore lost body function.

Wigs are covered prosthetics in certain cases and may be subject to a *benefit lifetime maximum*. In addition, the use of initial and subsequent prosthetic devices to replace breast tissue removed due to a mastectomy is covered.

Glasses, cataract lenses, contact lenses, and scleral shells prescribed after cataract or intra-ocular *surgery* **without** a lens implant, or used for initial eye replacement (i.e., artificial eye) are also covered.

The replacement of cataract lenses (except when new cataract lenses are needed because of prescription change) and certain dental appliances are not covered.

Skilled Nursing Facility

Benefits for *skilled nursing facilities* include services provided when you require *inpatient skilled nursing services* on a daily basis and these *skilled nursing services* are provided in accordance with a *physician*'s order. We must concur with the *physician's* certification that the care and the *inpatient* setting are both *medically necessary*.

Substance Use Disorder Services

Detoxification – Inpatient

Benefits for *inpatient* detoxification include services to assist an alcohol and/or drug intoxicated or dependent *member* in the elimination of the intoxicating alcohol or drug as well as alcohol or drug dependency factors while minimizing the physiological risk to the *member*.

Services must be performed in a facility licensed by the state in which it is located.

Rehabilitation

Benefits for *substance use disorder* rehabilitation include services to assist you with a diagnosis of *substance use disorder* in overcoming your addiction. You must be detoxified before rehabilitation will be covered. A *substance use disorder* treatment program provides rehabilitation care.

Inpatient - *Benefits* for *inpatient substance use disorder* treatment include: bed, board, and general *inpatient* nursing services. *Substance use disorder* care provided by a *professional provider* to you as an *inpatient* for *substance use disorder* treatment is also covered.

Benefits also include treatment received at a *residential treatment facility* when preauthorized and *medically necessary*.

Outpatient - *Benefits* for *outpatient substance use disorder* treatment include services that would be covered on an *inpatient* basis but are otherwise provided for *outpatient, in an intensive outpatient treatment program (IOP), partial hospitalization,* medication assisted treatment (MAT)*, or through opioid treatment program (OTP)*.

Surgery

Benefits for *surgery* include facility and professional services for preoperative care, surgical procedures, and post-operative care.

Surgical Procedure

Benefits for surgical procedures include surgical services required for the treatment of a disease or injury when performed by a *physician* or other *professional provider* in an *inpatient hospital* or *outpatient* setting. Certain rules and guidelines apply if an additional surgeon or multiple surgeries are needed.

Outpatient Surgery

Outpatient surgery may be performed in an acute care *hospital* or *ambulatory surgical facility*. *Benefits* for *ambulatory surgical facilities* include those *outpatient surgeries* that, in the judgment of the provider, are not life-threatening, can be provided in a facility other than an acute care *hospital*, and are performed at an *ambulatory surgical facility* by a duly licensed associated *physician* or allied health professional practicing within the scope of his/her licensure and specialty. Facility charges for *outpatient surgeries* performed in an acute care *hospital* may be subject to higher *cost sharing amounts*.

Anesthesia Related to Surgery

Benefits for the administration of anesthesia related to *surgery* include services ordered by the attending *professional provider* and rendered by a *professional provider*, including the operating

physicians under certain circumstances, but other than the assistant at *surgery*, or the attending *physician*.

Benefits also include hospitalization and all related medical expenses normally incurred as a result of the administration of general anesthesia in a hospital or ambulatory surgical facility setting for noncovered dental procedures or noncovered oral surgery for an eligible dental patient, provided we have determined services to be *medically necessary* and when a successful result cannot be expected for treatment under local anesthesia and for whom a superior result can be expected under general anesthesia. An eligible dental patient is a patient who is seven years of age or younger or developmentally disabled. Anesthesia and all related *benefits* for eligible dental patients are subject to all applicable *cost sharing amounts.*

Mastectomy and Related Services

A mastectomy is the surgical removal of all or part of a breast. *Benefits* for a mastectomy include a mastectomy performed on an *inpatient* or *outpatient* basis and *surgery* performed to reestablish symmetry or alleviate *functional impairment*, including, but not limited to augmentation, mammoplasty, reduction mammoplasty and mastopexy. *Reconstructive surgery* to reestablish symmetry is covered for the unaffected breast as well as the affected breast. *Benefits* are also provided for physical complications due to the mastectomy such as lymphedema.

Oral and Orthognathic Surgery

Benefits for oral *surgery* include surgical extractions of full or partial bony impactions, root recovery, surgical exposure of impacted or unerupted teeth, surgical excisions (e.g., cysts, tori, exostosis), to improve function and lingual frenulum repairs.

Orthognathic *surgery* is limited to conditions resulting in significant functional impairment, fractures and dislocations of the face or jaw, and when major disease, trauma or surgery results in insufficient boney structure to support dentures or other oral prosthetics in order to chew. Orthognathic surgery is also covered for the first 31 days after birth for the treatment of congenital birth defects, even where *functional impairment* is not present.

Anesthesia charges associated with oral surgery are covered for an eligible dental patient when we determine the anesthesia is *medically necessary* and when a successful result cannot be expected for treatment under local anesthesia and for whom a superior result can be expected under general anesthesia. An eligible dental patient is a patient who is seven years of age or younger or developmentally disabled. Anesthesia and all related *benefits* for an eligible dental patient are subject to all applicable *cost sharing amounts.*

Other Surgeries

Benefits for other specialized surgical procedures include the following services:

- Routine neonatal circumcisions.
- Sterilization and reversal of sterilization procedures.

Therapy Services

Rehabilitative Services are healthcare services and devices that are provided to help a person regain, maintain, or improve skills or functioning for daily living that have been acquired but then lost or impaired due to illness, injury, or disabling condition.

Habilitative services are healthcare services and devices that are provided for a person to attain, maintain, or improve skills or functioning for daily living that were never learned or acquired due to a disabling condition (for example, therapy for a child who isn't walking or talking at the expected age).

Benefits for therapy services include services provided for evaluation and treatment of your illness or injury when an expectation exists that the therapy will result in significant, measurable improvement in your level of functioning within a reasonable period of time appropriate to your condition.

Acupuncture

Acupuncture is a treatment that consists of inserting very thin needles into specific locations of the body.

Benefits for acupuncture include services for medically necessary treatment of migraine and tension headaches, as well as chronic back and neck pain (longer than three months) that do not respond to conservative treatment, including physical therapy and/or pharmacotherapies such as nonsteroidal anti-inflammatory drugs, muscle relaxants, and analgesics.

Cardiac Rehabilitation Therapy

Benefits for cardiac rehabilitation therapy include regulated exercise programs that are proven effective in the physiologic rehabilitation of a patient with a cardiac illness.

Maintenance cardiac rehabilitation therapy is not covered.

Chemotherapy

Chemotherapy involves the treatment of infections or other diseases with chemical or biological antineoplastic agents approved by and used in accordance with the Food and Drug Administration (FDA) guidelines.

Benefits for chemotherapy include chemotherapy drugs and the administration of these drugs provided in either an *inpatient* or *outpatient* setting.

Manipulation Therapy

Benefits for manipulation therapy include treatment involving movement of the spinal or other body regions when the services rendered have a direct therapeutic relationship to the patient's condition, are performed for a musculoskeletal condition, and there is an expectation of restoring the patient's level of function lost due to this condition.

Benefits include maintenance manipulation therapy for chronic pain management.

Occupational Therapy

Benefits for occupational therapy include the evaluation and treatment of a physically disabled person by means of constructive activities designed to promote the restoration of the ability to satisfactorily accomplish the ordinary tasks of daily living.

Benefits for occupational therapy include rehabilitative and habilitative services.

Physical Therapy

Benefits for physical therapy include evaluation and treatment by physical means or modalities, such as: mechanical stimulation, heat, cold, light, air, water, electricity, sound, massage, mobilization, and

the use of therapeutic exercises or activities performed to relieve pain and restore a level of function following disease, illness or injury.

Benefits for physical therapy include rehabilitative and habilitative services.

Radiation Therapy

Benefits for radiation therapy (also known as radiation oncology or therapeutic oncology) include the *inpatient* or *outpatient* treatment of a disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, and radium or radioactive isotopes, including the cost of the radioactive material.

Respiratory/Pulmonary Rehabilitation Therapy

Benefits for respiratory therapy include the treatment of acute or chronic lung conditions using intermittent positive breathing (IPPB) treatments, chest percussion, and postural drainage.

Pulmonary therapy includes treatment through a multi-disciplinary program. This program combines physical therapy with an educational process directed towards the stabilization of pulmonary diseases and the improvement of functional status.

Maintenance respiratory and pulmonary therapy is not covered.

Speech Therapy

Benefits for speech therapy include those services necessary for the evaluation, diagnosis, and treatment of certain speech and language disorders as well as services required for the diagnosis and treatment of swallowing disorders.

Benefits for speech therapy include rehabilitative and habilitative services.

Transplant Services

Benefits for transplant services are provided for *inpatient* and *outpatient* services related to human organ and tissue transplants that we have found not to be *investigational*.

Pre-Transplant Evaluation

Benefits for pre-transplant evaluations include testing performed to determine donor compatibility, pre-operative testing, medical examination of the donor in preparation for harvesting the organ or tissue, and organ bank registry fees. Costs associated with registration, evaluation, or duplicate services at more than one transplantation institution are not covered. If you assume financial responsibility for obtaining and maintaining a duplicate organ listing at an additional facility and the organ becomes available at that location, the transplantation may be eligible for *coverage*.

The cost of screening is covered up to the cost of the identification of one viable donor candidate. Additional community or global screenings for a donor are not covered.

Acquisition and Transplantation

Benefits for acquisition and transplantation include the removal of an organ from a living donor or cadaver and implantation of the organ or tissue into a recipient.

- When the transplant requires surgical removal of the donated part from a living donor and we cover both the recipient and donor, we provide *benefits* to both, each pursuant to the terms of each person’s respective contract.

- If we cover only the transplant recipient, we provide *benefits* for the recipient and for the donor, but only to the extent that donor *benefits* are not available under any other health benefit plan or paid by a procurement agency. *Benefits* provided for the donor are charged against, and limited by, the recipient's *coverage*.
- If we cover the transplant recipient and the donor is deceased, the costs of recovering the organ or tissue (including the cost of transportation) will be paid if billed by a *hospital*. Such costs are charged against, and limited by, the recipient's *benefits* under this *coverage*.

Donor charges accumulate towards the recipient's *benefit period maximums* or any other applicable limits and maximums.

Payment will not be made for the purchase of human organs that are sold rather than donated to the recipient.

Transplantation of placental umbilical cord blood stem cells from related or unrelated donors may be considered *medically necessary* in patients with an appropriate indication for allogeneic stem-cell transplant.

Collection and storage of cord blood from a neonate may be considered *medically necessary* when an allogeneic transplant is imminent in an identified recipient with a diagnosis that is consistent with the possible need for allogeneic transplant.

Transplantation of cord blood stem cells from related or unrelated donors is considered *investigational* in all other situations.

Post-Transplant Services

Benefits for post-transplant services include post-surgical care.

Blue Distinction Centers for Transplant (BDCT)

Blue Distinction Centers for Transplant are a cooperative effort of the Blue Cross and/or Blue Shield Plans, the Blue Cross Blue Shield Association and in-network medical institutions to provide patients who need transplants with access to leading transplant centers through a coordinated, streamlined program of transplant management.

When a transplant is performed at a BDCT facility designated for that transplant type, certain *benefits* are provided for travel and lodging expenses for you and one support companion. Items that are not covered include, but are not limited to, alcohol, tobacco, car rental, entertainment, telephone calls, personal care items, and expenses for persons other than you and your companion.

Other Services

Contraceptives

Unless otherwise covered under a *prescription drug* program, *benefits* for contraceptives include those contraceptive products or devices mandated by PPACA including but not limited to contraceptive implants such as intrauterine devices (IUD) and services related to the fitting, insertion, implantation and removal of such devices.

Diagnostic Hearing Services

Benefits for hearing services include only hearing testing for diagnostic purposes.

Hearing aids and exams for the purchase and fitting of *hearing aids* are not covered.

Foot Care

Benefits for nonroutine foot care include surgical treatment of structural defects or anomalies such as fractures or hammertoes. *Benefits* also include surgical removal of ingrown toenails and bunions when provided for specific medical diagnoses. An injectable local anesthetic must be used in order for a foot procedure to be considered “toenail surgery”.

Routine foot care services are not covered unless the services are *medically necessary* for specific medical diagnoses.

Orthodontic Treatment of Congenital Cleft Palates

Benefits for orthodontics include orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus.

Routine Costs Associated with Approved Clinical Trials

If a *member* is eligible to participate in an *approved clinical trial* (according to the trial protocol), with respect to treatment of cancer or other life-threatening disease or condition, and the *member’s provider* has concluded the *member’s* participation in the trial would be appropriate, *benefits* for *routine costs associated with approved clinical trials*.

Vision Care for Illness or Accidental Injury

Benefits for vision services include only eye care that is *medically necessary* to treat a condition arising from an illness or accidental injury to the eye. Covered services include *surgery* for medical conditions, symptomatic conditions and trauma. Vision screening related to a medical diagnosis, only for diagnostic purposes, is also covered.

When cataract *surgery* is performed, *benefits* for vision services include lens implants, with limitations, as described in the **Prosthetic Appliances** section.

Routine eye care examinations, refractive lenses (glasses or contact lenses) and routine tests are not covered. Replacement refractive lenses (glasses or contact lenses) prescribed for use with an intra-ocular lens transplant are not covered.

Prescription Drugs

Benefits for *prescription drugs* include *prescription drugs* dispensed for your *outpatient* use. You may purchase *prescription drugs* at *retail pharmacies,* through the designated *home delivery pharmacy*, or through the designated specialty pharmacy.

PRESCRIPTION DRUG BENEFIT LIMITATIONS

The *benefits* provided under your *prescription drug coverage* have the following limitations:

1. A *pharmacy* need not dispense a *prescription order* that in its professional judgment, should not be filled for any reason.
2. Unless the *provider* requests that the *brand drug* be dispensed, your *pharmacy* may replace a *brand drug* with a *generic drug*. If you ultimately decided to fill/refill your prescription with the *brand drug*, you will be charged the *brand drug cost share* plus the cost difference between the *generic* and *brand* medication.
3. Refills may be dispensed subject to federal and state law limitations and only in accordance with the number of refills designated on the original *prescription order*. Refills may not be dispensed more than one year after the date of the original *prescription order*.
4. When a *prescription order* is written for a *prescription drug* that has previously been dispensed to you or a *prescription order* is presented for a refill, the *prescription drug* will be dispensed only at such time as you have used 60% of the previous supply dispensed through the designated *home delivery pharmacy* or 75% of the previous supply dispensed through a *retail pharmacy* or specialty pharmacy in accordance with the associated *prescription order*. Extended release opioid medications will only be dispensed if you have used 83% of the previous supply. See **Summary of Restrictions Applicable to Prescriptions Drug Benefits** section for example.
5. Certain *prescription drugs* are not available for *home delivery dispensing* due to safety or quality concerns. These *prescription drugs* are available by *retail dispensing* or *specialty pharmacy* dispensing only.
6. All *prescription drugs* are subject to availability at the *retail*, *specialty*, or *home delivery pharmacy*.
7. Immunization agents for Preventive Drug *Coverage* are available at in-network pharmacies that are licensed to administer immunizations.
8. Select *specialty prescription drugs* will be subject to dispensing only through a designated *specialty pharmacy* unless otherwise approved by us.
9. *Prescription drugs* classified by the federal government as narcotics may be subject to dispensing or dosage limits based on standards of good pharmaceutical practice or state or federal regulations.
10. We reserve the right to determine the reasonable supply of any *prescription drug* based on standards of good pharmaceutical practice.
11. Certain *prescription drugs*, which are dispensed pursuant to a *prescription order* for your *outpatient* use, are subject to quantity limits. *Benefits* for these *prescription drugs* shall be available based on the quantity which we will determine, in our sole discretion, is a reasonable per prescription or per day supply for *retail dispensing*, *specialty pharmacy* dispensing, or *home delivery dispensing*.
12. Certain *prescription drugs* require *prior authorization* for *coverage* prior to the delivery of *covered drugs*.
13. Certain *prescription drugs*, which are dispensed pursuant to a *prescription order* for your *outpatient* use, are subject to step therapy.

EXCLUSIONS

Except as specifically provided in this *Benefits Booklet* or as we are required to provide based on state or federal law, we will not provide *benefits* for the following services, supplies, equipment, *prescription drugs* or charges:

Anesthesia	• Anesthesia when administered by the assistant to the operating *physician* or the attending *physician*
Blood and Administration	• Prophylactic blood, cord blood or bone marrow storage to be used in the event of an accident or unforeseen *surgery* or transplant
Clinical Trials	• Services or supplies that we consider to be *investigational*, except *Routine Costs Associated with Approved Clinical Trials*. *Routine costs for Clinical Trials* do not include any of the following and are therefore excluded from *coverage*: o The *investigational* drug, biological product, device, medical treatment, or procedure itself, unless otherwise covered under an agreement between a *provider* and *Capital* (or other Blue plan) o Items and services that are provided solely to satisfy data collection and analysis needs and not used in the direct clinical management of the patient. o Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis o Services and supplies customarily provided by the research sponsors free of charge for any enrollee in the approved clinical trial o Your travel expenses
Convenience	• Personal hygiene, comfort, or convenience items such as, but not limited to: o Air conditioners, humidifiers, air purifiers and filters o Physical fitness or exercise equipment (including, but not limited to inversion, tilt, or suspension device or table) o Radios and televisions o Beauty or barber shop services o Incontinence supplies, deodorants o Guest trays, chairlifts, elevators, or any other modification to real or personal property, whether or not recommended by a *provider* o Spa or health club memberships • Membership dues, subscription fees, charges for service policies, insurance premiums, and other payments such as premiums, which entitle those enrolled to services; repairs; or replacement of devices, equipment, or parts without charge or at a reduced charge

Cosmetic Surgery	• Cosmetic procedures or services related to cosmetic procedures performed primarily to improve the appearance of any portion of the body and from which no significant improvement in the functioning of the body part can be expected, except as otherwise required by law. This exclusion does not apply to cosmetic procedures or services related to cosmetic procedures performed to correct a deformity resulting from *birth defect,* medical condition or disease, or accidental injury. For purposes of this exclusion, prior *surgery* is not considered an accidental injury.
Court Ordered Services	• Court ordered services when not *medically necessary* or not a covered *benefit*
Custodial Care	• *Custodial care*, domiciliary care, residential care, protective care, and supportive care, including educational services, rest cures, convalescent care, or respite care not related to *hospice* services
Dental Care	• All dental services after stabilization in an emergency following an accidental injury, including but not limited to, oral *surgery* for replacement teeth, oral prosthetic devices, bridges, or orthodontics • Services directly related to the care, filling, removal, or replacement of teeth; orthodontic care; treatment of injuries to or diseases of the teeth, gums, or structures directly supporting or attached to the teeth; or for dental implants, except where mandated by law or as specifically provided in this *Benefits Booklet*
Durable Medical Equipment (DME)/Supplies	• Back-up or secondary DME and prosthetic appliances, except ventilators • DME requested specifically for travel purposes, recreational or athletic activities, or when the intended use is primarily outside the home, except as specified in this *Benefits Booklet*. • Replacement of lost or stolen DME, including prosthetic appliances, within the expected useful life of the originally purchased DME • Continued repair of DME after its useful life is exhausted • Replacement of defective or nonfunctional DME when the manufacturer's warranty covers the equipment. • Upgrade or replacement of DME when the existing equipment is functional, except when there is a change in your health such that the current equipment no longer meets your medical needs • Modifications and adjustments to and accessories for DME, orthotics, prosthetics, and diabetic shoes that do not improve the functionality of the equipment • DME intended for use in a facility (*hospital* grade equipment) • Home delivery, education, and set-up charges associated with purchase or rental of DME, as such charges are not separately

	reimbursable and are considered part of the rental or purchase price
	• Items including but not limited to items used as safety devices and for elastic sleeves (except where otherwise required by law), thermometers, bandages, gauze, dressings, cotton balls, tape, adhesive removers, face masks, replacement batteries or alcohol pads.
	• Supportive environmental materials and equipment such as handrails, ramps, telephones, and similar service appliances and devices
Education	• Services provided at unapproved sites, for your individualized education program (IEP), or as part of your education, except as required by statute or explicit legal requirement
Eligibility	• Services incurred prior to your *effective date of coverage*
	• Services incurred after your termination date of *coverage* except as provided for in this *Benefits Booklet*
Eligible Provider	• Services not billed and either performed by, or under the supervision of, an eligible *provider*
	• Services rendered by a *provider* who is a member of your *immediate family*
	• Services performed by a *professional provider* enrolled in an education or training program when such services are related to the education or training program, including services performed by a resident *physician* under the supervision of a *professional provider*
	• Services from *providers* that are excluded or debarred from government plans
Experimental or Investigational	• Services or supplies we consider to be *investigational,* except where otherwise required by law
Fertility Services	• Donor services related to assisted fertilization
	• Any treatment or procedure leading to or in connection with assisted fertilization, such as, but not limited to, in vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT),and artificial insemination except as provided in this *Benefits Booklet*
	• For *fertility* services if the present condition of *infertility* is due, in part or in its entirety, to either party having undergone a voluntary sterilization procedure and/or an unsuccessful reversal of a voluntary sterilization procedure
Food/ Nutritional Support	• Enteral nutrition due to lactose intolerance or other milk allergies
	• Blenderized baby food, regular shelf food, or special infant formula, except as specified in this *Benefits Booklet*
	• All other enteral formulas, nutritional supplements, and other enteral products administered orally or through a tube and

	provided due to the inability to take adequate calories by regular diet, except where mandated by law and as specifically provided in this *Benefits Booklet*
Foot Care	• Routine foot care, unless otherwise mandated by law. Routine foot care involves, but is not limited to, hygiene and preventive maintenance (e.g., cleaning and soaking of feet, use of skin creams to maintain skin tone); treatment of bunions (except capsular or bone surgery), toe nails (except *surgery* for ingrown nails); corns, removal or reduction or warts, calluses, fallen arches, flat feet, weak feet, chronic foot strain, or other foot complaints • Supportive devices of the feet, unless otherwise mandated by law and when not an integral part of a leg brace. Supportive devices of the feet include foot supports, heel supports, shoe inserts, and all foot orthotics, whether custom fabricated or sold as is.
Genetic Testing	• At-home genetic testing, including confirmatory testing for abnormalities detected by at-home genetic testing, and genetic testing performed primarily for the clinical management of family members who are not *members* and are, therefore, not eligible for *coverage*
Hearing Aids	• Hearing aids, examinations for the prescription or fitting of hearing aids, and all related services
Immunizations	• Immunizations required for travel or employment except as required by law • Immunizations administered at a pharmacy are not eligible under the medical benefit
Legal Obligation	• Services received in a country with which United States law prohibits transactions • Services which you would have no legal obligation to pay • Services not permitted by state law • Supplying medical testimony
Medically Necessary	• Services not *medically necessary* as determined by our Medical Director(s) or his/her designee(s)
Medicare	• Items or services paid for by *Medicare* when *Medicare* is primary, consistent with the Medicare Secondary Payer Laws, for any *member* who is enrolled in *Medicare*. This exclusion does not apply to the extent the *contract holder* is obligated by law to offer the *member* the *benefits* of this *coverage* as primary to *Medicare.*
Medications	• All prescription and *over-the-counter* drugs dispensed by a pharmacy or *provider* for your *outpatient* use, whether or not billed by a *facility provider*, except for allergy serums, mandated pharmacological agents used for controlling blood sugar, FDA-approved drugs for the treatment of substance use disorder, and where otherwise required by law

	• All prescription and *over-the-counter* drugs dispensed by a *home health care agency provider*, with the exception of intravenous drugs administered under a treatment plan that we approved
Military Services	• Services received by veterans and active military personnel at facilities operated by the U.S. Department of Veterans Affairs or by the Department of Defense, unless payment is required by law
Miscellaneous	• Care of conditions that federal, state, or local law requires to be treated in a public facility • Any services rendered while in custody of, or incarcerated by any federal, state, territorial, or municipal agency or body, even if the services are provided outside of any such custodial or incarcerating facility or building, unless payment is required by law • Services you receive from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group • Charges for: failure to keep a scheduled appointment with a *provider*, completion of a claim or insurance form, obtaining copies of medical records, your decision to cancel a *surgery*, or hospital-mandated on-call service • Charges that exceed the *allowed amount*, except as otherwise provided for in this *Benefits Booklet* • *Cost sharing* amounts you must pay as outlined in this *Benefits Booklet* • Autopsies or any other services rendered after a *member's* death • Any services related to or rendered in connection with a noncovered service, including but not limited to anesthesia and diagnostic services • Any other service or treatment, except as provided in this *Benefits Booklet* • Routine examination, counseling services, testing, screening, immunization, treatment or preparation of specialized reports solely for insurance, licensing, or employment, including but not limited to: pre-marital examinations, employment or occupational screenings, physicals for college, camp, sports, or travel • Community support services or programs, including but not limited to community-based wrap-around services, self-help/peer support, community integration support, employment support, psychoeducational services, mental clubhouses, and outreach services
Motor Vehicle Accident	• Cost of *hospital*, medical, or other *benefits* resulting from accidental bodily injury due to a motor vehicle accident, to the extent such *benefits* are payable under any medical expense payment provision (by whatever terminology used, including such *benefits* mandated by law) of any motor vehicle insurance policy

Oral Surgery	• Oral *surgery* except as specifically provided in this *Benefits Booklet*
Prosthetics	• Prosthetic appliances dispensed to a patient prior to performance of the procedure that will necessitate the use of the device • Wigs and other items intended to replace hair loss due to male or female pattern baldness
Private Duty Nursing	• Private duty nursing services
Sexual Dysfunction	• Treatment, medicines, devices, or drugs in connection with sexual dysfunction, both male and female, not related to organic disease or injury
Sports Medicine	• Sports medicine treatment or equipment intended primarily to enhance athletic performance
Surgery	• Non-neonatal circumcisions, unless *medically necessary* • All types of skin tag removal, regardless of symptoms or signs that might be present, except when the condition of diabetes is present
Therapy Services	• Applied behavior analysis therapy services provided for any diagnoses other than autism spectrum disorders. • Other biofeedback therapy • Maintenance therapy services, except for manipulation therapy for chronic pain management or as required by law • Occupational therapy or physical therapy for work hardening, vocational and prevocational assessment and training, and functional capacity evaluations, as well as this therapy's use towards enhancement of athletic skills or activities • All rehabilitative therapy, other than as described in the *Benefits Booklet*, including but not limited to play, music, hippotherapy, and recreational therapy
Temporomandibular Joint Disorder	• Treatment of temporomandibular joint disorder (TMJ) including, but not limited to *surgery*, intra-oral devices, splints, physical therapy, and other therapeutic devices and interventions, except for evaluation to diagnose TMJ or treatment of TMJ caused by physical trauma resulting from an accident • Intra-oral removable prosthetic devices or appliances regardless of the cause of TMJ
Transplant	• Services related to organ donation where you serve as an organ donor to a nonmember • Transplant services where human organs were sold rather than donated and for devices functioning as total artificial organs that are not approved by the FDA
Travel	• Travel expenses incurred together with *benefits* unless specifically identified as a covered service elsewhere in this *Benefits Booklet*

Vision Care	• Routine eyeglasses, refractive lenses (glasses or contact lenses), replacement refractive lenses, and supplies, including but not limited to refractive lenses prescribed for use with an intra-ocular lens transplant • Routine vision examinations, except for vision screening related to a medical diagnosis for diagnostic purposes. Vision examinations include, but are not limited to: routine eye exams, prescribing or fitting eyeglasses or contact lenses (except for aphakic patients); and refraction, regardless of whether it results in the prescription of glasses or contact lenses. • Surgical procedures performed solely to eliminate the need for or reduce the prescription of corrective vision lenses, including but not limited to corneal surgery, radial keratotomy, and refractive keratoplasty
War	• Any illness or injury suffered after your *effective date of coverage*, which resulted from an act of war, whether declared or undeclared. War is a hostile conflict by means of armed forces, carried on between countries, states or rulers, or sometimes between political communities within the same country or state. An act of terrorism does not constitute an act of war. Terrorism is the use of threat of violence to intimidate or cause panic, especially as a means of achieving a political end.
Weight Loss	• *Inpatient* stays to bring about nonsurgical weight reduction
Work-Related Illness or Injury	• Any illness or injury that occurs in the course of employment if *benefits* or compensation are available or required, in whole or in part, under a workers' compensation policy or any federal, state, or local government's workers' compensation law or occupational disease law, including but not limited to the United States Longshoreman's and Harbor Workers' Compensation Act as amended from time to time. This exclusion applies whether or not you make a claim for the *benefits* or compensation under the applicable workers' compensation policy or *coverage*, or the applicable law.

In addition, under the *Prescription Drug benefits*, except as specifically provided in this *Benefits Booklet* or as we are required to provide based on state or federal law, we will not provide *benefits* for:

Prescription Drugs (Drug Program)	• Drugs that do not legally require a prescription as determined by us unless payment is required by law • *Prescription drugs* that have an *over-the-counter* equivalent or *over-the-counter* alternative, except as mandated by law • Devices or appliances, including but not limited to, therapeutic devices, artificial appliances, or similar devices or appliances, except for diabetic supplies • The administration or injection of covered drugs

- *Prescription drugs* received in and billed by a hospital, nursing home, home for the aged, convalescent home, home health care agency, residential treatment facility, or similar institution
- All formulations of allergy immunotherapy (including oral), serums, desensitization serums, venom
- *Cost sharing amounts*, differences between *brand drug* and *generic drug* prices (i.e. *ancillary charges*), and balances paid or due to *out-of-network pharmacies* required to be paid by you under this *coverage*
- *Prescription drugs* that require *prior authorization* if *prior authorization* is not obtained before dispensing the *prescription drugs*
- *Prescription drugs* that require step therapy if *prior authorization* is not obtained before dispensing the *prescription drugs*
- Quantities that exceed the limits/levels we established*,* unless *prior authorization* is obtained before the *prescription drug* is dispensed
- Durable medical equipment (DME), except glucose monitors
- Medical foods, blenderized baby food, regular shelf food, or special infant formula, except as required by law
- Immunization agents, except immunization agents for *preventive coverage*, biological sera, blood, blood products
- Requests for reimbursement of *covered drugs* submitted after the allowed timeframe for reimbursement except for requests for reimbursements from state and federal agencies
- *All prescription drugs* and *over-the-counter* drugs dispensed:
  - during travel by a *physician* employed by a hotel, cruise line, spa, or similar facility.
  - in a physician's office or by a facility provider.

- *Prescription drugs* and *over-the-counter* drugs used:
  - primarily to enhance physical or athletic performance or appearance.
  - to promote hair growth.
  - for cosmetic purposes.
- Injectable medications that cannot be self-administered except immunization agents for *preventive coverage*;
- *Coverage* through coordination of *benefits*;
- *Requests* received through *home delivery dispensing* and submitted for reimbursement under *retail dispensing benefits*;
- Requests received through a *retail pharmacy* for *retail dispensing* and submitted for reimbursement under *home delivery dispensing benefits*

- Requests received for select *specialty drugs* through a *retail* or *home delivery pharmacy* and submitted for reimbursement under *specialty drug* dispensing benefits
- Replacement of lost, stolen or damaged *prescription drugs, unless otherwise approved by* us
- *Prescription drugs* used for immunizations required for travel or employment except as required by law
- *Drugs* received through an out-of-network home delivery or specialty pharmacy
- *Prescription drugs* used in connection with noncovered medical services
- Any other *prescription drugs* and *over-the-counter* drugs, service or treatment, except as provided in this *Benefits Booklet*

CLINICAL MANAGEMENT PROGRAMS FOR MEDICAL BENEFITS

We offer Clinical Management programs intended to provide a personal touch to the administration of your *benefits* available under this *coverage*. We focus program goals on providing you with the skills necessary to become more involved in the prevention, treatment and recovery processes for your specific condition, illness or injury.

Clinical Management programs include:

- Utilization Management
- Population Health Management
- Quality Improvement

All of our standard products include the full array of these programs.

Utilization Management

The purpose of the Utilization Management (UM) Program is to ensure that high quality, cost-effective, and medically appropriate services are provided to *members* through a comprehensive framework in accordance with applicable *coverage* terms and conditions, regulatory and accreditation requirements. The UM program includes *Preauthorization*, Concurrent Review and Retrospective Review.

Medical Necessity Review

Your *coverage* provides *benefits* only for services we or our designee determine to be *medically necessary* as defined in the **Definitions** section.

When *preauthorization* is required, we, or our designee, determine *medical necessity* before the service is provided. However, when *preauthorization* is not required, a service may still undergo a *medical necessity* review and must still be considered *medically necessary* to be eligible for *coverage*.

An *in-network provider* will accept our determination of *medical necessity*. You will not be billed by an *in-network provider* for services that we determine are not *medically necessary*.

An *out-of-network provider* is not obligated to accept our *preauthorization* denial or determination of *medical necessity*, and therefore, may bill you for services determined not to be *medically necessary*. You are solely responsible for payment of such services and can avoid this responsibility by choosing an *in-network provider*.

Even if an *in-network provider* recommends that you receive services from an *out-of-network provider*, you are responsible for payment of all services determined by us to be not *medically necessary*.

NOTE: A *provider's* belief that a service is appropriate for you does not mean the service is covered. Likewise, a *provider's* recommendation to you to receive a given healthcare service does not mean that the service is *medically necessary* and/or a covered service.

You or the *provider* may contact *our Utilization Management* department to determine whether a service is *medically necessary*. The criteria for *medical necessity* determinations, including those made with respect to mental *health* or *substance use disorder benefits*, will be made available to any current *member* or *in-network provider* upon request.

Investigational Treatment Review

Your *coverage* does not include services we determine to be *investigational* as defined in the **Definitions** section.

However, we recognize that situations occur when you elect to pursue *investigational* treatment at your own expense. If you receive a service we consider to be *investigational*, you are solely responsible for payment of these services and the noncovered amount will not be applied to the *out-of-pocket maximum* or *deductible,* if applicable.

You or a *provider* may contact us to determine whether we consider a service to be *investigational*.

Preauthorization

Preauthorization is a process for evaluating requests for services prior to the delivery of care. The general purpose of the *preauthorization* program is to help you receive the following:

- Medically appropriate treatment to meet individual needs and
- Care provided by *in-network providers* delivered in an efficient and effective manner.

In-network providers are responsible for obtaining required *preauthorizations*.

However, if an *out-of-network provider* is used, you are responsible for obtaining the required *preauthorization;* failure to *preauthorize* may result in a denial of *coverage*.

You should refer to the **Preauthorization Program** attachment for information on this program. You should carefully review this attachment to determine whether services you wish to receive must be preauthorized by us and for instructions on how to obtain *preauthorization*. This listing may be updated periodically.

A *preauthorization* decision is issued within 15 calendar days of receiving all necessary information for nonurgent requests.

Concurrent Review Program

The Concurrent Review program includes concurrent review and discharge planning.

Concurrent Review – Concurrent review is conducted by our experienced clinicians and board-certified *physicians* who evaluate and monitor the quality and appropriateness of initial and ongoing medical care provided in *inpatient* settings (acute care hospitals, skilled nursing facilities, inpatient rehabilitation hospitals, and long-term acute care hospitals). In addition, the program is designed to facilitate identification and referral of *members* to other Clinical Management programs to identify potential quality of care issues; and to facilitate timely and appropriate discharge planning. A concurrent review decision is generally issued within one day of receiving all necessary information.

The UM program also includes concurrent review for select outpatient services. The outpatient concurrent review process involves the review of care and services received, consumption of resources, current clinical status, and progress experienced while treatment is being delivered. This process allows for modification of treatment plans to align with the clinical picture and ensure continued medical necessity requirements are met. A concurrent review decision for non-urgent requests for an outpatient service is issued within fifteen (15) calendar days of receiving all necessary information.

Discharge Planning – Discharge planning is performed by concurrent review clinicians who communicate with hospital staff to facilitate the delivery of post-discharge care at the level most appropriate to the patient's condition. Discharge planning is also intended to promote the use of

appropriate outpatient follow-up services to prevent avoidable complications and/or readmissions following inpatient confinement.

Retrospective Review

Our clinicians conduct retrospective review through the review of medical records to determine whether the care and services provided and submitted for payment were *medically necessary*. Retrospective review is performed when we receive a claim for services that have already been provided. Claims that require retrospective review include, but are not limited to, claims incurred any of the following ways:

- Under *coverage* that does not include the *preauthorization* program.
- In situations such as an emergency when securing an authorization within required time frames is not practical or possible.
- For services that are potentially *investigational* or cosmetic in nature.
- For services that have not complied with *preauthorization* requirements.

We issue a retrospective review decision generally within 30 calendar days of receiving all necessary information.

If a retrospective review finds a procedure to not be *medically necessary*, you may be liable for payment to the *provider* if the *provider* is *out-of-network*.

Population Health Management

Our Population Health Management programs improve member health through a seamless set of interdisciplinary interventional strategies. Our goal is to meet you where you are in your healthcare journey — healthy, rising risk, chronic or catastrophically ill. At each stage, we provide appropriate educational and clinical services to improve health and quality of life. To meet our population health management strategies, we deliver the following services and programs:

Care Management

Our Care Management programs are proactive, and designed for *members* with chronic, acute and/or complex medical needs who could benefit from additional support with coordinating their care.

Programs include, but are not limited to the following:

- Complex Case Management
- Chronic Condition/Disease Management
- High Risk Maternity Management
- Oncology Case Management
- Transitions of Care
- Transplant Case Management

Complex Case Management

The Complex Case Management program is an interdisciplinary service encompassing a wide variety of resources, information and specialized assistance for:

- With complex medical needs. Complex medical needs require additional support in order to respond to the *member's* health or medical needs requiring enhanced medical oversight.

- At risk for future adverse health events, which may include *hospital* admission or readmission.
- Identified with Social Determinants of Health (SDoH) barriers. SDoH barriers can impede one's health, well-being, and safety; examples include, but are not limited to, risk of eviction, access to healthy meals, and transportation barriers.

The Complex Case Management resources can help *members* manage complex health needs and improve quality of life.

Chronic Condition/Disease Management

The Chronic Condition/Disease Management program is an interdisciplinary, collaborative program that assesses the health needs of *members* with chronic conditions and provides customized member education, counseling, and information to increase the *member's* ability to self-manage their condition(s).

The goal of chronic condition management is to improve the following:

- Member and caregiver knowledge and self-management.
- Resource utilization.
- Quality of life through achieving and maintaining a steady state of health.
- Achieve and maintain a steady state of health.

Although the program has many areas of concentration, self-management action plans, education, knowledge enhancement, and medication optimization and adherence are of particular importance.

Examples of conditions addressed in the program could include, but are not limited to, adult and pediatric asthma, coronary artery disease, chronic obstructive pulmonary disease (COPD), adult and pediatric diabetes, heart failure, digestive disorders, kidney disease, and hypertension.

High Risk Maternity Management

We offer a comprehensive high risk maternity management program that provides care coordination, educational materials and support to pregnant women in all phases of pregnancy and delivery, including high-risk labor and delivery, newborn care and post-partum care.

The focus of the Maternity Management program is to help pregnant members have a healthy pregnancy and baby through a variety of interventions, based upon individual needs.

Oncology Case Management

Registered nurses, experienced in cancer care and advanced care planning, provide assessment and support to *members* at all stages of adjustment to a cancer diagnosis.

Transitions of Care

The Transitions of Care program assists *members* in understanding their post-discharge treatment plan and thereby helps prevent avoidable complications and readmissions.

Transplant Case Management

Registered nurses experienced in transplant care provide assessment, education, and support during the transplant process. Core goals of this program include education and support regarding treatments, medical benefit plan, and Blue Distinction Centers for Transplants®.

Health Education and Wellness

Our Health Education and Wellness programs are provided through various areas/services at Capital Blue Cross. We believe that motivating individuals to adopt healthier lifestyles results in better outcomes when individuals have access to comprehensive and accurate health and wellness information.

Care Navigation and Advocacy

We provide *member*-specific care navigation and advocacy services including but not limited to:

- Answering questions about enrollment and *coverage*.
- Assisting with transfers to care management, as needed, for chronic conditions and acute healthcare needs.
- Providing access to health and wellness tools that help tobacco cessation, nutrition or stress management.
- Providing access to decision-support tools and a Symptom Checker so that you can make informed choices for your lifestyle and healthcare needs.

Quality Improvement Program

The Quality Improvement Program is a multidisciplinary program we designed to help you get accessible quality care and services. The program provides for the monitoring, evaluation, measurement, and reporting on the quality and safety of medical care, programs, and services.

The scope of our Quality Improvement Program encompasses all aspects of the care and services provided to our *members* and includes, but is not limited to the following:

- Improvement in our *members'* health and experience of care.
- Coordination and continuity of programs and services across all levels of care.
- Facilitation of appropriate accessibility and availability of care and services.
- Monitoring the effectiveness of the care and services our *members* receive.
- Evaluation and investigation of complaints and clinical appeals.
- Identification and evaluation of and intervention (as necessary) for all potential quality issues.
- Conducting and analyzing *member* satisfaction surveys.
- Monitoring of *provider* practice patterns and ensuring they are meeting our *members'* needs.
- Compliance with all regulatory and accrediting standards.

How We Evaluate New Technology

Changes in medical procedures, behavioral health procedures, drugs, and devices occur at a rapid rate. We strive to remain knowledgeable about recent medical developments and best practice standards to facilitate processes that keep our medical policies up to date. A committee of local practicing *physicians* representing various specialties evaluates the use of new medical technologies and new applications of existing technologies. This committee is known as the Clinical Advisory Committee. The *physicians* on this committee provide clinical input to us concerning our medical policies, with an emphasis on community practice standards. The Committee, along with our Medical Directors and Medical Policy staff, look at issues such as the effectiveness and safety of the new technology in treating various conditions, as well as the associated risks.

The Clinical Advisory Committee meets regularly to review information from a variety of sources, including technology evaluation bodies, current medical literature, national medical associations, *specialists* and professionals with expertise in the technology, and government agencies such as the FDA, the National Institutes of Health, and the CDC. The five key criteria used by the Committee to evaluate new technology are:

- The technology must have final approval from the appropriate governmental regulatory bodies.
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
- The technology must improve the net health outcome.
- The technology must be as beneficial as any established alternatives.
- The improvement must be attainable outside the investigational setting.

After reviewing and discussing all of the available information and evaluating the new technology based on the criteria listed above, the Clinical Advisory committee makes final determinations concerning medical policy after assessing *provider* and *member* impacts of recommended policies.

Our medical policies are developed to assist us in administering *benefits* and do not constitute medical advice. Although the medical policies may assist you and your *provider* in making informed healthcare decisions, you and your treating *providers* are solely responsible for treatment decisions. *Benefits* for all services are subject to the terms of this *coverage*.

Alternative Treatment Plans

Notwithstanding anything under this *coverage* to the contrary, the *contract holder*, in its sole discretion, may elect to provide *benefits* pursuant to an approved alternative treatment plan for services that would otherwise not be covered. Such services require *preauthorization* from *Capital*. All decisions regarding the treatment to be provided to a *member* remain the responsibility of the treating *physician* and the *member*.

If the *contract holder* elects to provide alternative *benefits* in one instance, it does not obligate the *contract holder* to provide the same or similar *benefits* in any other instance, nor can it be construed as a waiver of *Capital's* right to administer this *coverage* thereafter in strict accordance with its express terms.

PHARMACEUTICAL UTILIZATION MANAGEMENT PROGRAMS

Pharmaceutical Utilization Management Programs are designed to safeguard you from potentially harmful drug interactions and side effects. They promote clinically appropriate therapy, prescription *drug* utilization and compliance with recommended drug quantity, dosage and intended use of product.

A wide range of Pharmaceutical Utilization Management Programs are available under this *coverage*.

Programs include, but are not limited to the following:

- Drug Utilization Review
- *Prior Authorization*
- Step Therapy
- Drug Quantity Management (Quantity Level Limits)

All of our standard products include the full array of Pharmaceutical Utilization Management Programs. Under specific circumstances, groups may choose not to include all or some of the Pharmaceutical Utilization Management Programs described here. Therefore, it is important for you to determine program eligibility with the *contract holder* before assuming that all of these programs are available or apply to you.

Drug Utilization Review (DUR)

Drug utilization review (DUR) evaluates each *prescription drug* dispensed to you against your prescription profile. This profile reflects all *prescription drugs* acquired from in-network *retail pharmacies*, in-network *specialty pharmacies*, and in-network *home delivery pharmacies* while covered by us. Concurrent DUR alerts the *pharmacist* to clinical and plan-specific criteria/edits warranting consideration prior to dispensing. Retrospective DUR alerts the *provider* to potential issues that may require further assessment.

A *covered drug* filled through *retail dispensing* from an *in-network pharmacy*, in-network *specialty pharmacy*, or from the designated *home delivery pharmacy* will be subject to a drug utilization review at the point-of-sale to identify potential concerns such as adverse drug interactions, duplicate therapies, early refills, and maximum dose.

Your prescription profile may be reviewed periodically to monitor appropriate care based on standards of good pharmaceutical practice. The retrospective drug utilization review assists in identifying any potential drug interactions, duplicate drug therapy, drug dosage and duration issues, drug misuse, drug over utilization, less than optimal drug utilization, and drug abuse. If a potential problem is identified, the *provider* will be notified to further assess and make any necessary changes in therapy or when appropriate and applicable. Interventions may include limiting access to a *provider* and/or dispensing *pharmacy* under appropriate circumstances.

Investigational Treatment Review

This *coverage* does not include *prescription drugs* and/or services that we or our designee determine to be *investigational* as defined in the **Definitions** section.

However, we recognize that situations occur when you elect to pursue *investigational* treatment at your own expense. If you receive a *prescription drug* and/or service which we consider to be *investigational*, you are solely responsible for payment of this *prescription drug* and/or service; and the noncovered amount will not be applied to the annual *out-of-pocket maximum* or *deductible,* if applicable.

You, a *provider*, or a *pharmacy* may contact us to determine whether we consider a *prescription drug* or service to be *investigational*.

Prior Authorization

To promote appropriate utilization, select *prescription drugs* require *prior authorization* before the *prescription drug* is dispensed by the *pharmacy* to be eligible as a *covered drug*. These *prescription drugs* are designated in the *formulary*. A copy of the *formulary* can be requested by going to **CapitalBlueCross.com** or calling Member Services. You will find the number on the back of your ID card.

Certain *covered drugs*, which are dispensed pursuant to a prescription order for your *outpatient* use, are subject to other limits and/or *prior authorization* requirements, as determined by us in our sole discretion from time to time and as thereafter communicated to you. For information as to which *covered drugs* are subject to any limits and/or require *prior authorization*, you can go to **CapitalBlueCross.com** or call Member Services. You will find the number on the back of your *ID card*.

You may initiate a *prior authorization* request by going to **CapitalBlueCross.com** or calling Member Services. You will find the number on the back of your ID card. *In-network providers* may assist you in obtaining the required *prior authorizations*. However, you are ultimately responsible for ensuring the required *prior authorization* is obtained.

A *prior authorization* decision is generally issued within two days of receiving all necessary information for nonurgent requests.

Step Therapy

Certain covered drugs that are dispensed pursuant to a *prescription order* for your *outpatient* use are subject to other limits and/or Step Therapy requirements, as determined by us in our sole discretion from time to time and as thereafter communicated to you.

Step Therapy uses clinical practice guidelines to encourage the use of the most cost effective and safest drug as a first-line therapy prior to progressing to costlier second-line therapy, if necessary. Drugs that are designated as second line or higher are automatically authorized at the point-of-sale if the prerequisite steps have been met. Drugs subject to Step Therapy are designated in the formulary.

For information as to which covered drugs are subject to any limits and/or Step Therapy, you can go to **CapitalBlueCross.com** or call Member Services. You will find the number on the back of your *ID card*.

Drug Quantity Management (Quantity Level Limits)

To facilitate proper utilization and encourage the use of therapeutically indicated drug regimens, some *prescription drugs*, which are dispensed pursuant to a *prescription order* for your *outpatient* use, are limited to specific quantities on a per prescription or per day supply basis. The quantity level limit for each drug is supported by drug studies, U.S. Food and Drug Administration and manufacturer guidelines, medical literature, safety, and accepted medical practice. Quantity level limits are applied to medications when the majority of clinically appropriate utilization will be addressed within the quantity allowed.

Benefits for such *covered drugs* shall be available based on the quantity which we will determine, in our sole discretion, is a reasonable supply for up to 30 days through *retail dispensing* and *specialty pharmacy* dispensing or up to 90 days through *home delivery dispensing*; or for each *prescription order*.

These *prescription drugs* are designated in the *formulary*. A copy of the *formulary* can be requested by going to **CapitalBlueCross.com** or calling Member Services. You will find the number on the back of your ID card.

For information as to which *covered drugs* are subject to any limits and/or require *prior authorization*, you can go to **CapitalBlueCross.com** or call Member Services. You will find the number on the back of your ID card.

Restrictive Generic Substitution Program

When a *prescription order* is filled with a *generic drug*, you are responsible for the applicable *coinsurance* and/or *copayment*.

When you request a *prescription order* be dispensed for a *brand drug*, that has an approved *generic drug* equivalent, you are responsible for the applicable *brand drug coinsurance* and/or *copayment* in addition to the difference in cost between such *brand drug* and the *generic drug* equivalent.

However, if the *provider* requires such *brand drug* be dispensed in place of an approved *generic drug* equivalent, you are responsible for only the applicable *brand drug coinsurance* and/or *copayment*.

Alternative Treatment Plans

Notwithstanding anything under this *coverage* to the contrary, the *contract holder*, in its sole discretion, may elect to provide *benefits*, including but not limited to select products which do not legally require a prescription, pursuant to an approved alternative treatment plan for services that would otherwise not be covered. Such services require *prior authorization* from *Capital*. All decisions regarding the treatment to be provided to a *member* remain the responsibility of the treating *physician* and the *member*.

If the *contract holder* elects to provide alternative *benefits* for a *member* in one instance, it does not obligate the *contract holder* to provide the same or similar *benefits* for any *member* in any other instance, nor can it be construed as a waiver of *Capital's* right to administer this *coverage* thereafter in strict accordance with its express terms.

MEMBERSHIP STATUS

To be considered a *subscriber*, child or *dependent* under this *coverage*, an individual must meet certain eligibility requirements and enroll (apply) for *coverage* within a specific timeframe.

There is a limited period of time to submit an *enrollment application* for initial enrollment and enrollment changes. *Subscribers* should consult with the *contract holder* to determine the specific timeframes applicable to them. *Subscribers* who fail to submit an *enrollment application* within these specific timeframes may not be allowed to enroll themselves and/or their newly eligible *dependents* until the next *annual enrollment* period. *Subscribers* should refer to the Timelines for Submission of Enrollment Applications section for more details.

Eligibility

Individuals must meet specific eligibility requirements to enroll or to continue being enrolled for *coverage*, unless otherwise approved in writing by us in advance of the *effective date of coverage*.

Nondiscrimination

We will not discriminate against any *subscriber* or *member* in eligibility, continued eligibility or variation in premium amounts by virtue of any of the following: (i) the *subscriber* or *member* taking any action to enforce his/her rights under applicable law; (ii) on the basis of race, color, national origin, disability, sex, gender identity or sexual orientation; or (iii) health status-related factors pertaining to the *subscriber* or *member*. Factors include health status, medical condition, claims experience, receipt of healthcare, medical history, genetic information, evidence of insurability and disability.

Subscriber

An individual must meet all eligibility criteria specified by the *contract holder* and approved by us to enroll in this *coverage* as a *subscriber*. These criteria include meeting all requirements to participate in the *contract holder's* health benefit program, including compliance with any probationary or waiting period established by the *contract holder*.

Dependent – Spouse

An individual must be the lawful spouse of the *subscriber* to enroll in this *coverage* as a *dependent* spouse.

We reserve the right to require that a spouse of a *subscriber* provide documentation demonstrating marriage to the *subscriber*, including, but not limited to, marriage certificate, court order or joint statement of common law marriage as determined by us.

Dependent – Domestic Partner

To enroll in this *coverage* as a *dependent* domestic partner, an individual must be in a relationship with another adult partner of the same or opposite sex, and who live together and share a domestic life, but are not married or joined by a civil union.

We reserve the right to request documentation that demonstrates domestic partnership prior to commencing *coverage* for the domestic partner.

Child

To enroll under this *coverage* as a child, an individual must be under the age of 26 and meet one of the following criteria:

- A birth child of the *subscriber,* or the *subscriber's* spouse, or the *subscriber's* domestic partner.
- A child legally adopted by or placed for adoption with the *subscriber,* or the *subscriber's* spouse, or the *subscriber's* domestic partner.
- A ward (a child for whom the *subscriber,* or the *subscriber's* spouse, or the *subscriber's* domestic partner has been granted legal custody by a court of competent jurisdiction).
- A child for whom the *subscriber,* or the *subscriber's* spouse, or the *subscriber's* domestic partner is required to provide healthcare *coverage* pursuant to Qualified Medical Child Support Order (QMCSO).

Dependent ‑Child Age 26 or Older with a Disability

An individual must be an unmarried child age 26 or older to enroll under this *coverage* as a *dependent* child with a disability. The child must meet all of the following criteria:

- A birth child, adopted child, or *ward* of the *subscriber* or the *subscriber's* spouse, or the *subscriber's domestic partner*.
- Mentally or physically incapable of earning a living; or unable to engage in self-sustaining employment by reason of any medically determinable physical or mental impairment(s) which has lasted or can be expected to last for a continuous period of not less than 12 months.
- Chiefly dependent upon the *subscriber,* or the *subscriber's* spouse, or the *subscriber's domestic partner* for support and maintenance, provided that all the following are true:
  - The incapacity began before age 26.
  - The *subscriber* provides us with proof of incapacity within 31 days after the *dependent* child with a disability reaches age 26.
  - The *subscriber* provides related information as otherwise requested by us, but not more frequently than annually.

Extension of Eligibility for Students on Medically Necessary Leave of Absence

Eligibility to enroll under this *coverage* as a child will be extended past the limiting age when the child's education program at an accredited postsecondary educational institution has been interrupted due to a *medically necessary* leave of absence.

We shall not terminate *coverage* of a child due to a *medically necessary* leave of absence before the earlier of the following:

- The date that is one year after the first day of the *medically necessary* leave of absence.
- The date on which the *coverage* would otherwise terminate under the terms of the *group contract*.

To qualify for this extension of eligibility, the child or *subscriber* must submit to us certification by a treating physician that states the child is suffering from a serious illness or injury and that the leave of absence is *medically necessary*.

Extension of Eligibility for Students on Military Duty

Eligibility to enroll under this *coverage* as a child will be extended, regardless of age, when the child's education program at an accredited educational institution was interrupted due to military duty. In order to be eligible for the extension of eligibility, the child must have been a full-time student eligible for health insurance *coverage* under their parent's health insurance policy and either of the following:

- A member of the Pennsylvania National Guard or any reserve component of the armed forces of the United States who was called or ordered to active duty, other than active duty for training, for a period of 30 or more consecutive days, or
- A member of the Pennsylvania National Guard ordered to active State duty, including duty under 35 Pa.C.S. Ch. 76 (relating to Emergency Management Assistance Compact), for a period of 30 or more consecutive days.

The extension of eligibility will apply so long as the child maintains enrollment as a full-time student and shall be equal to the duration of service on active duty or active State duty.

To qualify for this extension of eligibility the child must submit the following forms to us:

- The form approved by the Pennsylvania Department of Military and Veterans Affairs which notifies an insurer that the *dependent* has been placed on active duty.
- The form approved by the Pennsylvania Department of Military and Veterans Affairs which notifies an insurer that the *dependent* is no longer on active duty.
- The form approved by the Pennsylvania Department of Military and Veterans Affairs which shows that the *dependent* has reenrolled as a full-time student for the first term or semester starting 60 or more days after the *dependent's* release from active duty.

The above forms can be obtained by contacting the Pennsylvania Department of Military and Veterans Affairs or visiting their website.

Enrollment

When *members* "enroll" with us, they agree to participate in a contract for *benefits* between the *contract holder* and us. All qualified requests to enroll or to change enrollment must be made through the *contract holder*.

Every *member* must complete and submit to *Capital*, through the *contract holder*, an application for *coverage*, which is available from the *contract holder*. Each *member* must also enroll within certain time periods after becoming eligible. These requirements are described in the *group policy*.

Timelines for Submission of Enrollment Applications

There is a limited period of time to submit an *enrollment application* for initial enrollment and enrollment changes. *Subscribers* should consult with the *contract holder* to determine the specific timeframes applicable to their *coverage*.

However, we will only accept from the *contract holder enrollment applications* for initial enrollment or enrollment changes up to 60 days after the *member* is eligible for *coverage* under the *group contract* or as allowed by law. Therefore, the *subscriber* should immediately submit an *enrollment application* to the *contract holder* to allow the *contract holder* ample time to submit the *enrollment application* to us.

Subscribers who fail to submit an *enrollment application* within these specific timeframes may not be allowed to enroll themselves and/or their newly eligible *dependents* until the next *annual enrollment* period.

Initial Enrollment

"Initial" is the term used to represent eligible *members* enrolling for *coverage* with us for the first time. The initial *group enrollment period* is during the time period designated by the *contract holder*. *Members* should refer to the sections below for more information on eligibility outside of the initial *group enrollment period*.

Newly Eligible Members

Eligible *subscribers* and *dependents* may enroll for *coverage* when they first meet the appropriate requirements described in the **Eligibility** section above. This may occur during the initial *group enrollment period* or at some other time, based on the eligibility rules established by the *contract holder* and us or as provided by law.

Subscriber

A new *subscriber* may enroll with us for *coverage* after becoming eligible, even though a *group enrollment period* is not in progress. *Subscribers* must immediately submit an *enrollment application* through the *contract holder* to ensure that they enroll within the required timeframes. Newly eligible *subscribers* should consult with the *contract holder* to determine the timeframes applicable to their *coverage*. *Members* should refer to the **Timelines for Submission of Enrollment Applications** section for more details.

Dependent - Newborns

For 31 days following birth, a *member's* newborn child is covered under this *coverage*.

An eligible newborn **must** be enrolled as a *dependent* under the *group contract* or enrolled under a separate contract, within 31 days of birth to have ongoing *coverage*. If the newborn child qualifies as a *dependent*, under the *group contract*, you must notify the *contract holder* immediately and application must be made through the *contract holder* within the required timeframes to add the newborn child as a *dependent*. *Subscribers* should consult with the *contract holder* to determine the timeframes applicable to enrolling a newborn as a *dependent*. Refer to the **Timelines for Submission of Enrollment Applications** section for more details.

If the newborn child does not qualify as a *dependent*, the newborn child may be converted to an individual contract under the terms and conditions described in the **Continuation of Coverage After Termination** section.

Life Status Change

An individual who does not enroll when first eligible must wait until the next *group enrollment period*. However, individuals who experience a life status change may enroll in *coverage* as a new *subscriber* or *dependent* even though a *group enrollment period* is not in progress. A life status change is an event based on, but not limited to the following:

- A change in job status
- A change in marital status
- A change in domestic partnership

- The birth, adoption, or placement for adoption of a child
- Acquiring a stepchild or becoming a legal guardian for a child
- A court order
- A change in *Medicare* status
- A change in the status of other insurance
- Loss of other minimum essential *coverage*, including but not limited to the following:
  - A loss due to termination of employment or reduction in hours.
  - Divorce or legal separation.
  - Relocation outside our *service area*.
- A child ceasing to be eligible for *coverage* under the *group contract*.

If one of these events occurs, you must notify the *contract holder* immediately. To enroll with us for *coverage*, *members* must enroll within the required timeframe after the date of the applicable event noted above (or in the case of a ward for a child, the date specified in the legal custody order).

The *subscriber* must submit an *enrollment application* through the *contract holder* within the required timeframes after the newly eligible *dependent* becomes eligible for *coverage* under the *group contract*. *Subscribers* should consult with the *contract holder* to determine the timeframes applicable to enrolling newly eligible *dependents*. Refer to the **Timelines for Submission of Enrollment Applications** section above for more details.

Group Enrollment Period

During a *group enrollment period*, you have the opportunity to make healthcare *coverage* changes, if applicable, and to add eligible *dependents* previously not enrolled. A *group enrollment period* occurs at least once annually.

Effective Date of *Coverage*

Initial and Newly Eligible Members

Coverage for initial and newly eligible *members* is effective as of the date specified by the *contract holder and approved by* us*. Members* should contact the *contract holder* for details regarding specific *effective dates of coverage*. These requirements are also described in the *group policy*.

Life Status

Individuals who enroll within the required timeframes are covered as of the following dates, as applicable:

- The date of birth, adoption, or placement for adoption.
- The date specified in the legal custody order, in the case of a ward
- The date of marriage.
- The date of attaining eligibility as a d*omestic partner.*
- First date after loss of other health insurance coverage.
- First day of the month following enrollment after an individual loses other minimum essential *coverage*.

Except as set forth above, *coverage* will begin the first day of the first calendar month beginning after the date we receive the request for enrollment following a life status change.

TERMINATION OF COVERAGE

This section explains when and why your *coverage* with us may end.

Termination of Group Contract

When the *group contract* ends, it automatically terminates *coverage* with us for all *members* in that group. The terms and conditions related to the termination and renewal of the *group contract* are described in the *group contract*, a copy of which is available for inspection at the office of the *contract holder* during regular business hours.

Termination of *Coverage* for Members

You cannot be terminated based on health status, healthcare need, or the use of *Capital's* adverse benefit determination appeal procedures.

However, there are situations where a *member's coverage* is terminated even though the *group contract* is still in effect. These situations include, but are not limited to the following:

- *Subscriber* – *Coverage* ends on the date in which a *subscriber* is no longer employed by, or a member of, the company or organization sponsoring this *coverage*. When *coverage* of a *subscriber* is terminated, *coverage* for all of the *subscriber's dependents* is also terminated.
- *Dependent* Spouse – *Coverage* of a *dependent* spouse ends on the date in which the *dependent* spouse ceases to be eligible under this *coverage*.
- *Dependent* Domestic Partner – *Coverage* of a *dependent* domestic partner ends on the date in which the *dependent* domestic partner ceases to be eligible under this *coverage.*
- Child – *Coverage* of a child ends on the date in which the child is no longer eligible as described in the **Enrollment** section. However, *coverage* of a child may continue as a *dependent* disabled child as described in the **Membership Status** section.
- *Dependent* Child Age 26 or Older with a Disability – *Coverage* of a *dependent* child age 26 or older with a disability ends when the *subscriber* does not submit to us, through the *contract holder*, the appropriate information as described in the **Membership Status** section. The *subscriber* must notify us of a change in status regarding a *dependent* child with a disability.

In addition, *coverage* terminates for *members* if they participate in fraudulent behavior or intentionally misrepresent material facts, including but not limited to the following:

- Using an *ID card* to obtain goods or services:
  - Not prescribed or ordered for the subscriber or the subscriber's dependents.
  - To which the subscriber or the subscriber's dependents are otherwise not legally entitled.
- Allowing any other person to use an *ID card* to obtain services. If a *dependent* allows any other person to use an *ID card* to obtain services, *coverage* of the *dependent* who allowed the misuse of the *ID card* is terminated.
- Knowingly misrepresenting or giving false information, or making false statements that materially affect either the acceptance of risk or the hazard assumed by us, on any *enrollment application* form.

The actual termination date is the date specified by the *contract holder* and approved by us. *Members* should check with the *contract holder* for details regarding specific termination dates. Except as provided for in this *Benefits Booklet*, if a *member's benefits* under this *coverage* are terminated under

this section, all rights to receive *benefits* cease at 11:59:59 PM, local Harrisburg, Pennsylvania time, on the date of termination, including maternity *benefits*.

CONTINUATION OF COVERAGE AFTER TERMINATION

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) Coverage

COBRA is a federal law, and mini-COBRA, a Pennsylvania law, which requires that, under certain circumstances, the *contract holder* give the *subscriber* and the *subscriber's dependents* the option to continue under this *coverage*.

Members should contact the *contract holder* if they have any questions about eligibility for *COBRA or* mini-*COBRA coverage*. The *contract holder* is responsible for the administration of *COBRA* and mini-COBRA *coverage*.

Members should refer to the section below for any other *coverage* they may be eligible for if they do not qualify for *COBRA* or mini-COBRA *coverage* or when *COBRA* or mini-COBRA *coverage* ends.

Eligibility for Continuation of *Coverage*

A *member* whose *coverage* is about to terminate may be eligible for enrollment in individual products on or off the *Marketplace*.

Examples of situations in which a *member* may be eligible, but are not limited to the following:

- Termination of employment
- Ineligibility to remain on this *coverage* due to a divorce, reaching a specific age limit, a change in job status
- Termination of the *group contract* due to the *contract holder's* nonpayment of *fees*.

We are not liable for the cost of *benefits* provided to *members* after the date of termination.

Enrollment forms are available from our Member Services department and can be obtained by calling the Member Services number located on the back of the *ID card*.

APPLYING FOR INDIVIDUAL PRODUCTS IS THE *MEMBER'S* RESPONSIBILITY.

Coverage for Medicare-Eligible Members

If a *member* is no longer eligible for this *coverage*, is age 65 or older, and is enrolled in *Medicare* Parts A and B; the *member* can enroll in a *Medicare* Supplemental or a *Medicare* Advantage product offered by the Capital Blue Cross family of companies.

Enrollment forms are available from our Member Services department and can be obtained by calling the Member Services number located on the back of the *ID card*.

APPLYING FOR *MEDICARE* SUPPLEMENTAL OR *MEDICARE* ADVANTAGE *COVERAGE* IS THE *MEMBER'S* RESPONSIBILITY.

Coverage for Totally Disabled Members

Benefits will be furnished to a totally disabled *subscriber* or a totally disabled *dependent* for services **directly related** to the condition that caused this total disability and for no other condition, illness,

disease, or injury if the *subscriber* or the *dependent* is totally disabled on the date *coverage* is terminated.

Totally disabled (or total disability) is a condition resulting from disease or injury in which, as determined by our Medical Director, one of the following conditions may exist:

- The individual is unable to perform the substantial and material duties of his/her regular occupation and is not in fact engaged in any occupation for wage or profit.
- If the individual does not usually engage in any occupation for wage or profit, the *member* is substantially unable to engage in the normal activities of an individual of the same age and sex.
- If an eligible *member* meets the definition of totally disabled, extended disability *benefits* are provided, based on whichever occurs first:
  - Up to a maximum period of 12 consecutive months
  - Until the maximum amount of *benefits* has been paid
  - Until the *total disability* ends
  - Until the *member* becomes covered, without limitation as to the disabling condition, under any other *coverage*

A *member* must contact Member Services to start the application process for *coverage* under this provision.

APPLYING FOR COVERAGE FOR TOTALLY DISABLED MEMBERS IS THE MEMBER'S RESPONSIBILITY. COVERAGE FOR TOTALLY DISABLED MEMBERS IS NOT AVAILABLE FOR PRESCRIPTION DRUG BENEFITS.

CLAIMS REIMBURSEMENT FOR MEDICAL BENEFITS

Claims and How They Work

To receive payment for *benefits* under your *coverage,* a claim for *benefits* must be submitted to us. The claim is based upon the itemized statement of charges for healthcare services and/or supplies provided by a *provider*. After receiving the claim, we will process the request and determine if the services and/or supplies provided under this *coverage* are *benefits* provided by your *coverage*, and if applicable, make payment on the claim. The method by which we receive a claim for *benefits* is dependent upon the type of *provider* from which you receive services.

In-Network Providers

When you receive services from an *in-network provider*, show your *ID card* to the *provider*. The *in-network provider* will submit a claim for *benefits* directly to us. You will not need to submit a claim. Payment for *benefits* — after applicable *cost sharing amounts*, if any, are deducted — is made directly to the *in-network provider*.

Out-of-Network Providers

If you visit an *out-of-network provider*, the *provider* may require you to pay for the service at the time it is rendered. Although many *out-of-network providers* file claims on behalf of *our members*, they are not required to do so. Therefore, you need to be prepared to submit your claim to us for reimbursement. Unless we otherwise negotiated with the *provider*, or as provided in this section, payment for services provided by *out-of-network providers* is made directly to the *subscriber*. It is then the *subscriber's* responsibility to pay the *out-of-network provider*, if payment has not already been made. However, we will make payment to the *out-of-network provider*, and not directly to the *subscriber*, for *emergency services*, air ambulance services, or non*emergency services* received at an in-network hospital, hospital outpatient department, critical access hospital*, or ambulatory surgical facilities.*

Out-of-Area Providers

If you receive services from a *provider* outside of our *service area,* and the *provider* is a member of the local Blue Plan, show your *ID card* to the *provider*. The *provider* will file a claim with the local Blue Plan that will in turn electronically route the claim to us for processing. We apply the applicable *benefits* and *cost sharing amounts* to the claim. We send this information back to the local Blue Plan and they will make payment directly to the *in-network provider*.

Allowed Amount

For *professional providers* and *facility providers*, we base the *benefit* payment amount on the *allowed amount* on the date the service is rendered, except as otherwise required by law.

Benefit payments to *hospitals* or other *facility providers* may be adjusted from time to time based on settlements with such *providers*. Such adjustments will not affect your *cost sharing amount* obligations.

Filing a Claim

If it is necessary for you to submit a claim to us, be sure to request an itemized bill from your healthcare *provider*. Submit the itemized bill to *us* with a completed Capital Blue Cross Medical Claim Form.

Obtain a copy of this claim form at CapitalBlueCross.com or by calling Member Services at the number found on the back of your *ID card*. Your claim will process more quickly when the form is used. A separate claim form must be completed for each person enrolled for *coverage* who received medical services.

A Special Note about Medical Records

To determine if services are *benefits* covered under your *coverage*, you (or the *provider* on your behalf) may need to submit medical records, *physician* notes, or treatment plans. We will contact you and/or the *provider* if we need additional information to determine if the services and/or supplies received are *medically necessary*.

Where to Submit Medical Claims

Submit your claims with a completed Capital Blue Cross Medical Claim Form and an itemized bill to the following address:

Capital Blue Cross
PO Box 211457
Eagan, MN 55121

If you need help submitting a medical claim, call Member Services at the number on the back of your *ID card* (TTY: **711**)**.**

Out-of-Country Claims

There are special claim filing requirements for services received outside of the United States.

Inpatient Hospital Claims

Claims for *inpatient hospital* services arranged through the Blue Cross Blue Shield Global Core service center require you to pay only the usual *cost sharing amounts*. The *hospital* files the claim for you. If you receive *inpatient hospital* care from an *out-of-network hospital* or services that were not coordinated through the service center you may have to pay the *hospital* and submit the claim to the service center at P.O. Box 2048, Southeastern, PA 19399.

Professional Provider Claims

For all *outpatient* and professional medical care, you pay the *provider* and then submit the claim to the Blue Cross Blue Shield Global Core service center at P.O. Box 2048, Southeastern, PA 19399. The claim should be submitted showing the currency used to pay for the services.

International Claim Form

There is a specific claim form that must be used to submit international claims. Itemized bills must be submitted with the claim form. The international claim form can be accessed at CapitalBlueCross.com.

Claim Filing and Processing Time Frames

Time Frames for Submitting Claims

All claims must be submitted within 12 months from the date of service with the exception of claims from certain state and federal agencies.

Time Frames Applicable to Medical Claims

If your claim involves a medical service or supply that has not yet been received (pre-service claim), we will process the claim within 15 days of receiving the claim.

If your claim involves a medical service or supply that was already received (post-service claim), we will process the claim within 30 days of receiving the claim.

We may extend the 15 or 30-day period one time for up to 15 days for circumstances beyond our control. We will notify you prior to the expiration of the original time period if we need an extension. We may also mutually agree to an extension if either of us requires additional time to obtain information needed to process the claim.

Special Time Frames Applicable to "Urgent Care" Claims

An urgent care claim is one in which application of the nonurgent time periods for making a determination could seriously jeopardize your life or health, your ability to regain maximum function, or in the opinion of a *physician* with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

We will notify you of the decision on an urgent care claim as soon as possible but not later than 72 hours after receipt of the claim, unless information is insufficient to make a determination of *coverage*.

If such is the case, we will notify you of the additional information needed within 24 hours of receipt of the claim.

- We will give you a reasonable amount of time but no less than 48 hours to submit the additional necessary information.
- We will notify you of the decision on such an urgent care claim as soon as possible but not later than 48 hours after receipt of the additional information or the end of the period allowed to you to provide the information, whichever is earlier.

Special Time Frames Applicable to "Concurrent Care" Claims

Medical circumstances may arise under which we approve an ongoing course of treatment to be provided to you over a period of time or number of treatments. If you or your *provider* believe that the period of time or number of treatments should be extended, follow the steps described below.

If you believe that any delay in extending the period of time or number of treatments would jeopardize your life, health, or ability to regain maximum function, you must request an extension at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. You must make a request for an extension by calling Member Services at the number listed on the back of your ID card. We will review your request and will notify you of our decision within 24 hours after receipt.

If you are dissatisfied with the outcome of your request, you may submit an appeal. Refer to the **Appeal Procedures** section for instructions on submitting an appeal.

For all other requests to extend the period of time or number of treatments for a prescribed course of treatment, contact Member Services.

Coordination of Benefits (COB)

The coordination of *benefits* provision applies when a person has healthcare *coverage* under more than one Plan as defined below.

The order of benefit determination rules govern the order in which each Plan pays a claim for benefits.

- The Plan that pays first is the "Primary Plan." The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses.
- The Plan that pays after the Primary Plan is the "Secondary Plan." The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total *Allowable* Expense.

Definitions Unique to Coordination of Benefits

In addition to the defined terms in the **Definitions** section, the following definitions apply to this provision:

Plan: Plan means This *Coverage* and/or Other Plan.

Other Plan: Other Plan means any individual *coverage* or group arrangement providing healthcare benefits or services through any of the following:

- Individual, group, blanket, or franchise insurance *coverage* except that it shall not mean any blanket student accident *coverage* or hospital indemnity plan of $100 or less.
- Blue Cross, Blue Shield, group practice, individual practice, and other prepayment *coverage*.
- *Coverage* under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans.
- *Coverage* under any tax-supported or any government program to the extent permitted by law.

Other Plan shall be applied separately with respect to each arrangement for benefits or services and separately with respect to that portion of any arrangement which reserves the right to take benefits or services of Other Plans into consideration in determining its benefits and that portion which does not.

This Coverage: This *Coverage* means, in a COB provision, the part of the contract providing the healthcare benefits to which the COB provision applies, and which may be reduced because of the benefits of other plans. Any other part of the contract providing healthcare benefits is separate from This *Coverage*. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

Order of Benefit Determination Rule: The order of benefit determination rules determine whether This *Coverage* is a Primary Plan or Secondary Plan when you have healthcare *coverage* under more than one Plan.

Primary Plan: The Plan that typically determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits.

Secondary Plan: The Plan that typically determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total *Allowable* Expense deemed customary and reasonable by *Capital*.

Covered Service: A service or supply specified in This *Coverage* for which *benefits* will be provided when rendered by a *provider* to the extent that such item is not covered completely under the Other Plan.

When *benefits* are provided in the form of services, the reasonable cash value of each service shall be deemed the *benefit*.

NOTE: When *benefits* are reduced under the primary contract because you do not comply with the provisions of the Other Plan, the amount of such reduction will not be considered an *Allowable* Expense under This *Coverage*. Examples of such provisions are those related to second surgical opinions and *preauthorization* of admissions or services.

We will not be required to determine the existence of any Other Plan, or amount of benefits payable under any Other Plan, except This *Coverage*.

The payment of *benefits* under This *Coverage* shall be affected by the benefits that would be payable under Other Plans only to the extent that we are furnished with information regarding Other Plans by the *contract holder* or *subscriber* or any other organization or person.

Allowable Expense: Allowable expense is a healthcare expense, including *deductibles*, *coinsurance*, and *copayments*, that is covered at least in part by any Plan covering the *member*. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the *member* is not an Allowable Expense. In addition, any expense that a *provider* by law or in accordance with a contractual agreement is prohibited from charging a *member* is not an Allowable Expense.

Examples of expenses that are not Allowable Expenses include, but are not limited to the following:

- The difference between the cost of a semi-private *hospital* room and a private *hospital* room, unless one of the Plans provides *coverage* for private *hospital* room expenses.
- Any amount in excess of the highest reimbursement amount for a specific benefit when two or more Plans that calculate benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology cover the *member*.
- Any amount in excess of the highest of the negotiated fees when two or more Plans that provide benefits or services on the basis of negotiated fees cover the *member*.
- If the *member* is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology covers a person and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the *Allowable* Expense for all Plans. However, if the *provider* has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the *provider's* contract permits, the negotiated fee or payment shall be the *Allowable* Expense used by the Secondary Plan to determine its benefits.
- The amount of any benefit reduction by the Primary Plan because the *member* has failed to comply with the Plan provisions. Examples of these types of Plan provisions include second surgical opinions, *preauthorization*, and preferred provider arrangements.

Closed Panel: Closed panel plan is a Plan that provides healthcare benefits to covered persons primarily in the form of services through a panel of *providers* that have contracted with or are employed by the Plan, and that excludes *coverage* for services provided by other *providers*, except in cases of emergency or referral by a panel member. An HMO is an example of a closed panel plan.

Custodial Parent: Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Dependent: A dependent means, for any Other Plan, any person who qualifies as a dependent under that plan.

Order of Benefit Determination Rules

When a *member* is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

1. The Primary Plan pays or provides its benefits according to its terms of *coverage* and without regard to the benefits under any other Plan.
2. A Plan that does not have a coordination of benefits provision as described in this section is always the Primary Plan unless both Plans state that the Plan with a coordination of benefits provision is primary.
3. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
4. Each Plan determines its order of *benefits* using the first of the following rules that apply:

    a. Nondependent or Dependent.

    The Plan that covers the *member* as an employee, policyholder, subscriber or retiree is the Primary Plan. The Plan that covers the *member* as a Dependent is the Secondary Plan.

    For information regarding coordination of benefits with *Medicare*, please refer to the **Coordination of Benefits with Medicare** section.

    b. Child Covered Under More Than One Plan.

    Unless there is a court decree stating otherwise, when a child is covered by more than one Plan, the order of benefits is determined as follows:

    (i) For a child whose parents are married or are living together, whether or not they have ever been married:

    - The Plan of the parent whose birthday falls earlier in the calendar year is the primary Plan. This is known as the Birthday Rule; or
    - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan; or
    - If one of the Plans does not follow the Birthday Rule, then the Plan of the child's father is the Primary Plan. This is known as the Gender Rule.

    (ii) For a child whose parents are divorced, separated or not living together, whether or not they have ever been married:

    - If a court decree states that one of the parents is responsible for the child's healthcare expenses or *coverage* and the Plan of that parent has actual knowledge of this decree, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
    - If a court decree states that both parents are responsible for the child's healthcare expenses or *coverage*, the provisions of subparagraph (i) determine the order of benefits;

- If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or *coverage* of the child, the provisions of subparagraph (i) determine the order of benefits; or
- If there is no court decree allocating responsibility for the child's healthcare expenses or *coverage*, the order of benefits for the child is as follows:
    - The Plan covering the Custodial Parent;
    - The Plan covering the spouse of the Custodial Parent;
    - The Plan covering the noncustodial parent; and then
    - The Plan covering the spouse of the noncustodial parent.

(iii) For a child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (i) or (ii) above shall determine the order of benefits as if those individuals were the parents of the child.

c. Active Employee or Retired or Laid-off Employee.

The Plan that covers the *member* as an active employee is the Primary Plan. The Plan covering that same *member* as a retired or laid-off employee is the Secondary Plan. The same would hold true if the *member* is a Dependent of an employee covered by the active, retired or laid-off employee.

If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the "Non-Dependent or Dependent" rule can determine the order of benefits.

d. *COBRA* or State Continuation *Coverage*.

If a *member* whose *coverage* is provided pursuant to *COBRA* or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the *member* as an employee, subscriber or retiree or covering the *member* as a Dependent of an employee, subscriber or retiree is the Primary Plan. The *COBRA* or state or other federal continuation *coverage* is the Secondary Plan.

If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the "Non Dependent or Dependent" rule can determine the order of benefits.

e. Longer or Shorter Length of *Coverage*.

The Plan that covered the *member* as an employee, policyholder, subscriber or retiree longer (as measured by the effective date of *coverage*) is the Primary Plan and the Plan that covered the *member* the shorter period of time is the Secondary Plan. The status of the *member* must be the same for all Plans for this provision to apply. The same primacy would be true if the *member* is a dependent of an employee covered by the Longer or Shorter length of *coverage*.

If the preceding rules do not determine the order of benefits, the *Allowable* Expense is shared equally between the Plans. In addition, This *Coverage* will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Coverage

When This Coverage is secondary, it may reduce benefits so that the total paid or provided by all Plans for a service are not more than the total Allowable Expenses.

In determining the amount to be paid, the Secondary Plan calculates the benefits it would have paid in the absence of other healthcare *coverage*. That amount is compared to any Allowable Expense unpaid by the Primary Plan. The Secondary Plan may then reduce its payment so that the unpaid Allowable Expense is the considered balance. When combined with the amount paid by the Primary Plan, the total benefits paid by all Plans may not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan credits to its *deductible* any amounts it would have otherwise credited to the *deductible*.

If a *member* is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non panel *provider*, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

Certain facts about healthcare *coverage* and services are needed to apply these COB rules and to determine benefits payable under This *Coverage* and other Plans. We may obtain and use the facts it needs to apply these rules and determine benefits payable under This *Coverage* and other Plans covering the *member* claiming benefits. We need not tell, or get the consent of, the *member* or any other person to coordinate benefits. Each *member* claiming benefits under This *Coverage* must give us any facts needed to apply those rules and determine *benefits* payable.

Failure to complete any forms required by us may result in claims being denied.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This *Coverage*. If it does, we may pay that amount to the organization that made the payment. That amount is treated as though it is a benefit paid under This *Coverage*. We will not pay that amount again. The term “payment made” includes providing *benefits* in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by us is more than the amount that should have been paid under this COB provision, we may recover the excess amount. The excess amount may be recovered from one or more of the persons or organization paid or for whom it has paid, or any other person or organization that may be responsible for the *benefits* or services provided for the *member*. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Coordination of Benefits with Medicare

Active Employees and Spouses Age 65 and Older

If a *subscriber* (or *subscriber’s* spouse), age 65 or older, is entitled to benefits under *Medicare*, and the *subscriber* works for an employer that did not employ 20 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year, then *Medicare* shall be

primary for the *subscriber* or spouse. The *benefits* of the *group contract* will then be the secondary form of *coverage*.

If a *subscriber* (or *subscriber's* spouse), age 65 or older, is entitled to benefits under *Medicare*, and the *subscriber* works for an employer that employed 20 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year, the following rules apply:

- The *group contract* will be primary for any person age 65 or older who is an Active Employee (defined as a person with "current employment status" under applicable *Medicare* Secondary Payer Laws) or the spouse of an Active Employee of any age.
- A *member* may decline *coverage* under the *group contract* and elect *Medicare* as the primary form of *coverage*. If the *member* elects *Medicare* as the primary form of *coverage*, the *group contract*, by law, cannot pay *benefits* secondary to *Medicare* for *Medicare*-covered *members*. However, the *member* will continue to be covered by the *group contract* as primary unless: (a) the *member*, or the *contract holder* on behalf of the *member*, notifies us, in writing, that the *member* does not want *benefits* under the *group contract*; or (b) the *member* otherwise ceases to be eligible for *coverage* under the *group contract*.

Disability

If a *member* is under age 65, and the *subscriber* has current employment status with an employer with fewer than 100 employees (as defined under the *Medicare* Secondary Payer Laws), and the *member* becomes disabled and entitled to benefits under *Medicare* due to such disability, then *Medicare* shall be primary for the *member*; and the *group contract* will be the secondary form of *coverage*.

If a *member* is under age 65, and the *subscriber* has current employment status with an employer with at least 100 employees (as defined under the *Medicare* Secondary Payer Laws), and the *member* becomes disabled and entitled to benefits under *Medicare* due to such disability (other than end-stage renal disease as discussed below) the *group contract* will be primary for the *member*, and *Medicare* will be the secondary form of *coverage*.

End-Stage Renal Disease (ESRD)

The *group contract* will pay primary for the first 30 months of a *member's* eligibility or entitlement to *Medicare* due to ESRD, as defined under applicable *Medicare* statutes. Upon the expiration of this 30-month period: (1) if the *member* is enrolled in *Medicare* due to ESRD, the *group contract* will pay benefits as secondary to *Medicare* for so long as the member remains enrolled, and (2) if the *member* is eligible for, but to *Capital's* knowledge has not enrolled in, *Medicare* due to ESRD, the *group contract* will remain primary to *Medicare*. However, if the *group contract* is currently paying *benefits* as secondary to *Medicare* for a *member*, the *group contract* will remain secondary upon a *member's* entitlement to *Medicare* due to ESRD.

Retirees

Upon the effective date of the *member's* enrollment in *Medicare* Part A and B, *Medicare* shall become primary for the *member* to the extent permitted under the *Medicare* Secondary Payer Laws, and the *group contract* will be the secondary form of *coverage*.

Third Party Liability/Subrogation

Subrogation is the right of the *contract holder* to recover the amount it has paid on behalf of a *member* from the party responsible for the *member's* injury or illness.

To the extent permitted by law, a *member* who receives *benefits* related to injuries caused by an act or omission of a third party or who receives benefits and/or compensation from a third party for any care or treatment(s) regardless of any act or omission, shall be required to reimburse the *contract holder* for the cost of such *benefits* when the *member* receives any amount recovered by suit, settlement, or otherwise for his/her injury, care or treatment(s) from any person or organization. The *member* shall not be required to pay the *contract holder* more than any amount recovered from the third party.

In lieu of payment above, and to the extent permitted by law, the *contract holder* may choose to be subrogated to the *member's* rights to receive compensation including, but not limited to, the right to bring suit in the *member's* name. Such subrogation shall be limited to the extent of the *benefits* received under the *group contract*. The *member* shall cooperate with the *contract holder* should the *contract holder* exercise its right of subrogation. The *member* shall cooperate with *Capital* if the *contract holder* chooses to have *Capital* pursue the right of subrogation on behalf of the *contract holder*. The *member* shall not take any action or refuse to take any action that would prejudice the rights of the *contract holder* under this **Third Party Liability/Subrogation** section.

The right of subrogation is not enforceable if prohibited by applicable controlling statute or regulation.

There are three basic categories of medical claims that are included in *the contract holder's* subrogation process: third party liability, workers' compensation insurance, and automobile insurance.

Third Party Liability

Third party liability can arise when a third party causes an injury or illness to a *member*. A third party includes, but is not limited to, another person, an organization, or the other party's insurance carrier.

When a *member* receives any amount recovered by suit, settlement or otherwise from a third party for the injury or illness, subrogation entitles the *contract holder* to recover the amounts already paid by the *contract holder* for claims related to the injury or illness. The *contract holder* does not require reimbursement from the *member* for more than any amount recovered. The *contract holder* may choose to have *Capital* pursue these rights on its behalf.

Workers' Compensation Insurance

Employers are liable for injuries, illness, or conditions resulting from an on-the-job accident or illness. Workers' compensation insurance is the only insurance available for such occurrences. The *contract holder* denies coverage for claims where workers' compensation insurance is required.

If the workers' compensation insurance carrier rejects a claim because the injury was not work-related, the *contract holder* may consider the charges in accordance with the *coverage* available under the *group contract*. *Benefits* are not available if the workers' compensation carrier rejects a claim for any of the following reasons:

- The employee did not use the *provider* specified by the employer or the workers' compensation carrier;
- The workers' compensation timely filing requirement was not met;
- The employee has entered into a settlement with the employer or workers' compensation carrier to cover future medical expenses; or
- For any other reason, as determined by the *contract holder*.

Motor Vehicle Insurance

To the extent *benefits* are payable under any medical expense payment provision (by whatever terminology used, including such *benefits* mandated by law) of any motor vehicle insurance policy, such *benefits* paid by the *contract holder* and provided as a result of an accidental bodily injury arising out of a motor vehicle accident are subject to coordination of benefit rules and subrogation as described in the **Coordination of Benefits (COB)** and **Subrogation** sections.

Assignment of Benefits

Except as otherwise required by applicable law, *members* are not permitted to assign any right, *benefits* or payments for *benefits* under the *group contract* to other *members* or to *providers* or to any other individual or entity. Further, except as required by applicable law, *members* are not permitted to assign their rights to receive payment or to bring an action to enforce the *group contract*, including, but not limited to, an action based upon a denial of *benefits*.

Payments Made in Error

We reserve the right to recoup from the *member* or *provider*, any payments made in error, whether for a *benefit* or otherwise.

CLAIMS REIMBURSEMENT FOR PRESCRIPTION DRUG BENEFITS

Claims and How They Work

To receive payment for *benefits* under your *coverage,* a claim for *benefits* must be submitted to the *PBM*. The claim is based upon the itemized statement of charges for *prescription drugs* and/or services provided by a *pharmacy*. After receiving the claim, the *PBM* will process the request and determine if the *prescription drugs* and/or services provided under this *coverage* are *benefits* provided by your *coverage*, and if applicable, make payment on the claim. The method by which the *PBM* receives a claim for *benefits* is dependent upon the type of *provider* from which you receive services.

In-Network Pharmacies

When you receive services from an *in-network pharmacy*, you should show your *ID card* to the *pharmacy*. The *in-network pharmacy* will submit a claim for *benefits* directly to the *PBM*. You will not need to submit a claim. Payment for *benefits* — after applicable *cost sharing amounts*, if any — is made directly to that *in-network pharmacy*.

Out-of-Network Pharmacies

If you visit an *out-of-network pharmacy*, you will be required to pay for the *prescription drug* and/or service at the time the *prescription drug* is dispensed or at the time the service is rendered. *Out-of-network pharmacies* do not file claims on behalf of you. Therefore, you need to submit your claim to Pharmacy Services at the address list below for reimbursement.

Allowed Amount

The *benefit* payment amount is based on the *allowed amount* on the date the *prescription drug* is dispensed or the date the service is rendered.

Filing a Claim

When you submit a prescription to a *retail*, *home delivery,* or *specialty pharmacy*, the prescription is not considered to be a claim. You should call the telephone number on your *ID card* if there are any concerns about fulfillment of the prescription or any of the following occur:

- The pharmacy tells you that you are not eligible for *coverage*.
- *Coverage* for the prescription was denied in whole or in part.
- You feel the wrong *cost sharing amount* was paid for the prescription.
- You were required to pay other amounts you feel you are not required to pay.
- You have another dispute or discrepancy regarding the prescription drug *coverage*.

If it is necessary for you to submit a claim to the *PBM*, you should be sure to request an itemized bill from the *pharmacy*. The itemized bill should be submitted to the *PBM* with a completed and signed *Prescription Drug* Claim Form.

You can obtain a copy of the *Prescription Drug* Claim Form by contacting Member Services or go to CapitalBlueCross.com. Your claim will be processed more quickly when the *Prescription Drug* Claim Form is used. A separate claim form must be completed for each *member* who received *prescription drugs* or services.

You should review the instructions provided on the back of the claim form and include all of the requested information.

You should also provide additional information, if applicable, including but not limited to, other insurance payment information.

Where to Submit Prescription Drug Claims

You can submit claims, with a completed *Prescription Drug* Claim Form, an itemized bill, and all required information listed above, to the following address:

Pharmacy Services
PO Box 25136
Lehigh Valley PA 18002-5136

Members who need help submitting a *prescription drug* claim can contact Member Services at the number on the back of their *ID card*.

Claim Filing and Processing Time Frames

Time Frames for Submitting Claims

All *prescription* claims must be submitted within 90 days from the date of service with the exception of claims from certain state and federal agencies.

Time Frames Applicable to Prescription Drug Claims

Paper claims submitted to the *PBM* are processed within 15 business days, on average, of receiving the properly completed claim. We may extend the filing/processing timeframe period one time for up to 15 days for circumstances beyond our control. We will notify you prior to the expiration of the original time period if an extension is needed. We may also mutually agree to an extension if either of us requires additional time to obtain information needed to process the claim.

Coordination of Benefits (COB)

Coordination of *benefits* is not applicable to this *coverage*.

Third Party Liability/Subrogation

Subrogation is the right of the *contract holder* to recover the amount it has paid on behalf of a *member* from the party responsible for the *member's* injury or illness.

To the extent permitted by law, a *member* who receives *benefits* related to injuries caused by an act or omission of a third party or who receives benefits and/or compensation from a third party for any care or treatment(s) regardless of any act or omission, shall be required to reimburse the *contract holder* for the cost of such *benefits* when the *member* receives any amount recovered by suit, settlement, or otherwise for his/her injury, care or treatment(s) from any person or organization. The *member* shall not be required to pay the *contract holder* more than any amount recovered from the third party.

In lieu of payment above, and to the extent permitted by law, the *contract holder* may choose to be subrogated to the *member's* rights to receive compensation including, but not limited to, the right to bring suit in the *member's* name. Such subrogation shall be limited to the extent of the *benefits* received under the *group contract*. The *member* shall cooperate with the *contract holder* should the *contract holder* exercise its right of subrogation. The *member* shall cooperate with *Capital* if the

contract holder chooses to have *Capital* pursue the right of subrogation on behalf of the *contract holder*. The *member* shall not take any action or refuse to take any action that would prejudice the rights of the *contract holder* under this **Third Party Liability/Subrogation** section.

The right of subrogation is not enforceable if prohibited by applicable controlling statute or regulation.

There are three basic categories of *prescription drug* claims that are included in the *contract holder's* subrogation process: third party liability, workers' compensation insurance, and automobile insurance.

Third Party Liability

Third party liability can arise when a third party causes an injury or illness to a *member*. A third party includes, but is not limited to, another person, an organization, or the other party's insurance carrier.

When a *member* receives any amount recovered by suit, settlement or otherwise from a third party for the injury or illness, subrogation entitles the *contract holder* to recover the amounts already paid by the *contract holder* for claims related to the injury or illness. The *contract holder* does not require reimbursement from the *member* for more than any amount recovered. The *contract holder* may choose to have *Capital* pursue these rights on its behalf.

Workers' Compensation Insurance

Employers are liable for injuries, illness, or conditions resulting from an on-the-job accident or illness. Workers' compensation insurance is the only insurance available for such occurrences. The *contract holder* denies coverage for claims where workers' compensation insurance is required.

If the workers' compensation insurance carrier rejects a claim because the injury was not work-related, the *contract holder* may consider the charges in accordance with the *coverage* available under the *group contract*. *Benefits* are not available if the workers' compensation carrier rejects a claim for any of the following reasons:

- The employee did not use the *provider* specified by the employer or the workers' compensation carrier;
- The workers' compensation timely filing requirement was not met;
- The employee has entered into a settlement with the employer or workers' compensation carrier to cover future medical expenses; or
- For any other reason, as determined by the *contract holder*.

Motor Vehicle Insurance

To the extent *benefits* are payable under any medical expense payment provision (by whatever terminology used, including such *benefits* mandated by law) of any motor vehicle insurance policy, such *benefits* paid by the *contract holder* and provided as a result of an accidental bodily injury arising out of a motor vehicle accident are subject to subrogation as described in the **Third Party Liability/Subrogation** section.

Assignment of Benefits

Except as otherwise required by applicable law, *members* are not permitted to assign any right, *benefits* or payments for *benefits* under the *group contract* to other *members* or to *providers* or to any other individual or entity. Further, except as required by applicable law, *members* are not permitted to assign

their rights to receive payment or to bring an action to enforce the *group contract*, including, but not limited to, an action based upon a denial of *benefits*.

Payments Made in Error

We reserve the right to recoup from the *member* or *pharmacy*, any payments made in error, whether for a *benefit* or otherwise.

APPEAL PROCEDURES

This section explains your right to appeal a decision we make about the *benefits* under *coverage*.

An adverse benefit determination is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) under your *coverage* with us for a service:

- Based on a determination of your eligibility to enroll under the *group contract*.
- Resulting from the application of any utilization review.
- Not provided because it is determined to be *investigational* or not *medically necessary*.

If you disagree with an adverse benefit determination with respect to *benefits* available under this *coverage* you may seek review of the adverse benefit determination by submitting a written appeal within 180 days of receipt of the adverse benefit determination.

To Appeal an Adverse Benefit Determination

An adverse benefit determination is any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a *benefit*, including any such denial, reduction, termination of, or a failure to provide or make payment that is based on a determination of a *member's* eligibility to participate under the *group contract*; and a decision by us that, based upon the information provided and upon application of utilization review, a request for a benefit does not meet our requirements for *medical necessity* and appropriateness, health care setting, level of care or effectiveness or is determined to be experimental or *investigational*, such that the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit. A rescission of *coverage* also constitutes an adverse benefit determination.

Internal Appeal Process

Whenever you disagree with an adverse benefit determination, you may seek internal review of that determination by submitting a written appeal. At any time during either the internal or external appeal process, you may appoint an authorized representative to act on your behalf as more fully discussed below. The appeal should include the reason(s) you disagree with the adverse benefit determination. The appeal must be received by us within 180 days after you received notice of the adverse benefit determination. Your appeal must be sent to:

Capital Blue Cross
PO Box 779518
Harrisburg, PA 17177-9518

You may submit written comments, documents records, and other information relating to the appeal of the Notice of Adverse Benefit Determination. Upon receipt of the appeal, we will provide you with a full and fair internal review. We will provide you, free of charge, (1) with any new or additional evidence considered or relied upon, or generated in connection with the claim as well as (2) any new or additional rationale which may be the basis of a final internal adverse appeal determination as soon as possible and prior to issuing a decision on the appeal in order for you to have a reasonable opportunity to respond prior to the issuance of the final internal appeal determination.

In reviewing the appeal, *we* will use healthcare professionals with appropriate training and experience in the field of medicine involved in the appeal matter at issue and who were not the individuals nor subordinates of such individuals who made the initial adverse benefit determination. You may contact us at **800.962.2242** (TTY: 711) to receive information on the internal review process and to receive

additional information including copies, free of charge, of any internal policy rule, guideline criteria, or protocol which we relied upon in making the adverse benefit determination. *Para obtener asistencia en Español, llame al* ***800.962.2242****.* We will provide you with a determination within 30 days for an appeal of an adverse benefit determination for a pre-service claim (where services or supplies have not yet been received) and within 60 days for an appeal of an adverse benefit determination for a post-service claim (where services or supplies have already been received). If our determination is still adverse to you in whole or in part, you will receive a Final Internal Adverse Benefit Determination.

You may request an external appeal through an Independent Review Organization (IRO) of a Final Internal Adverse Benefit Determination that involves medical judgment (including, decisions based on our requirements for *medical necessity*, heath care setting, level of care or effectiveness of a covered benefit as well as whether the requested treatment is experimental /investigational or cosmetic or a rescission) or the special rules applicable to out-of-network emergency services, air ambulance services, and other (nonemergency) services received at certain in-network facilities.

In order to request an external appeal pertaining to *medical necessity*, you must write to us at the address set forth above within four months from receipt of the Final Internal Adverse Benefit Determination. We will forward the appeal along with all materials and documentation to an IRO. You will be able to submit additional information to the IRO for consideration in the external appeal.

The IRO must notify you of its decision on the appeal in writing within 45 days from receipt of the request for external review.

*Member*s of a group health plan subject to ERISA (collectively, the Employee Retirement Income Security Act of 1974 and its related regulations, each as amended) may have a right to bring a civil action under Section 502(a) of ERISA.

Expedited Appeal Process for Claims Involving Urgent Care

Special rules apply to appeals of adverse benefit determinations involving "urgent care decisions."

Expedited Internal Appeal Process for Claims Involving Urgent Care. You may seek expedited internal review of the determination of a claim involving urgent care by contacting us at the telephone number above. We will respond with a determination within 72 hours. You may also request an expedited external appeal simultaneously with the request for an expedited internal appeal. If our determination is still adverse to you in whole or in part, you will receive a Final Internal Adverse Benefit Determination.

Expedited External Appeal Process for Claims Involving Urgent Care. You may request an expedited external review of the Final Internal Adverse Benefit Determination involving an urgent care claim as defined above or where the decision concerns an admission, availability of care, continued stay or healthcare service for which you received emergency services but have not been discharged from a facility. To request an expedited external appeal review of such a Final Internal Adverse Benefit Determination, you or your *physician* must contact us at the telephone number above and may provide a *physician's* certification indicating *your* claim is urgent in accordance with the definition above. Upon receipt of a request for an expedited external review, we will assign an IRO and will transmit the file to the assigned IRO to review the appeal. The IRO will issue a determination within 72 hours of receipt of the request.

Simultaneous Internal and External Appeal Process for Claims Involving Urgent and Concurrent Care. You may request a simultaneous internal and external review of a Final Internal Adverse Benefit

Determination involving an urgent care claim as defined above and a concurrent care situation as defined below.

How to Appeal a Concurrent Care Claim Determination

Special rules apply to adverse benefit determinations involving "concurrent care decisions."

If we approve an ongoing course of treatment to be provided over a period of time or number of treatments, you have the right to an expedited appeal of any reduction or termination of that course of treatment by us before the end of such previously approved period of time or number of treatments. We will notify you of our decision to reduce or terminate your course of treatment at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain an appeal decision before your *benefits* are reduced or terminated.

If you wish to appeal you must call Member Services at **800.962.2242** (TTY: **711**). We will notify you of the outcome of the appeal via telephone or facsimile not later than 72 hours after we receive the appeal. We will defer any reduction or termination of your ongoing course of treatment until a decision is reached on the appeal.

Simultaneous Internal and External Appeal Process for Claims Involving Urgent and Concurrent Care. You may request a simultaneous internal and external review of a Final Internal Adverse Benefit Determination involving an urgent care claim as defined above and a concurrent care situation.

Designating an Individual To Act on Your Behalf

You may designate another individual to act on your behalf in filing a benefit claim or appeal of an unfavorable benefit decision.

To designate an individual to serve as your *authorized representative* you must complete, sign, date, and return *Capital's* Authorization of Designated Appeals Representative (ADAR) Form. You may request this form from our Member Services department at **800.962.2242** (TTY: 711) or obtain a copy on the CapitalBlueCross.com website.

We will communicate with your authorized representative only after we receive the completed, signed, and dated authorization form. Your authorization form will remain in effect until you notify us in writing that the representative is no longer authorized to act on your behalf, or until you designate a different individual to act as your authorized representative.

For purposes of reviewing *member* appeals, if *benefits* are provided under:

- An insured arrangement, we are the named fiduciary.
- A self-funded or "self-insured" arrangement, either we or the *plan sponsor* of the self-funded group health plan may serve as the named fiduciary.

The named fiduciary, with respect to any specific appeal, has full and sole discretionary authority to interpret all plan documents and to make all interpretive and factual determinations as to whether any *member* is entitled to receive *benefits* under the terms of the group health plan. Any construction of terms of any plan document and any determination of fact adopted by the named fiduciary will be final and legally binding on all parties, subject to review only if such construction or determination is arbitrary, or capricious, or otherwise an abuse of discretion.

GENERAL PROVISIONS

Discounts and Incentives

We may make available to our *members* access to health- and wellness-related discount or incentive programs. Incentive programs may be available only to targeted populations and may include cash or other incentives.

These discount and incentive programs are not insurance and are not an insurance *benefit* or promise under the *group contract*. *Member* access to these programs is provided by us separately or independently from the *group contract*. There is no additional charge to *members* for accessing these discount and incentive programs. Contact the Plan Administrator for information on these programs.

Benefits are Nontransferable

No person other than a *member* is entitled to receive payment for *benefits* to be furnished by *Capital* under the *group contract*. Such right to payment for *benefits* is not transferable.

Changes

By this *Benefits Booklet*, the *contract holder* makes *Capital coverage* available to eligible *members*. However, this *Benefits Booklet* shall be subject to amendment, modification, and termination in accordance with any provision hereof or by mutual agreement between *Capital* and *contract holder* without the consent or concurrence of the *members*. By electing *Capital* or accepting *Capital benefits*, all *members* legally capable of contracting, and the legal representatives of all *members* incapable of contracting, agree to all terms, conditions, and provisions hereof.

Changes in State or Federal Laws and/or Regulations and/or Court or Administrative Orders

Changes in state or federal law or regulations or changes required by court or administrative order may require *Capital* to change *coverage* for *benefits* and any *cost sharing amounts*, or otherwise change *coverage* for *benefits* in order to meet new mandated standards. Moreover, local, state, or federal governments may impose additional taxes or fees with regard to *coverages* under this *contract*. Changes in *coverage* for *benefits* or changes in taxes or fees may result in upward adjustments in cost of *coverage* to reflect such changes. Such adjustments may occur on the earlier of either the *group contract* renewal date or the date such changes are required by law.

Capital will provide the *contract holder* with an official notice of change at least 60 days prior to the effective date of any change in *coverage* for *benefits.* However, if such change occurred due to a change in law, regulation or court or administrative order which makes the provision of such notice within 60 days not possible, *Capital* will provide such notice to the *contract holder* as soon as reasonably practicable.

Discretionary Changes by Capital

Capital may change *coverage* for *benefits* and any *cost sharing amounts*, or otherwise change *coverage* upon the renewal of the *group contract*.

Capital will provide the *contract holder* with an official notice of change at least 60 days prior to the effective date of any change in *coverage* for *benefits.*

Notwithstanding the above, changes in *Capital's* administrative procedures, including but not limited to changes in medical policy, *preauthorization* requirements, and underwriting guidelines, are not *benefit* changes and are, therefore, not subject to these notice requirements.

In the future, should terms and conditions associated with this *coverage* change, updates to these materials will be issued. These updates must be kept with this document to ensure the *member's* reference materials are complete and accurate.

Conformity with Statutes

The parties recognize that the *group contract* at all times is subject to applicable federal, state and local law. The parties further recognize that the *group contract* is subject to amendments in such laws and regulations and new legislation.

Any provisions of law that invalidate or otherwise are inconsistent with the terms of this *coverage* or that would cause one or both of the parties to be in violation of the law, is deemed to have superseded the terms of this *coverage*; provided that the parties exercise their best efforts to accommodate the terms and intent of the *group contract* consistent with the requirements of law.

In the event that any provision of the *group contract* is rendered invalid or unenforceable by law, or by a regulation, or declared null and void by any court of competent jurisdiction, the remainder of the provisions of the *group contract* remain in full force and effect.

Choice of Forum

The *contract holder* and *members* hereby irrevocably consent and submit to the jurisdiction of the federal and state courts within Dauphin County, Pennsylvania and waive any objection based on venue or forum non conveniens with respect to any action instituted therein arising under the *group contract* whether now existing or hereafter and whether in contract, tort, equity, or otherwise.

Choice of Law

All issues and questions concerning the construction, validity, enforcement, and interpretation of the *group contract* is governed by, and construed in accordance with, the laws of the Commonwealth of Pennsylvania, without giving effect to any choice of law or conflict of law rules or provisions, other than those of the federal government of the United States of America, that would cause the application of the laws of any jurisdiction other than the Commonwealth of Pennsylvania.

Choice of Provider

The choice of a *provider* is solely the *member's*. *Capital* does not furnish *benefits* but only makes payment for *benefits* received by *members*. *Capital* is not liable for any act or omission of any *provider*. *Capital* has no responsibility for a *provider's* failure or refusal to render *benefits* or services to a *member*. The use or nonuse of an adjective such as in-network or out-of-network in describing any *provider* is not a statement as to the ability, cost or quality of the *provider*.

Capital cannot guarantee continued access during the term of the *member's Capital* enrollment to a particular healthcare *provider*. If the *member's provider* ceases to be in-network, *Capital* will provide access to other *providers* with similar training and experience.

Clerical Error

Clerical error, whether of the *contract holder* or *Capital*, in keeping any record pertaining to the *coverage* hereunder, will not invalidate *coverage* otherwise validly in force or continue *coverage* otherwise validly terminated.

Entire Agreement

The *group contract* sets forth the terms and conditions of coverage of *benefits* under this Pennsylvania Preferred Provider Organization ("PPO") program that is administered by *Capital* and offered by the *contract holder* to *subscribers* and their *dependents* due to the *subscriber's* relationship with the *contract holder*. The *group contract* (including all of its attachments) and any riders or amendments to the *group contract* constitute the entire agreement between the *contract holder* and *Capital*. If there is a conflict of terms between the *policy/contract* and the *Benefits Booklet*, the terms of the *policy/contract* shall control and be enforceable over the terms of the *Benefits Booklet*.

Exhaust Administrative Remedies First

Neither the *contract holder* nor any *member* may bring a cause of action in a court or other governmental tribunal (including, but not limited to, a Magisterial District Justice hearing) unless and until all administrative remedies described in the *group contract* have first been exhausted.

Waiver

Our failure or delay in enforcing any provision of the *group contract* does not constitute, and shall not be deemed or construed to be, a waiver of the enforceability of such provision or of any other provisions of the *group contract*. Further, any failure or delay in enforcement of any provision shall not prohibit the future enforceability of any such provision.. Similarly, our failure to enforce any remedy arising from a default under the terms of the *group contract* shall not be deemed or construed to be a waiver of such remedy. Moreover, payment of a claim does not waive our right to deny payment or *coverage* for the reasons specified in the *group contract*.

Failure to Perform Due to Acts Beyond Capital's Control

The obligations of *Capital* under the *group contract*, including this *Benefits Booklet*, shall be suspended to the extent that *Capital* is hindered or prevented from complying with the terms of the *group contract* because of labor disturbances (including strikes or lockouts); acts of war; acts of terrorism, vandalism, or other aggression; acts of God; fires, storms, accidents, governmental regulations, impracticability of performance or any other cause whatsoever beyond its control. In addition, *Capital's* failure to perform under the *group contract* shall be excused and shall not be cause for termination if such failure to perform is due to the *contract holder* undertaking actions or activities or failing to undertake actions or activities so that *Capital* is or would be prohibited from the due observance or performance of any material covenant, condition, or agreement contained in the *group contract.*

Gender

The use of any gender herein shall be deemed to include the other gender, and, whenever appropriate, the use of the singular herein shall be deemed to include the plural (and vice versa).

ID Cards

Capital provides *ID cards* to all *subscribers* and other *members* as appropriate. For purposes of identification and specific *coverage* information, an *ID card* must be presented when service is requested.

ID cards are the property of *Capital* and should be destroyed when a *member* no longer has *coverage*. Upon request, *ID cards* must be returned to us within 31 days of the end of a *member's coverage*. *ID cards* are for purposes of identification only and do not guarantee eligibility to receive *benefits*.

Legal Action

No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Notwithstanding the foregoing, *Capital* does not waive or otherwise modify any defense, including the defense of the statute of limitations, applicable to the type or theory of action or to the relief being sought, including but not limited to the statute of limitations applicable to actions in tort.

Notices

Any and all notices under the *group contract* shall be given in writing and addressed as follows:

- If to a *member*: to the latest electronic and/or physical address reflected in *Capital's* records.
- If to the *contract holder*: to the latest electronic and/or physical address provided by the *contract holder* to *Capital*.
- If to *Capital*: to PO Box 772132, Harrisburg, PA 17177-2132.

Proof of Loss

Claims for proof of loss must be submitted within 12 months after completion of the covered services to receive benefits from *Capital*. *Capital* will not be liable under this *group contract* unless proper and prompt notice is furnished to *Capital* that covered services have been rendered to a *member*. No payment will be issued until the deductible or any other cost share obligation has been met, as set forth in the Summary of Cost Sharing section in this *Benefits Booklet*. The claims must include the data necessary for *Capital* to determine benefits. An expense will be considered incurred on the date the service or supply was rendered. Claims should be sent to:

Capital Blue Cross
PO Box 211457
Eagan, MN 55121

Capital reserves the right to verify the validity of each claim with the provider or pharmacy and to deny payment if the claim is not adequately supported. Failure to furnish proof of loss to *Capital* within the time specified will not reduce any benefit if it is shown that the proof of loss was submitted as soon as reasonably possible, but in no event will *Capital* be required to accept the proof of loss more than 12 months after benefits are provided, except if the person lacks legal capacity.

Time of Payment of Claims

Claim payment for *benefits* payable under this agreement will be processed immediately upon receipt of proper proof of loss.

Member's Payment Obligations

A *member* has only those rights and privileges specifically provided in the *group contract*. Subject to the provisions of the *group contract*, a *member* is responsible for payment of any amount due to a *provider* in excess of the *benefit* amount paid by *Capital*. If requested by the *provider*, a *member* is responsible for payment of *cost sharing amounts* at the time service is rendered.

Payments

Capital is authorized by the *member* to make payments directly to *in-network providers* furnishing services for which *benefits* are provided under the *group contract*. In addition, *Capital* is authorized by the *member* to make payments directly to a state or federal governmental agency or its designee whenever *Capital* is required by law or regulation to make payment to such entity.

Once a *provider* renders services, *Capital* will not honor *member* requests not to pay claims submitted by the *provider*. *Capital* will have no liability to any person because of its rejection of the request.

Payment of *benefits* is specifically conditioned on the *member's* compliance with the terms of the *group contract*.

Payment Recoupment

Under certain circumstances, federal and state government programs will require *Capital* to reimburse costs for services provided to *members*. *Capital* reserves the right to recoup these reimbursements from *members* when services were provided to the *members* which should not have been paid by *Capital.*

Policies and Procedures

Capital may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this *Benefits Booklet*, with which *members* shall comply.

Relationship of Parties

Healthcare *providers* maintain the *physician*-patient relationship with *members* and are solely responsible to *members* for all medical services. The relationship between *Capital* and healthcare *providers* (including *PCPs* and other *physicians*) is an independent contractor relationship. Healthcare *providers* are not agents or employees of *Capital*, nor is any employee of *Capital* an employee or agent of a healthcare *provider*. *Capital* shall not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the *member* while receiving care from any healthcare *provider*.

Neither the *contract holder* nor any *member* is an agent or representative of *Capital*, and neither is liable for any acts or omissions of *Capital* for the performance of services under the *group contract*.

The *contract holder* is the agent of the *members*, not of *Capital*.

Certain services, including administrative services, relating to the *benefits* provided under the *group contract* may be provided by *Capital* or other companies under contract with *Capital*, Capital Blue Cross, or Keystone Health Plan Central.

Waiver of Liability

Capital shall not be liable for injuries or any other harm or loss resulting from negligence, misfeasance, nonfeasance or malpractice on the part of any *provider*, whether an *in-network provider* or *out-of-network provider*, in the course of providing *benefits* for *members*.

Workers' Compensation

The *group contract* is not in lieu of and does not affect any requirement for *coverage* by workers' compensation insurance.

Public Health Emergency

In the event that *Capital* reasonably determines that there is a public health emergency, such as but not limited to, a pandemic or natural disaster, *Capital* may, but is not required to, waive or modify term(s) of the contract related to the application of clinical management programs, *member* cost share, provisions related to the use of an *in-network provider* or pharmacy, or such other terms in order to reduce the cost of or to expedite the provision of care. *Capital* will provide notice of such change as circumstances allow.

Physical Examination and Autopsy

Capital at its own expense shall have the right and opportunity to examine the person of the *member* when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

ADDITIONAL INFORMATION

You may submit a written request for any of the following written information:

- A list of the names, business addresses and official positions of the membership of the board of directors or officers of *Capital*.
- The procedures adopted by *Capital* to protect the confidentiality of medical records and other *member* information.
- A description of the credentialing process for *in-network providers*.
- A list of the *in-network providers* affiliated with in-network *hospitals*.
- If *prescription drugs* are provided as a *benefit* under this *coverage,* whether a specifically identified drug is included or excluded from this *coverage*.
- A description of the process by which an *in-network provider* can prescribe specific drugs, drugs used for an off-label purpose, biologicals and medications not included in the *Capital* drug *formulary* for *prescription drugs* or biologicals when the *formulary's* equivalent has been ineffective in the treatment of the *member's* disease or if the drug causes or is reasonably expected to cause adverse or harmful reactions in the *member's* case, if *prescription drugs* are provided as a *benefit* under the *member's coverage*.
- A description of the procedures followed by *Capital* to make decisions about the nature of individual drugs, medical devices or treatments.
- A summary of the methodologies used by *Capital* to reimburse *providers* for covered services. Please note that we will not disclose the terms of individual contracts or the specific details of any financial arrangement between *Capital* and an *in-network provider*.
- A summary of the methodologies used by *Capital* to reimburse *pharmacies* for *covered drugs* and/or covered services. Please note that we will not disclose the terms of individual contracts or the specific details of any financial arrangement between *Capital* and an *in-network pharmacy* or a *contracting Rx entity*.
- A description of the procedures used in *Capital's* Quality Management Program as well as progress towards meeting goals.

Requests must specifically identify what information is being requested and should be sent to:

Capital Blue Cross
PO Box 779519
Harrisburg, PA 17177-9519

You may also fax your requests to **717.541.6915** or by accessing CapitalBlueCross.com, an email can be sent to Member Services.

You may inform us of your dissatisfaction with the quality of care or service you may have received by writing to the address above or by faxing us at the number above. You can also call Member Services to register the dissatisfaction. Refer to the **How to Contact Us** section for contact information.

For Products issued by:
Capital Advantage Assurance Company®
Subsidiary of Capital Blue Cross

2025 Schedule of Preventive Care Services

This information highlights the preventive care services available under this *coverage* and lists items/services required under the Patient Protection and Affordable Care Act of 2010 (PPACA), as amended. It is reviewed and updated periodically based on the recommendations of the U.S. Preventive Services Task Force (USPSTF); Health Resources and Services Administration (HRSA), Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services (HHS), and other applicable laws and regulations. Accordingly, the content of this schedule is subject to change.

Your specific needs for preventive services may vary according to your personal risk factors. It is not intended to be a complete list or complete description of available services. In-network preventive services are provided at no Member cost-share. Additional diagnostic studies may be covered if *medically necessary* for a particular diagnosis or procedure; if applicable, these diagnostic services may be subject to cost-sharing. Members may refer to the benefit contract for specific information on available *benefits or contact Customer Service at the number listed on their ID card.*

Schedule for Adults: Age 19 years and older

GENERAL HEALTHCARE*		
For routine history and physical examination, including pertinent patient education. Adult counseling and patient education include:		
Women		
• Breast Cancer Chemoprevention • Contraceptive Methods/Counseling[1] • Folic Acid (childbearing age)	• Hormone Replacement Therapy (HRT) – Risk vs. Benefits • Urinary Incontinence Assessment	At least annually
Men and Women		
• Aspirin Prophylaxis (high-risk) • Drug Use • Family Planning • Fall Prevention (age 65 and older)	• Physical Activity/Exercise • Seat Belt Use • Statin Medication (high-risk) • Unintentional Injuries	At least annually

SCREENINGS/PROCEDURES*	
Women (Preventive care for pregnant women, see Maternity section.)	
Bone Mineral Density (BMD) Test	Age 65 and older, test every 2 years. Age 19-64, test if postmenopausal and at risk for osteoporosis.
BRCA Screening/Genetic Counseling/ Testing	BRCA screening and counseling if at risk and not previously diagnosed with BRCA-related cancer and who have a personal or family history of cancer. BRCA testing once per lifetime if recommended by your healthcare provider.
Domestic/Interpersonal/Partner Violence Screening and Support	Age 19 and older: Screening annually and offer support services as determined by your healthcare provider.
Mammogram (2D or 3D)	Beginning at age 40, every 1-2 years. Includes one additional MRI or Ultrasound if at high risk for breast cancer.
Obesity in Midlife Women	Age 40-60 with normal to overweight body mass index (BMI), offer counseling to prevent obesity.
Pelvic Exam/Pap Smear/HPV DNA	Pelvic Exam/Pap Smear: Age 21-65: every 3 years; HPV DNA: Age 30-65, every 5 years.
Men	
Abdominal Aortic Aneurysm Screening	Age 65-75, one-time screening for abdominal aortic aneurysm in men who have ever smoked.
Prostate Cancer Screening	Beginning at age 50, annually. Begin at age 19 for high-risk males.
Prostate Specific Antigen	Beginning at age 50, annually.
Men and Women	
Alcohol Use Screening/Counseling	Age 19 and older: Offer behavioral counseling interventions for adults who are engaged in risky or hazardous drinking.
Anxiety/Depression Screening	Age 19 and older: Annually or as determined by your healthcare provider.
Cardiovascular Disease Prevention	Age 19 and older at increased risk of cardiovascular disease (CVD); screening and offer behavioral counseling.
Chlamydia and Gonorrhea Test	Age 19-24 years, test all sexually active women and 25 years and older test based on individual risk and recommendation by your healthcare provider. Test as recommended when prescribed HIV PrEP.
CT Colonography[2]	Beginning at age 45, every 5 years.
Colonoscopy[3]	Beginning at age 45, every 10 years.
Diabetes Screening	Age 35-70, screening and testing if overweight or obese. If normal, rescreen every 3 years. If abnormal, offer behavioral counseling.
Fasting Lipid Profile	Beginning at age 20, every 5 years.
Fecal Occult Blood Test (gFOBT/FIT)[4]	Beginning at age 45, annually.
FIT-DNA Test	Beginning at age 45, every 1-3 years.
Flexible Sigmoidoscopy[3]	Beginning at age 45, every 5 years.
Hepatitis B Test	Age 19 and older if at high risk. Periodic repeat testing with continued risk factors.
Hepatitis C Test	Age 19 and older, offer one-time testing. Periodic repeat testing with continued risk factors.
High Blood Pressure (HBP)	Age 19-39, testing every 3-5 years with no other risk factors. Age 40 and older, or younger if at increased risk, test annually.

HIV PrEP Medication with related Testing/Counseling	If prescribed HIV Preexposure Prophylaxis (PrEP) medications, offer related testing and counseling services as determined by your healthcare provider.
HIV Test	Age 19-65, offer one time testing with unknown risk for HIV. Periodic repeat testing with continued risk factors.
Latent Tuberculosis (TB) Infection Test	Age 19 and older at high risk, offer one time testing. Periodic repeat testing with continued risk factors.
Low-dose CT Scan for Lung Cancer	Age 50-80 at high risk, test annually until smoke-free for 15 years.
Obesity/Weight Loss Interventions	Age 19 and older with a BMI of 30 or greater: Offer behavioral interventions.
STI Counseling	Age 19 and older at increased risk: Behavioral counseling as determined by your healthcare provider.
Skin Cancer Prevention Counseling	Age 19-24: Counseling to minimize exposure to ultraviolet (UV) radiation for adults with fair skin.
Syphilis Test	Age 19 and older test if at high-risk. Periodic repeat testing with continued risk factors as determined by your healthcare provider.
Tobacco Use Assessment/ Counseling/Cessation Interventions	Age 19 and older: 2 cessation attempts per year including behavioral counseling interventions (each attempt includes a maximum of 4 counseling visits of at least 10 minutes per session); Food and Drug Administration (FDA)-approved tobacco cessation medications.[5]
IMMUNIZATIONS**	
COVID-19	Age 19 and older: 2 or 3 dose primary series and booster.
Haemophilus Influenza Type B (Hib)	Age 19 and older: Based on individual risk or healthcare provider recommendation, 1 or 3 doses depending on indication.
Hepatitis A (HepA)	Age 19 and older: Based on individual risk or healthcare provider recommendation, 2, 3 or 4 doses.
Hepatitis B (HepB)	Age 19 and older: Based on individual risk or healthcare provider recommendation, 2 to 4 doses.
Human Papillomavirus (9vHPV)	Age 19-45: 2 or 3 doses, depending on age at series initiation or healthcare provider recommendation.
Influenza	Age 19 and older: 1 dose annually.
Measles/Mumps/Rubella (MMR)	Age 19 and older: Based on indication (born 1957 or later) or healthcare provider recommendation, 1 or 2 doses.
Meningococcal A, C, W, Y (MenACWY)	Age 19 and older: Based on individual risk or healthcare provider recommendation, 1 or 2 doses depending on indication, then booster every 5 years if risk remains.
Meningococcal B (MenB)	Age 19 and older: Based on individual risk or healthcare provider recommendation, 2 or 3 doses depending on indication, then booster every 2-3 years if risk remains.
Monkeypox (Mpox)	Age 19 and older based on individual risk or healthcare provider recommendation, 2 doses.
Pneumococcal (PCV15/PCV20/PPSV23)	Age 19 and older: Based on individual risk and healthcare provider recommendation, 1 or 2 doses.
Respiratory Syncytial Virus (RSV)	Age 60 and older: Based on individual risk and healthcare provider recommendation, 1 dose annually.
Tetanus/Diphtheria/Pertussis (Td/Tdap)	Age 19 and older: 1 dose of Tdap, then Td or Tdap booster every 10 years.
Varicella/Chickenpox (VAR)	Beginning at age 19: 1 or 2 doses (born 1980 or later) based upon past immunization or medical history.
Zoster/Shingles (RZV)	Age 19 and older: Based on individual risk or healthcare provider recommendation, 2 doses.

[1] Coverage is provided without cost-share for all FDA-approved contraceptive methods. See the Rx Preventive Coverage List at capitalbluecross.com for details. Coverage includes clinical services, including patient education and counseling, needed for provision of the contraceptive method. If a member's provider recommends a specific FDA-approved method based on medical necessity, the service or item is covered without cost-sharing.
[2] CT Colonography is listed as an alternative to a flexible sigmoidoscopy and colonoscopy.
[3] Only one endoscopic procedure is covered at a time.
[4] For guaiac-based testing (gFOBT), six stool samples are obtained (2 samples on each of 3 consecutive stools, while on appropriate diet, collected at home). For immunoassay testing (FIT), specific manufacturer's instructions are followed.
[5] Refer to the most recent formulary located on the Capital Blue Cross website at capitalbluecross.com.

Schedule for Maternity

SCREENING/PROCEDURES*

The recommended services listed below are considered preventive care (including prenatal visits) for pregnant women. You may receive the following screenings and procedures at no member cost share:

- Alcohol Use Screening/Counseling
- Anemia Screening (CBC)
- Anxiety/Depression Screening (prenatal/postpartum)
- Breastfeeding Support/Counseling/Supplies
- Gestational Diabetes Screening (prenatal/postpartum)
- Healthy Weight Gain during Pregnancy
- Hepatitis B Screening (first prenatal visit)
- HIV Screening•
- Low-dose Aspirin Therapy (after 12 weeks gestation with high- risk for preeclampsia)
- Preeclampsia Screening
- Rh Blood Typing
- Rh Antibody Testing for Rh-negative Women
- Rubella Titer
- STI Screening/Testing (Chlamydia/Gonorrhea/Syphilis)
- Tobacco Use Assessment, Counseling and Cessation Interventions
- Urine Bacteria Screening (Asymptomatic)
- Other preventive services may be available as determined by your healthcare provider

* Services that need to be performed more frequently than stated due to specific health needs of the member and would be considered medically necessary may be eligible for coverage when submitted with the appropriate diagnosis and procedure(s) and are covered under the core medical benefit. If a clinician determines that a patient requires more than one well-woman visit annually to obtain all necessary recommended preventive services, the additional visits will be provided without cost-sharing. Occupational, school, and other "administrative" exams are not covered.
** Refer to the guidelines set forth by the Centers for Disease Control and Prevention (CDC) for additional immunization information.

Schedule for Children: Birth through the end of the month child turns 19 years old

GENERAL HEALTHCARE

Routine History and Physical Examination – Recommended Initial/Interval of Service:
Newborn, 3-5 days, by 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, and 30 months; and 3 years to 19 years annually

Exams may include:

- Blood pressure (risk assessment up to 2 1/2 years)
- Body mass index (BMI; beginning 2 years of age)
- Developmental milestones surveillance (except at time of developmental screening)
- Head circumference (through 24 months)
- Height/Length/Weight
- Newborn evaluation (including gonorrhea prophylactic topical eye medication)
- Sudden cardiac arrest/death (risk assessment beginning 11 years of age)
- Weight for Length (through 18 months)
- Anticipatory guidance for age-appropriate issues including:
  - Growth and development, obesity prevention, physical activity and psychosocial/behavioral health
  - Breastfeeding/nutrition/support/counseling/supplies
  - Safety, unintentional injuries, firearms, poisoning, media access
  - Contraceptive methods/counseling (females)
  - Alcohol, tobacco, or drug use assessment/education
  - Oral health risk assessment/dental care/fluoride supplementation (greater than 6 months)[1]
  - Fluoride varnish painting of primary teeth (up to age 5 years)
  - Folic Acid (childbearing age)

	Newborn	9-12 months	1 year	2y years	3 years	4 years	5 years	6 years	7 years	8 years	9 years	10 years	11 years	12 years	13 years	14 years	15 years	16 years	17 years	18 years	19 years
SCREENINGS/PROCEDURES*																					
Alcohol, Tobacco and Drug Use Assessment (CRAFFT)													✓	✓	✓	✓	✓	✓	✓	✓	✓
Alcohol Use Screening/Counseling																				✓	✓
Anemia Screening			✓	Assess risk at all other well child visits																	
Anxiety/Depression (PHQ-2)/ Suicide Risk Screening										✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Autism Spectrum Disorder Screening	At 18 months			✓																	
Chlamydia and Gonorrhea Test	For sexually active females: suggested testing interval is 1-3 years.																				
Developmental Screening		✓	✓	✓	At 9 months, 18 months, and 2 1/2 years.																
Domestic/Interpersonal/ Intimate Partner Violence Screening and Support	Annually for adolescents of childbearing age, 11 years and older; offer support services as determined by your healthcare provider.																				
Hearing Screening/Risk Assessment	Between 3-5 days through 3 years; repeat at 7 and 9 years.																				
Hearing Test (objective method)	✓					✓	✓	✓		✓		✓	Once between ages 11-14, 15-17 and 18+								
Hepatitis B Test	Beginning at newborn, screening if at high-risk for infection. Periodic repeat testing of children with continued high risk.																				
Hepatitis C Test	One-time testing beginning at age 18 years. Periodic repeat testing with continued high risk.																			✓	✓
High Blood Pressure (HBP)					✓	Beginning at 3 years or younger if at high-risk: At every well-child visit. Ambulatory Blood Pressure Monitoring (ABPM) recommended for confirming HBP.															
HIV Screening/Risk Assessment													✓	✓	✓	✓	✓	✓	✓	✓	✓
HIV Test	Routine one-time testing between 15-18 years old. If indicated by high-risk assessment testing may begin earlier. Periodic repeat testing (at least annually) of all high-risk children.																				
Lead Screening Test/Risk Assessment	Screening Test: 12 to 24 months (at risk) 2; Risk Assessment at 6, 9, 12, 18, 24 months and 3-6 years.																				
Lipid Screening/ Risk Assessment				✓		✓		✓		✓				✓	✓	✓	✓	✓	✓		
Lipid Test	Once between 9-11 years (younger if risk is assessed as high) and once between 17-19 years.																				
Maternal Depression Screening	By 1 month, 2 months, 4 months, and 6 months.																				
Newborn Bilirubin Screening	✓																				
Newborn Blood Screen *(as mandated by the PA Department of Health)*	✓																				
Newborn Critical Congenital Heart Defect Screening	✓																				
Obesity								✓	Beginning at 6 years: At every well-child visit. Offer/refer to intensive counseling and behavioral interventions.												

	Newborn	9-12 months	1 year	2 years	3 years	4 years	5 years	6 years	7 years	8 years	9 years	10 years	11 years	12 years	13 years	14 years	15 years	16 years	17 years	18 years	19 years
SCREENINGS/PROCEDURES*																					
STI Screening/Counseling	Beginning at 11 years (at risk, if sexually active): Offer behavioral counseling.												✓	✓	✓	✓	✓	✓	✓	✓	✓
Skin Cancer Prevention Counseling	Beginning at 6 months, counseling to minimize exposure to ultraviolet (UV) radiation for children with fair skin.																				
Syphilis Test	For high-risk children; suggested testing interval is 1-3 years.																				
Tobacco Smoking Screening and Cessation	Beginning at age 18: Two (2) cessation attempts per year including behavioral counseling interventions; (each attempt includes a maximum of 4 counseling visits); FDA approved tobacco cessation medications[3]																			✓	✓
Tuberculin Test	Assess risk at every well child visit, test if recommended by healthcare provider.																				
Vision Risk Assessment	Up to 2 1/2 years								✓		✓		✓		✓	✓		✓	✓	✓	✓
Vision Test (objective method)					✓	✓	✓	✓		✓		✓		✓			✓				
	Optional annual instrument-based testing may be used between 1-5 years of age and between 6-19 years of age in uncooperative children.																				

IMMUNIZATIONS**	
COVID-19	6 months – 18 years; 2 or 3 primary dose series and booster
Diphtheria/Tetanus/Pertussis (DTaP)	2 months, 4 months, 6 months, 15–18 months, 4–6 years; 5 doses
Haemophilus Influenza Type B (Hib)	2 months, 4 months, 6 months, 12–15 months, and 1–18 years based on individual risk; 3 or 4 doses
Hepatitis A (HepA)	12–23 months; 2 doses
Hepatitis B (HepB)	Birth, 1–2 months, 6–18 months; 3 doses
Human Papillomavirus (HPV)	9-18 years: Starting age and doses are based on individual risk and healthcare provider recommendations; 2 or 3 doses
Influenza[4]	6 months–18 years; annual vaccination, 1 or 2 doses
Measles/Mumps/Rubella (MMR)	12–15 months, 4–6 years; 2 doses
Meningococcal (MenACWY)	11–12 years, 16 years; 2 months–18 years for those at high-risk; 2 doses
Meningococcal B (MenB)	10–18 years based on individual risk or healthcare provider recommendation; 2 or 3 doses
Monkeypox (Mpox)	Age 18 and older based on individual risk or healthcare provider recommendation, 2 doses
Pneumococcal (PCV15, PCV20, or PPSV23)	2 months, 4 months, 6 months, 12–15 months and 2-18 years based on individual risk and healthcare provider recommendation; 4 doses
Polio (IPV)	2 months, 4 months, 6–18 months, 4–6 years; 4 doses
Respiratory Syncytial Virus (RSV)	Birth, 1–19 months; 1 dose. Children up to 24 months based on individual risk or healthcare provider recommendation; 1 dose annually
Rotavirus (RV)	2 months, 4 months, 6 months; 2 or 3 doses
Tetanus/Reduced Diphtheria/Pertussis (Tdap)	11–12 years; 1 dose
Varicella/Chickenpox (VAR)	12–15 months, 4–6 years; 2 doses

1 Fluoride supplementation pertains only to children who reside in communities with inadequate water fluoride.
2 Encourage all PA Children's Health Insurance Program (CHIP) Members to undergo blood lead level testing before age 2 years. If not previously tested, test between the ages of 3 to 6 years old.
3 Refer to the most recent formulary located on the Capital Blue Cross web site at capitalbluecross.com.
4 Children aged 6 months to 8 years who are receiving influenza vaccines for the first time should receive 2 separate doses (greater than 4 weeks apart), both of which are covered.
* Services that need to be performed more frequently than stated due to specific health needs of the member and would be considered medically necessary may be eligible for coverage when submitted with the appropriate diagnosis and procedure(s) and are covered under the core medical benefit. If a clinician determines that a patient requires more than one well-woman visit annually to obtain all necessary recommended preventive services, the additional visits will be provided without cost-sharing. Occupational, school, and other "administrative" exams are not covered.
** Refer to the guidelines set forth by the Centers for Disease Control and Prevention (CDC) for additional immunization information including special situations and catch-up vaccinations if necessary.

This preventive schedule is periodically updated to reflect current recommendations from the U.S. Preventive Services Task Force (USPSTF); Health Resources and Services Administration (HRSA), National Institutes of Health (NIH); NIH Consensus Development Conference Statement, March 27–29, 2000; Advisory Committee on Immunization Practices (ACIP); Centers for Disease Control and Prevention (CDC); American Diabetes Association (ADA); American Cancer Society (ACS); Eighth Joint National Committee (JNC 8); U.S. Food and Drug Administration (FDA), American Academy of Pediatrics (AAP), Women's Preventive Services Initiative (WPSI).

For Products issued by:
Capital Advantage Assurance Company®
Subsidiary of Capital Blue Cross

Preauthorization Program for Commercial Medical Benefits

MEDICAL SERVICES REQUIRING PREAUTHORIZATION

When members use an in-network provider (including a BlueCard® facility participating provider providing **inpatient services**) for services subject to preauthorization, the in-network provider is responsible for obtaining the preauthorization. If members use an out-of-network provider or a BlueCard participating provider providing **non-inpatient services**, the member is responsible for getting the required preauthorization. However, the out-of-network provider or BlueCard participating provider may request preauthorization on the member's behalf. Providers or members may call us toll-free at **1.800.730.7219** to obtain the necessary preauthorization. In-network providers should access the provider portal to request preauthorization. Out-of-network and out-of-area providers may access the out-of-area/network provider resources on capbluecross.com for direction to request preauthorization.

Providers or Members should request preauthorization of non-urgent admissions and services well in advance of the scheduled date of service. We will make a determination on your non-urgent request within 15 calendar days of receipt of all necessary information. Investigational procedures are not covered benefits. Providers and members may access our medical policies at [capbluecross.com], and may contact us to see if we consider a service to be investigational.

We only pay for services and items that are considered medically necessary. Please refer to our medical policies for questions regarding medical necessity. Members should consult their Benefits Booklets, Capital Blue Cross' Medical Policies, or contact Member Services at the number listed on the back of their ID card for questions relating to terms and conditions of coverage. Preauthorization approvals are not a guarantee of payment. Payment for preauthorized services/items is subject to the member's benefits and eligibility on the date of service.

PREAUTHORIZATION OF MEDICAL SERVICES INVOLVING CARE THAT IS NEEDED URGENTLY

If the member's request for preauthorization involves care that is required urgently, the member or the member's provider must advise us of the urgent medical circumstances when submitting the preauthorization request. This is considered an urgent request. We will respond to an urgent request no later than 72 hours after we receive all necessary information for a determination. If the request is related to continuing health care services you are currently receiving, the request must be made at least 24 hours prior to the reduction or termination of your current treatment, and we will respond within 24 hours from the receipt of all necessary information for a determination.

FAILURE TO OBTAIN PREAUTHORIZATION

Failure to obtain preauthorization for a service could result in a payment reduction or denial for the provider and benefit reduction or denial for the member, based on the provider's contract and the member's Benefits Booklet or Contract. Services or items provided without preauthorization may also be subject to retrospective medical necessity review.

If the member presents their ID card to an in-network provider in the 21-county area and the in-network provider fails to obtain or follow preauthorization requirements, payment for services will be denied and the provider may not bill the member for the services performed.

EMERGENT SERVICES AND NON-ROUTINE MATERNITY ADMISSIONS

Preauthorization requirements do not apply to services provided by a hospital emergency department. If an acute inpatient admission results from an emergency department visit, notification must occur within two business days of the admission. All such services will be reviewed and must meet medical necessity criteria from the first hour of admission. Failure to notify us of an admission may result in an administrative denial.

Diagnostic services do not require preauthorization when emergently performed during an emergency room visit, observation stay, or inpatient admission.

Non-routine maternity admissions, including preterm labor and maternity complications, require notification within two business days of the date of admission.

Below is a non-exhaustive listing of services for which preauthorization is required. Items listed in the Details column are examples of services requiring preauthorization; however, members should view the Single Source

Preauthorization List **for a complete listing of services currently requiring preauthorization. We may from time to time change preauthorization requirements for items and services covered under your health plan.**

Category	Details	Comments
Inpatient Admissions	• Acute care • Long-term acute care • Non-routine maternity admissions and newborns requiring continued hospitalization after the mother is discharged • Skilled nursing facilities • Rehabilitation hospitals • Behavioral health admissions (mental health or substance use disorder diagnoses)	
Diagnostic Services	• Genetic testing. • High tech imaging such as but not limited to: Cardiac nuclear medicine studies including nuclear cardiac stress tests, CT (computerized tomography) scans, MRA (magnetic resonance angiography), MRI (magnetic resonance imaging), PET (positron emission tomography) scans, and SPECT (single proton emission computerized tomography) scans.	
Durable Medical Equipment (DME), Prosthetic, Appliances, Orthotic Devices, Implants		
Office Procedures When Performed in a Facility		
Outpatient Procedures/ Surgery	• Weight loss surgery (Bariatric) • Meniscal transplants, allografts and collagen meniscus implants (knee) • Ovarian and Iliac Vein Embolization • Photodynamic therapy • Radioembolization for primary and metastatic tumors of the liver • Radiofrequency ablation of tumors • Transcatheter aortic valve replacement • Valvuloplasty • Treatment of Varicose Veins and Venous Insufficiency	
Transplant Surgeries	Evaluation and services related to transplants	Preauthorization will include referral assistance to the Blue Distinction Centers for Transplant network if appropriate.
Reconstructive or Cosmetic Services and Items	• Removal of excess fat tissue (Abdominoplasty/Panniculectomy and other removal of fat tissue such as Suction Assisted Lipectomy) • Breast Procedures - Breast Enhancement (Augmentation) - Breast Reduction - Mastectomy (Breast removal or reduction) for Gynecomastia - Breast Lift (Mastopexy) - Removal of Breast implants • Correction of protruding ears (Otoplasty) • Repair of nasal/septal defects (Rhinoplasty/Septoplasty) • Skin related procedures	

Category	Details	Comments
	- Acne surgery - Dermabrasion - Hair removal (Electrolysis/Epilation) - Face Lift (Rhytidectomy) - Removal of excess tissue around the eyes (Blepharoplasty/Brow Ptosis Repair) - Mohs Surgery when performed on two separate dates of service by the same provider	
Medical Injectable drugs and Gene Therapies		
Investigational procedures, devices, therapies, and pharmaceuticals		Investigational procedures are not usually covered benefits. Members and providers may request preauthorization to determine if a service/item is investigational.
New to market procedures, devices, therapies, and pharmaceuticals		Preauthorization may be required up to two years after the entry of a new procedure, device, therapy or pharmaceutical into the market.
Select Outpatient Behavioral Health Services	• Partial Hospitalization Program • Intensive Outpatient Programs • Applied Behavioral Analysis (ABA)	
Other Services	• Bio-engineered skin or biological wound care products • Category IDE trials (Investigational Device Exemption) • Enhanced external counterpulsation (EECP) • Home health care • Eye injections (Intravitreal angiogenesis inhibitors) • Non-emergency air ambulance transports • Enteral feeding supplies and services	
Pain Management	• Interventional Pain Management • Joint injections	
Oncology Services	Radiation therapy and related treatment planning and procedures performed for planning	
Select Cardiac Services		

PLEASE NOTE: This listing identifies those services that require preauthorization only as of the date it was printed. This listing is subject to change. Members should call us at 1.800.730.7219 (TTY: 711) with questions regarding the preauthorization of a particular service.

For HMO and Gatekeeper PPO members, all care rendered by out-of-network providers requires preauthorization, with the exception of Emergency Services. This includes care that falls under the Continuity of Care provision of the Benefits Booklet or Contract.

This information highlights the standard Preauthorization Program. Members should refer to their Benefits Booklet or Contract for the specific terms, conditions, exclusions, and limitations relating to their coverage.

Applicable Group Numbers

00501114 QHDHP PPO Plan 9 and Plan 10 with Rx Plan 9 and Plan 10

January, 2025