Employee Benefit Trust of Eastern PA
Career Institute of Technology Employee Benefit Plan

Plan Document

July 2019

Table of Contents

INTRODUCTION

We provide health and welfare benefits for the eligible employees and dependents of the Career Institute of Technology Employee Benefit Plan. Although these benefits are described in the attached Appendices, there are certain eligibility provisions and member rights that the appendices may not address.

The Career Institute of Technology Employee Benefit Plan includes the following plans:

- Medical
- Prescription Drug

This Plan Document is written in simple, direct language and is designed to help you understand the details of the benefits available, the eligibility requirements, and general information about the benefit plans. We urge you to become familiar with the contents of this document so that you and your dependents can fully utilize, whenever necessary, the benefits that are available to eligible Participants.

PLAN AND PROGRAM BENEFITS

Important information about your health benefits can be found in the Appendices at the end of this Plan Document. Within each Appendix you will find a summary of the benefits, the services that are covered, the services that are excluded, how the plan works, how to file a claim, how to appeal a benefit determination, member rights and responsibilities, who to call if you have questions and general information.

ELIGIBILITY FOR PARTICIPATION

In order to be considered for participation with this Plan, an individual must meet certain eligibility requirements and enroll (apply) for coverage within a specific timeframe.

Employees eligible to enroll in coverage are detailed in Appendix A.

You are eligible to become a member or participant in the Career Institute of Technology Employee Benefit Plan after you satisfy all of the following:

1) The eligibility requirements of the included Plan(s)

2) The enrollment requirements of the included Plan(s)

There is a limited period of time to apply for initial enrollment and enrollment changes. Please refer to the Open Enrollment section below.

Subscriber
An individual must meet all eligibility criteria specified in Appendix A to enroll in the Plan.

Dependent - Spouse
An individual must be the lawful spouse of the subscriber to enroll in the Plan as a dependent spouse. The term spouse shall mean the covered employee's legally married spouse as recognized under Pennsylvania law.

Dependent - Child
To enroll in the Plan as a child, an individual must be under the age of twenty-six (26) and be:

- A birth child of the subscriber or the subscriber's spouse;
- A child legally adopted by or placed for adoption with the subscriber or the subscriber's spouse;
- A ward of the subscriber or the subscriber's spouse; or
- A child for whom the subscriber or the subscriber's spouse is required to provide health care coverage pursuant to a Qualified Medical Child Support Order (QMCSO).

Dependent - Disabled Child
An individual must be an unmarried child age twenty-six (26) or older to enroll in the Plan as a disabled dependent child. The child must be:

- A birth child, adopted child, or ward of the subscriber or the subscriber's spouse;
- Mentally or physically incapable of earning a living; and
- Chiefly dependent upon the subscriber or subscriber's spouse for support and maintenance, provided that:
- The incapacity began before age twenty-six (26);
- The subscriber provides the district with proof of incapacity within thirty-one (31) days after the dependent disabled child reaches age twenty-six (26); and
- The subscriber provides related information as otherwise requested by the district, but not more frequently than annually.

Note that the district may require documentation to verify dependent eligibility in the plan, including, but not limited to, copies of marriage certificates, birth certificates, or joint bank account statements or tax returns for any dependents that are enrolled in the plan.

ENROLLMENT

Initial Enrollment for Newly Eligible Members
"Initial" is the term used to represent eligible members enrolling for the first time. Please refer to Appendix A to determine when you are eligible to enroll initially.

Dependent - Newborns
For thirty-one (31) days following birth, your newborn child is covered under this Plan.

Eligible newborns **must** be enrolled within thirty-one (31) days of birth to have ongoing coverage. If the newborn child qualifies as a dependent, you must notify the district immediately and add the newborn child as a dependent within the required timeframes.

If the newborn child does not qualify as a dependent under the terms of this plan, the newborn child may not be enrolled in ongoing coverage.

OPEN ENROLLMENT

Prior to September 1st of each year an open enrollment period will occur. Each employee will be given an opportunity to review the benefit options that are available and make changes if desired. This open enrollment period is also an opportunity to add or delete dependents from the coverage.

Benefit choices made during the open enrollment period will become effective September 1st and remain in effect until the next September 1st unless there is a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment. (see Group Health Plan Special Enrollment Rights section below).

A Plan Participant who fails to make an election during open enrollment will automatically retain the coverage that is currently in force. At initial plan eligibility, failure to make an election will result in non-enrollment. If the Plan Participant desires to waive coverage in the Medical and Prescription Drug plans, a certificate of alternative coverage will be required.

Plan Participants will receive detailed information regarding open enrollment from the district.

Group Health Plan Special Enrollment Rights

It's important that you understand your right to apply for group health insurance coverage outside of the annual open enrollment period. The Health Insurance Portability and Accountability Act (HIPAA) requires that employees be allowed to enroll themselves and/or their dependent(s) in an employer's Group Health Plan under certain circumstances, described below, provided that the employee notified the employer within 30 days of the occurrence of any following events:

- Loss of health coverage under another employer plan (including exhaustion of COBRA coverage) or after an individual loses other minimum essential coverage;
- Acquiring a spouse through marriage; or
- Acquiring a dependent child through birth, adoption, placement for adoption or foster care placement.
- Acquiring a stepchild or becoming a legal guardian for a child
- Receiving a legal custody order, in the case of a ward;
- A change in Medicare status

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

Effective April 1, 2009, the Children's Health Insurance Program Reauthorization Act of 2009 creates two new special enrollment rights for employees and/or their dependents. In addition to the special enrollment rights set forth above, all group health plans must also permit eligible employees and their dependent(s) to enroll in an employer plan if the employee requests enrollment under the group health plan within 60 days of the occurrence of following events:

Loss of coverage under Medicaid or a state child health plan: If you or your dependent(s) lose coverage under Medicaid or a state child health plan, you may request to enroll yourself and/or your dependent(s) in our group health plan not later than 60 days after the date coverage ends under Medicaid or the state child health plan.

Gaining eligibility for coverage under Medicaid or a state child health plan: If you and/or your dependent(s) become eligible for financial assistance from Medicaid or a state child health plan, you may request to enroll yourself and/or your dependent(s) under our group health plan, provided that your request is made not later than 60 days after the date that Medicaid or the state child health plan determines that you and/ or your dependent(s) are eligible for such financial assistance. If you and/or your dependent(s) are currently enrolled in our group health plan, you have the option of terminating your and/or your dependent's (s') enrollment in our group health plan and enroll in Medicaid or a state child health plan.

Please note that once you terminate your enrollment in our group health plan, your dependent's (s') enrollment will be also terminated.

Failure to notify us of your loss or gain of eligibility for coverage under Medicaid or a state child health plan within 60 days, will prevent you from enrolling in our plans and/or making any changes to your coverage elections until our next open enrollment period.

If one of these events occurs, you must notify the district immediately.

Timelines for Submission of Enrollment Applications
There is a limited period of time to apply for initial enrollment and enrollment changes as detailed above.

If you fail to apply these specific timeframes, you may not be allowed to enroll in the Plan until the next annual Open Enrollment period.

IMPORTANT DISCLOSURES

Maternity and Newborn Length of Stay

Group health plans and health insurance issuers generally may not, under Federal law, 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 cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Coverage for Reconstructive Surgery Following Mastectomy

Group health plans and health insurance issuers that offer coverage for mastectomy, under Federal law, must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. This coverage applies to both men and women. It is to include:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas (loss of normal lymph channel drainage).

Mental Health Parity and Addiction Equity

Group health plans and health insurance issuers that offer coverage for mental health benefits (including substance use disorder benefits), under Federal law, must provide that restrictions on these benefits are no more restrictive than the most common or frequent requirements that apply to substantially all medical and surgical benefits covered under the plan including 1) inpatient, in-network; 2) inpatient, out-of-network, 3) outpatient, in-network; 4) outpatient, out-of-network; 5) emergency care; and 6) prescription drugs. This equality or parity requirement applies to:

- Financial requirements including deductibles, co-payments, co-insurance, and out-of-pocket expenses;
- Treatment limitations including limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment; and
- Out-of-network benefits

Upon request you or your provider are entitled to receive the criteria for medical necessity determinations for mental health or substance use disorder benefits. The reasons for any denial of such benefits must also be made available upon request.

Genetic Information

Group health plans and health insurance issuers generally may not, under Federal law, obtain or use genetic information when determining premium charges, coverage, benefits, or any other purpose. This rule is not violated if the plan or issuer receives the information inadvertently or for use in monitoring the effects of toxic substances in the workplace. Also, you are free to authorize the disclosure of genetic information when making a FMLA or health-related claim.

Children's Health Insurance Program

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

PENNSYLVANIA – Medicaid
Website: http://www.dhs.state.pa.us/hipp
Phone: 1-800-692-7462

HIPAA Notice of Privacy Practices

The Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires your self-funded health plan(s) (SFHP) to keep protected health information private and to give you this notice of its legal duties and privacy practices for protected health information. The SFHP must obey the terms of this notice as now in effect. The SFHP can change the terms of this notice and the privacy practices it describes at any time. The change must agree with the Privacy Rule. Any change will apply to all protected health information held by the SFHP. If there is a change, the change will not happen until you receive a new notice describing it. You will receive your new notice either at work or at the mailing address that you gave your employer.

The Privacy Rule allows the SFHP to use and disclose your medical information in order to decide if you are eligible for benefits and to handle claims and any appeals.

When the SFHP discloses medical information to your employer and its employees that handle SFHP matters, the information will be kept confidential. Your employer agrees not to use or disclose the information for decisions about your employment (including fitness for duty determinations) or any other benefit or employee benefit plan. If an employee does not keep your medical information private, he will be disciplined.

If someone obtains, accesses, uses, or discloses your protected health information in a way not permitted under the Privacy Rule, the event will be investigated. You will receive a report of this breach if it compromises your protected health information.

If you do not give us a written authorization, the SFHP will not make any other uses or disclosures. Without your specific authorization, we cannot sell, use, or disclose your information for marketing or any other purpose. If your spouse or adult child files a claim without you, the SFHP will not discuss the claim with you without authorization from your spouse or adult child. An authorization can be revoked in writing. A revocation will not change anything the Plan has already done based on the earlier authorization.

YOUR PROTECTED HEALTH INFORMATION RIGHTS.

- You have the right to request restrictions on the use and disclosure of medical information used for claims or Plan operations. Your spouse and dependents may ask that their medical information not be disclosed to you. The Plan is not required to agree to the restriction.

- You have the right to receive confidential communications of medical information in a different way or at a different address, if you are in danger. The Plan will agree to reasonable requests. A reasonable request: (1) is in writing; (2) identifies the information; (3) states that disclosure of all or part of this information could endanger you; (4) tells how to handle the reimbursement; and (5) gives another address or other way to contact you.

- You have the right to see and copy your medical information. You will be allowed to see this information, except for one reason. If a licensed health care professional determines this will endanger someone, you will be denied access. Your request must be in writing and can only apply to records held by the Plan. You do not have the right under these rules to see or copy health information in your employment file.

- The Plan will respond in 30 days after receipt of the request. If the information is not on-site, the Plan will tell you in 30 days and will provide the information in 60 days of the request. If this cannot be done, the Plan will explain the reasons for the delay in writing and will give you the date by which it will provide the information. It cannot delay beyond this date.

- You can see your medical information during normal business hours at a place named by the Plan Administrator. If you request copies, the Plan will charge $0.25 per page plus the cost of mailing. If the Plan does not have the information, and it knows where to find the information, it will tell you.

- You have the right to amend your medical information. Since the Plan does not create this information, you should contact your health care provider to change your medical information and send the amended information to the Plan. However, if the creator of the medical information is not available, you may file a written amendment request with the Plan. The request must explain why you believe the information creator is not available and why the change is necessary. If the information is not a part of its records or if it determines the current information on file is accurate and complete, the Plan will deny the request.

- The Plan will respond in 60 days after receipt of the request. If your request cannot be met in 60 days, the Plan will explain the reasons for the delay in writing and will give you the date by which it will respond. This date cannot be more than 90 days after your request. It cannot delay beyond this date.

- If the Plan agrees, in whole or in part, it will tell you, identify the affected records, and attach the amendment to them. If you tell the Plan to tell anyone else, it will make reasonable efforts to send the amendment within a reasonable time to those persons.

- If the Plan denies the request, in whole or in part, it will give you a written denial that states: (1) the reason; (2) how to send a written statement disagreeing with the denial; and (3) how to complain to the Plan or to the Secretary of the Department of Health and Human Services. If you do not send a statement of disagreement, you may ask the Plan to include your amendment request and the denial with any future disclosures of the medical information. The Plan may write a rebuttal to your statement of disagreement. If there is a rebuttal, the Plan must send you a copy.

- You have the right to receive a record of medical information disclosures that have been made within the last 6 years. This record will not include disclosures to you or any you agreed to by an authorization form. The record will exclude disclosures to your employer that were made as a part of handling a claim. If you request more than one report in the same 12-month period, the Plan will charge a fee after the first report of $25 per report.

- You have the right to get a copy of this notice from the Plan by just asking.

If you believe your privacy rights have been violated, you may file a written complaint with the Contact Person. To file a complaint with the Plan hand-deliver or mail it to the address below. Please be as specific as possible and include any evidence you may have. Neither your employer nor the Plan will retaliate against you for filing a complaint.

If you do not get a response to your complaint in 30 days or if for any reason you do not feel comfortable filing your complaint with the Contact Person, contact Human Resources for your employer.

By law you can file a complaint with the Secretary of the Department of Health and Human Services. You may obtain further information regarding this option from your Office for Civil Rights (OCR) regional office or the web at http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html. OCR complaints should be filed within 180 days of the occurrence.

COBRA CONTINUATION COVERAGE UNDER GROUP HEALTH PLANS

The Consolidated Omnibus Budget Reconciliation Act (COBRA) may provide you with rights to health care continuation coverage. If you are covered by our group health plan, COBRA may give you the right to stay covered even if something happens, like losing your job, which would otherwise cause you to lose coverage. This continuation coverage under a group health plan is called "COBRA continuation coverage." COBRA continuation coverage lasts only for a limited time, and you have to pay for it.

Qualifying Beneficiaries and Qualifying Events

If you are covered by our group health plan, you, your spouse, and your dependent children may have rights under COBRA as "qualified beneficiaries" if:

- You lose or leave your job (other than by reason of your gross misconduct) (if you take an FMLA leave of absence and do not return to active employment, the qualifying event of termination of employment occurs at the end of the leave); or

- You work less hours and our group health plan says this makes you ineligible for coverage.

Your dependent children may include any child who is born to or placed for adoption with you during a period of COBRA continuation coverage, if certain requirements are met.

Your spouse and your dependent children have the right to be qualified beneficiaries for COBRA continuation coverage following your death or divorce or legal separation if they are covered by our group health plan and would lose coverage because of the qualifying event.

COBRA gives your dependent child the right to COBRA continuation coverage for up to 36 months if he or she is covered by our group health plan and would lose coverage because he or she has reached an age or satisfied a condition that causes dependent coverage to end. If you become entitled to Medicare benefits (under Part A, Part B, or both), this would be a qualifying event for your spouse and dependent children. You are not "entitled" to Medicare until you have actually completed the Medicare enrollment and you have been notified your Medicare coverage is in effect.

Notice of the Qualifying Event and COBRA Election

Notice from Us – The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. We are required to notify the Plan Administrator of the qualifying event when you lose or leave your job, your hours are reduced, you die, we commence bankruptcy proceedings, or you become entitled to Medicare benefits.

Notice from you – In order for the COBRA rights notice and election forms to be provided, the Plan Administrator must be notified if:

- there is a divorce or legal separation;
- a child, adopted child or stepchild attains age 26;
- a grandchild (great-grandchild, etc.), sibling, step-sibling, niece, or nephew ceases to be your dependent; or
- an individual receiving COBRA continuation coverage qualifies for or loses Social Security disability benefits.

You or any qualifying beneficiary are required to give notice within 60 days of the later of:

- The date of the qualifying event; or
- The date the qualified beneficiary would lose coverage on account of the qualifying event.

Notice is to be given in writing. The group health plan may require that a specific form be completed.

COBRA Election – Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. You may elect COBRA continuation coverage on behalf of your spouse, and either you or your spouse may elect COBRA continuation coverage on behalf of your children.

If COBRA continuation coverage is desired, it must be elected within 60 days after the later of:

- The date the qualified beneficiary would lose coverage on account of the qualifying event; or

- The date notice is provided to the qualified beneficiary of the right to elect COBRA continuation coverage.

If the Plan Administrator receives notice from you (or someone else who believes he/she is a qualified beneficiary) but determines that no COBRA continuation coverage is required, the Plan Administrator will provide you with a written explanation as to why you are not entitled to continuation coverage. This explanation will be provided within 14 days of the Plan's receipt of your notice.

Cost of Coverage - The group health plan is required to continue the same coverage. All costs of coverage are payable by you after the termination of your employment or by your spouse or child and are made on an after-tax basis. The charge would be equal to the entire cost of coverage, plus a small (2%) additional charge for administration. (If you are getting a longer period of coverage because of disability, you may have to pay more. If the coverage would not be required to be made available in the absence of a disability extension, the COBRA continuation coverage premium can be 150% of the regular cost of coverage.) COBRA continuation coverage charges can be paid in monthly installments.

Timely Payment – Coverage will cease if payment is not made timely. For the first payment, the plan must give you (or the qualified beneficiary) at least 45 days after the date of the election. Thereafter, timely payment usually means within 30 days after the first day of that coverage period. The group health plan may permit a later date; read its COBRA coverage notice. If you are receiving severance pay in connection with a termination of employment, you may choose to have your severance pay applied toward your COBRA coverage payments.

Period of Coverage - If COBRA continuation coverage is elected, coverage generally begins as of the date that coverage would otherwise have been lost. Coverage will then continue until the earliest of the following dates (unless it is terminated for cause):

- The last day of the 36-month maximum coverage period. This does not apply if the qualifying event was termination of employment or a reduction of hours of employment.

- The last day of the 18-month maximum coverage period required where the qualifying event was termination of employment or a reduction of hours of employment. This is subject to a "Disability Extension" or a "Second Qualifying Event Extension."

- You (or the qualified beneficiary) fail to make timely payment.

- The date we cease to provide any group health plan to any employee.

- The date, after the date of the election, as of which the qualified beneficiary first becomes covered under any other group health plan.

- The date, after the date of the election, as of which the qualified beneficiary first becomes entitled to Medicare benefits.

Special Medicare Related Coverage Period – If you become entitled to Medicare benefits less than 18 months before the qualifying event and the qualifying event is termination of employment or a reduction of hours of employment, COBRA continuation coverage for your spouse and your dependents (but not you) will continue until 36 months after the date of your Medicare entitlement. For example, if you become entitled to Medicare 8 months before the date you terminate employment, COBRA continuation coverage for your spouse and children will last 28 months after your termination (36 months minus 8 months).

Disability Extension – Under certain circumstances a disabled qualified beneficiary will receive 29 months of coverage, instead of 18 months. If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. In order to qualify, the disability would have to have started at some time before the 60th day of COBRA continuation coverage.

In order for notice to be properly and timely given to the Plan, notice must be given in writing to the Plan Administrator and must be accompanied by a copy of the Social Security Administration determination. The group health plan may require that a specific form be completed. You or any qualifying beneficiary are required to give notice within 60 days of the latest of:

- The date of the disability determination by the Social Security Administration;
- The date of the qualifying event; or
- The date the qualified beneficiary would lose coverage on account of the qualifying event.

However, if the notice is not given during the first 18 months of COBRA continuation coverage, it will be too late and COBRA coverage will not be extended.

If the Social Security Administration determines that the person is no longer disabled, notice is required to be given to the Plan Administrator within 30 days of this determination. Coverage will end as of the later of: (1) 30 days after the final determination; or (2) the end of the maximum coverage period that would have applied without regard to the disability extension.

Second Qualifying Event Extension – If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your spouse and dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to them if you die, become entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if a dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused your spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

In order for notice to be properly given to the Plan, notice must be given in writing to the Plan Administrator. The group health plan may require that a specific form be completed. You or any qualifying beneficiary are required to give notice within 60 days of the later of:

- The date of the qualifying event; or
- The date the qualified beneficiary would lose coverage on account of the qualifying event.

More Information on COBRA

COBRA has a number of special rules, and the information above does not cover everything in the governing regulations. The Plan Administrator is required to answer your questions about your COBRA rights. If you have any questions about your COBRA rights or would like additional information about COBRA and your group health plan, contact the appropriate plan administrator.

If you want to know more, the Department of Labor has a booklet called "Health Benefits under the Consolidated Omnibus Budget Reconciliation Act (COBRA)." You can request this booklet free of charge by calling 1-800-998-7542. The booklet is also available on the Internet at: http://www.dol.gov/ebsa.

GENERAL CLAIM PROCEDURES

Claims Payment / Denial Appeals Process

If you have a claim against a particular welfare benefit program, you will need to reference that particular plan under the claim procedure set out in that plan's booklet. If you have a claim against this Plan, you may file a written claim with the Plan Administrator describing the specifics of your claim.

MEDICAL APPEAL PROCEDURES

I. INTRODUCTION

The following procedures apply to the medical plans of LEA's which are members of the Employee Benefit Trust of Eastern Pennsylvania (EBTEP) which have adopted these procedures to amend their medical plans by Board Resolution. These appeal procedures will apply except in the case of plans which have a separate pharmacy provider, in which case the appeal provisions of the pharmacy provider shall be followed.

It is the intent of these procedures to conform to the requirements of the Affordable Care Act and applicable regulations. Further, these procedures shall apply to both grandfathered and non-grandfathered plans.

II. APPEAL PROCEDURE

- A participant shall receive an adverse benefit determination (ABD) if the claims administrator determines that there is a denial, reduction, termination of, or fails to provide or make a payment (in whole or in part) for a benefit; including if a denial, reduction, termination or failure to make a payment based on the determination of a participant's eligibility to participate in a plan. A rescission or a retroactive termination of coverage is considered an adverse benefit determination, even if there is no adverse effect on any particular benefit at the time.

- An ABD shall provide the following information:

  - Specific reasons for the denial;

  - The specific rule, guideline, protocol, or other similar criterion relied upon in making the decision or a statement or copy of the rule, guideline, protocol, or other similar criterion is available upon request;

  - An explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the participant's medical circumstances or a statement that such explanation will be provided free of charge upon request;

  - A description of any additional material or information needed to perfect the claim with an explanation of what is needed. This ABD is provided to the participant as an *initial benefit determination*.

- The participant may appeal the ABD by filing a written or oral request (an oral request in the case of an urgent care claim) with the claims administrator of the plan for the LEA within 180 days after the participant receives a notice of an ABD denying the initial claim for benefits. This appeal is known as the "internal appeal". The participant will be able to submit written comments, documents, records, testimony, and other information relating to the claim for benefits (regardless of whether such information was considered in the initial claim for benefits) to the claims

administrator for review and consideration. The participant will also be entitled to receive, upon request and free of charge, access to and copies of all documents, records and other information that is relevant to the appeal.

- The Claims Administrator Will Respond to This Internal Appeal Within the Following Time Periods:

  - *Post-Service Claim* – In the case of an appeal of a denied post-service claim, the claims administrator shall respond to participant within 60 days after receipt of the appeal unless it is necessary for the claims administrator to obtain additional information or the participant agrees to extend the time for the decision. The claims administrator may request an extension of 15 days due to matters beyond its control. The participant shall be afforded at least 45 days from receipt of a notice to submit information necessary to decide the claim to provide the specified information.

  - *Pre-Service Claim* – In the case of an appeal of a pre-service claim, the claims administrator shall respond to the participant with a decision within 30 days after receipt of the appeal unless it is necessary for the claims administrator to obtain additional information or the participant agrees to extend the time for the decision. The claims administrator may request an extension of 15 days due to matters beyond its control. The participant shall be afforded at least 45 days from receipt of a notice to submit information necessary to decide the claim to provide the specified information. .

  - *Expedited Pre-Service Claim or Urgent Claim* – In the case of an appeal of an urgent care claim, the claims administrator shall respond to the participant with a decision within 72 hours after classification of the appeal as urgent.

  - *Concurrent Care Review Claim* – In the case of a concurrent care review claim, the claims administrator shall respond to the participant before the ongoing treatment in question is reduced or terminated.

- Further Appeal from Adverse Decision of Claim Administrator's Internal Appeal to An Independent Review Organization (IRO) for Claims Concerning "Medical Judgment"*

  ***** Questions of "medical judgment" involve the plan's requirements for medical necessity, appropriateness, healthcare setting, level of care, or effectiveness of a covered benefit, or whether a service is experimental or investigational as determined by the external reviewer.

  - If the claims administrator denies a claim involving medical judgment in whole or in part, the claims administrator will provide the participant with written notice of the denial (although the initial notice of a denied urgent care claim may be provided to the participant orally or via facsimile or other similar expeditious means of communication). The notice will provide the legally required information, and will also state that the participant shall file a further appeal by filing a written request for review by an Independent Review Organization (IRO) within four months of the date of the claims administrator's decision, if the participant desires to appeal the decision of the IRO.

  - A decision by an IRO concerning a medical judgment appeal shall be issued to the participant within 45 days of the date of the request for the appeal.

  - If the decision of the IRO is to deny the participant's appeal, the participant shall have the right to elect to have the EBTEP Board of Trustees review the IRO's denial. This right of appeal to the EBTEP Board of Trustees is an elective right and is not a required appeal. For this elective appeal, the participant shall provide a written request to have the EBTEP

Board of Trustees review the IRO's decision within four months of the date of the decision. If the participant provides this notice to review the IRO's appeal at least 30 days before the next quarterly meeting of the Board of Trustees, the decision of the IRO shall be reviewed at the next quarterly board meeting of the Board of Trustees, and a decision shall be promptly provided to the participant and claims administrator within 30 days of the meeting of the Board of Trustees. If a participant's notice of appeal of the decision of the IRO is provided less than 30 days before the next quarterly meeting of the Board of Trustees, the appeal shall be reviewed at the Board of Trustees meeting in the following quarter and the written notice of the decision shall be provided to the participant within 30 days of the date of the meeting of the Board of Trustees. If the participant does not elect a further appeal to the EBTEP Board of Trustees for medical issues, the participant may seek other remedies available under state or federal law.

- Elective Appeal from Adverse Decision of Claim Administrator's Internal Appeal to EBTEP Board of Trustees Concerning Claims Involving "Non-Medical Judgment"

  - If the internal appeal decision of the claims administrator involves **non-medical judgment**, then the participant shall have the right to a further appeal to the EBTEP Board of Trustees. This right of appeal to the EBTEP Board of Trustees is an elective right and is not a required appeal. If the participant elects to have their non-medical claim reviewed by the EBTEP Board of Trustees, they shall submit their appeal in writing within four months of the date of receipt of the denial of their internal appeal. If the participant does not elect a further appeal to the EBTEP Board of Trustees for non-medical issues, the participant may seek other remedies available under state or federal law.

  - In the case of a further elective non-medical judgment appeal to the EBTEP Board of Trustees, the decision shall be made at the next quarterly board meeting of the Board of Trustees if the participant provides his/her notice of appeal at least 30 days before the next quarterly meeting of the Board of Trustees. If the appeal is provided less than 30 days before the next quarterly meeting of the Board of Trustees, the appeal shall be reviewed at the following quarterly meeting of the EBTEP Board of Trustees, and a decision shall be promptly provided to the participant and claims administrator within 30 days of the date of the meeting of the Board of Trustees.

- Remedies After Adverse Decision of EBTEP Board of Trustees

  If the EBTEP Board of Trustees denies a participant's further elective non-medical appeal or if the EBTEP Board of Trustees denies a participant's elective appeal from a determination of the IRO, the participant shall receive a written notice of the denial which includes information required by law and also provides that the participant may seek other remedies available under state or federal law.

TERMINATION OF COVERAGE

You may elect to terminate coverage as provided under the individual included plans and programs. We may terminate a plan or program for all employees, at our discretion. Coverage will terminate with your termination of employment unless the plan specifically provides for retiree benefits. Coverage will also terminate if you fail to pay your required part of the premium.

Medicare or Medicaid Coverage

If you become (or your spouse or your dependent becomes) entitled to Medicare or Medicaid coverage, you may make a prospective election to cancel or reduce coverage for the affected person under your health plan. In addition, if you lose (or your spouse or your dependent loses) eligibility for such coverage, you may make a prospective election to begin or increase coverage for the affected person under your health plan.

Family Medical Leave Act

Regardless of the established leave policies, this Plan shall at all times comply with the Family and Medical Leave Act (FMLA) of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

Military Leave - If you take an unpaid leave of absence due to military service that is protected by the Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA), special rules will apply. If you are employed in Pennsylvania, we will pay your group health plan premiums for the first 30 days. If you are absent for 31 days or more, you will need to arrange to pay for your full premium costs. We will not pay any portion of the premium. You may pay to continue your coverage for up to 24 months. If you are not employed in Pennsylvania, your cost will include a small (2%) additional charge for administration.

If You Leave

If you terminate your employment with us, you will no longer be a participant under most of the included plans and programs. However, you may be able to elect COBRA Continuation Coverage under the group health plan you have chosen. You will need to pay for any continuing coverage directly.

If You Die

If you die while you are actively employed, your spouse or estate can file claims for benefits. If no COBRA Continuation Coverage is elected, the claims must have been incurred before the termination of coverage due to your death.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about eligibility or other general information, contact your Human Resources office. For information about claims payment, you should contact the Claims Administrator:

Medical
Capital BlueCross
2500 Elmerton Avenue
Harrisburg, PA 17110
www.capbluecross.com
(800) 962-2242

Prescription Drug
Express Scripts, Inc.
One Express Way
St. Louis, MO 63121
www.express-scripts.com
(800) 467-2006

GENERAL INFORMATION

Plan Name	Career Institute of Technology Employee Benefit Plan
Plan Type	Self-funded health & welfare plans including: Medical and Prescription Drug plans
Employer Identification Number	23-1661367
Plan Number	501
Plan Dates	July 1st through June 30th
Plan Sponsor	Career Institute of Technology 5335 Kesslersville Road Easton, PA 18040
Plan Administrator	Employee Benefit Trust of Eastern PA 6 Danforth Dr. Easton, PA 18045
Named Fiduciary	Employee Benefit Trust of Eastern PA 6 Danforth Dr. Easton, PA 18045
Agent for Service of Legal Process	If, for any reason, you want to seek legal action against the Plan, you can serve legal process on the Plan Administrator for the Plan.
Claims Administrator	Medical Capital BlueCross 2500 Elmerton Avenue Harrisburg, PA 17110 Prescription Drug Express Scripts, Inc. One Express Way St. Louis, MO 63121

APPENDIX A

Eligibility Requirements
for Career Institute of Technology Employee Benefit Plan

Medical and Prescription Drug Plan

Eligible Classes of Employees:

- Full-time and Part-time Teachers
- Full-time and Part-time Act 93 employees
- Full-time Administrative Director
- Full-time Support Staff employees that work at least 6 hours a day, 5 days a week

If you are in an eligible class of employees, you are eligible to enroll in medical and prescription drug benefits on the first of the month following the date of employment.

Spousal Rule - If your spouse is offered coverage through his or her own employer, the spouse must enroll and be covered as primary in that coverage to be eligible for coverage in the Career Institute of Technology Employee Benefit Plan.

Eligible dependents may remain on the plan, as determined by the Affordable Care Act, until the age of 26 regardless of marital status and employment status.

If you are an eligible retiree, as determined by a Bargaining Unit agreement and state law, you may be eligible to participate in the plan until you are eligible for Medicare. Your eligible dependents may be able to remain on the plan, as well, until you are ineligible.

APPENDIX B

Career Institute of Technology

Capital BlueCross PPO Medical Benefits

In addition to the following Certificate of Coverage provided by Capital BlueCross, the following items are incorporated by reference into this Medical Plan:

Please consult the Appeal Process contained in the Plan Document which shall control the appeal procedure. The information contained in Appendix B regarding Appeals does not control how appeals will be handled for your Employer.

Capital BLUE

Capital BlueCross is an Independent Licensee of the BlueCross BlueShield Association

Employee Benefit Trust of Eastern Pennsylvania

00521914

PPO

GROUP PREFERRED PROVIDER CERTIFICATE OF COVERAGE

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

Please note:

To better serve you, members with questions about their coverage should call the Dedicated Customer Service phone number provided for your group at **1-866-787-9872**. For your convenience, this number is also located on your identification card.

Capital BLUE

Capital BlueCross is an Independent Licensee
of the BlueCross BlueShield Association

NONDISCRIMINATION AND FOREIGN LANGUAGE ASSISTANCE NOTICE

Capital BlueCross 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 BlueCross does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Capital BlueCross 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 BlueCross 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 BlueCross
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).

Table of Contents

Table of Contents

Table of Contents

Table of Contents

Table of Contents

WELCOME

INTRODUCTION

Thank you for choosing health care *coverage* from the Capital BlueCross family of companies. With the Capital BlueCross family of companies, *members* get outstanding coverage for themselves and their families. *Members* also receive access to a wide variety of *providers*, quality customer service and valuable *clinical management* programs.

THE CAPITAL BLUECROSS FAMILY OF COMPANIES

A full range of group health care coverage and related services is available through the Capital BlueCross family of companies.

- Capital Advantage Insurance Company®, a subsidiary of Capital BlueCross, offers CareConnect (Gatekeeper PPO), BlueJourney PPO (a Medicare Advantage plan), and Senior (*Medicare* complementary) coverages.
- Capital Advantage Assurance Company®, a subsidiary of Capital BlueCross, offers Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO), Traditional, Comprehensive, Prescription Drug, Dental (BlueCross *Dental*^{sm}) and Vision (BlueCross *Vision*^{sm}) coverages.
- Keystone Health Plan® Central, a subsidiary of Capital BlueCross, offers Health Maintenance Organization (HMO) and BlueJourney HMO (a Medicare Advantage plan) coverages.

Capital BlueCross, Capital Advantage Insurance Company, Capital Advantage Assurance Company and Keystone Health Plan Central are independent licensees of the BlueCross BlueShield Association.

***Coverage* is administered by Capital BlueCross and its subsidiary,**
Capital Advantage Assurance Company.

HOW TO USE THIS DOCUMENT

This *Certificate of Coverage* is provided to *subscribers* as part of the *group contract* entered into between the *contract holder* and *Capital*. It explains the terms of this *coverage* with *Capital*, including coverage for *benefits* available to *members* and information on how this *coverage* is administered.

Italicized words are defined in the **Definitions** section of this *Certificate of Coverage*, and in the **Definitions** section of the *group contract*.

There are five sections in this *Certificate of Coverage* that will help *members* to better understand their *coverage. Members* should take extra time to review the following sections:

1. **How to Access Benefits**, which serves as a guide to using and making the most of this *coverage*.
2. **Summary of Cost-Sharing and Benefits**, which contains a summary of *benefits* and *benefit* limitations under this *coverage*.
3. **Schedule of Exclusions**, which contains a list of the services excluded from this *coverage*.
4. **Claims Reimbursement**, which contains important information on how to file a claim for *benefits*.
5. **Appeal Procedures**, which details *Capital's* procedures for filing an appeal.

Also enclosed are the following attachments to this *Certificate of Coverage*, which are applicable to this *coverage*:

- **Schedule of Preventive Care Services,** which outlines the preventive care *benefits* available under this *coverage*.
- **Preauthorization Program**, which outlines the services requiring *preauthorization*.
- **Disease/Condition Management Programs**, which outlines the Disease Management Programs offered to *members*.

IMPORTANT NOTICES

There are a few important points that *members* need to know about their *coverage* with *Capital* before reading the remainder of this *Certificate of Coverage*:

- All of the *member's* health care expenses may not be covered. *Members* should read this *Certificate of Coverage* carefully to determine which health care services are provided as *benefits* under their *coverage*.
- To receive certain *benefits* or to have *benefits* paid at the highest allowable level, the *member's coverage* may require services to be performed by *participating providers*.
- *Benefits* may be subject to *cost-sharing amounts* such as *preauthorization penalties* for failure to obtain *preauthorization* when required, *copayments*, *deductibles*, *coinsurance*, *out-of-pocket maximums*, *benefit period maximums* and *benefit lifetime maximums*. *Members* should refer to the **Summary of Cost-Sharing and Benefits** section of this *Certificate of Coverage* to determine which *cost-sharing amounts* apply to their *coverage*.
- *Benefits* are subject to review for *medical necessity* and may be subject to *clinical management* by *Capital*.
- When applicable, if a *member* fails to follow *Capital's clinical management* requirements, *Capital* may impose a *preauthorization penalty* or reduce the level of payment for *benefits*, even if the *benefits* are *medically necessary*. *Members* should refer to the **Clinical Management** section of this *Certificate of Coverage* for the specific requirements applicable to their *coverage*.
- Clinical *medical necessity* determinations are based only on the appropriateness of services and whether *benefits* for such services are provided under this *coverage*. *Capital* does not reward individuals or practitioners for issuing denials of coverage or provide financial incentives of any kind to individuals to encourage decisions that result in underutilization.
- Other companies under contract with *Capital* may provide certain services, including administrative services, relating to this *coverage*.
- This *Certificate of Coverage* replaces any other *Certificates of Coverage* or Certificates of Insurance that may have been issued to the *member* previously under the *member's* coverage with the Capital BlueCross family of companies.
- The Summary of Benefits and Coverage (SBC) required by *PPACA* will be provided to *members* by the *contract holder*. The SBC contains only a partial description of the *benefits*, limitations and exclusions of this *coverage*. It is not intended to be a complete list or complete description of available *benefits*. In the event there are discrepancies between the SBC and *Certificate of Coverage*, 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.
- The *group contract* is available for inspection at the office of the *contract holder* during regular business hours.
- *Capital* does not assume any financial risk or obligation with respect to *benefits* or claims for such *benefits*.
- The *benefit period* for this *coverage* is the **calendar year**.

HOW TO CONTACT US

Capital is committed to providing excellent service to our *members*. The following pages outline various ways that *members* can contact *Capital*. *Members* may contact us if they have any questions or encounter difficulties using their *coverage* with *Capital*.

TELEPHONE

Monday through Friday, 8:00 a.m. to 6:00 p.m., *members* can call the following telephone numbers and speak with a Customer Service Representative.

Members can call the telephone number on their *identification card* or call:

Telephone:	1-800-962-2242
Telephone (TTY):	711

Physical Disabilities

Capital and its *providers* accommodate *members* with physical disabilities or other special needs. If *members* have any questions regarding access to *providers* with these accommodations, they should contact *Capital's* Customer Service Department.

PREAUTHORIZATION OR OTHER CLINICAL MANAGEMENT PROGRAMS

Members can call the telephone number on their *ID card* or call *Capital's* Customer Service at 1-800-962-2242 with questions on *preauthorization*. *Members* should refer to the **Preauthorization Program** attachment to this *Certificate of Coverage* for more information.

INTERNET AND ELECTRONIC MAIL (E-MAIL)

Our website, capbluecross.com, contains information about *Capital's* products and how to utilize *benefits* and access services. *Members* may access material on standard *benefits*, wellness programs and search our online *provider* directory to locate area *physicians*, *hospitals*, and ancillary *providers*.

Members may also access and update personal information through the Secure Services feature on our website. By using this feature *members* may verify eligibility, initiate a *Preauthorization* request, check claims status, change Primary Care Physicians, update their name and address, and request an *ID card*.

Members can e-mail us at capbluecross.com. E-mail inquiries are reviewed Monday through Friday, 8:00 a.m. to 4:30 p.m. A Customer Service Representative will respond within 24 hours or one business day of receiving the *member's* inquiry.

MAIL

Members can contact *Capital* through the United States mail. When writing to *Capital*, *members* should include their name, the identification number from their *Capital ID card*, and explain their concern or question. Inquiries should be sent to:

Capital BlueCross
PO Box 779519
Harrisburg, PA 17177-9519

Fax: 717-541-6915

IN PERSON

Members can meet with a Customer Service Representative at our offices at:

2500 Elmerton Avenue
Harrisburg, PA 17177

Staff is available to assist *members* Monday through Friday from 8:00 a.m. to 4:30 p.m.

RETAIL CENTERS

Members may also call or visit our Retail Center locations at:

Telephone: 1-855-505-BLUE (2583) Website: capitalbluestore.com

The Promenade Shops at Saucon Valley
2845 Center Valley Parkway, Suite 404/409
Center Valley, PA 18034

Store Hours:
Monday through Friday 9:00 a.m. to 6:00 p.m.
and Saturday 9:00 a.m. to 1:00 p.m.

or

Hampden Marketplace
4500 Marketplace Way
Enola, PA 17025

Store Hours:
Monday through Friday 9:00 a.m. to 6:00 p.m. and
Saturday 9:00 a.m. to 1:00 p.m.

LANGUAGE ASSISTANCE

Capital offers language assistance for individuals with limited English proficiency. Language assistance includes interpreting services provided directly in the individual's preferred language and document translation services available 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.

To access these services, individuals can simply call *Capital's* Customer Service Department at the telephone numbers listed above.

HOW TO ACCESS BENEFITS

MEMBER IDENTIFICATION CARD (ID CARD)

The *member's identification card* is the key to accessing the *benefits* provided under this *coverage* with *Capital*.

Members should show their card and any other identification cards they may have evidencing other coverage **each time they seek medical services**. *ID cards* assist *providers* in submitting *claims* to the proper location for processing and payment.

The following is important information about the *ID card*:

- ***Preauthorization***: The term *preauthorization* alerts *providers* that this element of a *member's coverage* is present. *Members* should refer to the **Preauthorization Program** attachment to this *Certificate of Coverage* for more information.
- **Suitcase Symbol**: This symbol shows *providers* that the *member's coverage* includes BlueCard® and Blue Cross Blue Shield Global® Core. With both programs, *members* have access to *BlueCard participating providers* nationwide and worldwide.
- ***Copayments**: Providers* will use this information to determine the *copayment* they may collect from *members* at the time a service is rendered.

On the back of the *ID card*, *members* can find important additional information on:

- *Preauthorization* instructions and toll-free telephone number.
- General instructions for filing claims.

Members should remember to destroy old *ID cards* and use only their latest *ID card*. *Members* should also contact *Capital's* Customer Service Department if any information on their *ID card* is incorrect or if they have questions.

OBTAINING BENEFITS FOR HEALTH CARE SERVICES

Depending on the *member's* specific *coverage*, the *benefits* provided and the level of payment for *benefits* is affected by whether the *member* chooses a *participating provider*.

Members can choose any *physician* for their care, although their costs are generally less when they see a *participating provider*. *Members* have the option to visit a *nonparticipating provider*, but it generally costs them more. *Providers*, including, without limitation, *participating providers*, are solely responsible for the medical care rendered to their patients.

NOTE: Some *benefits* are covered only when *members* obtain services from a *participating provider*.

Services Provided by Participating Providers

A *participating provider* is a health care *facility provider* or a *professional provider* who is properly licensed, where required, and has a contract **with *Capital*** to provide *benefits* under this *coverage*. Because *participating providers* agree to accept *Capital's* payment for covered *benefits* - along with any applicable *cost-sharing amounts* that *members* are obligated to pay under the terms of this *coverage* - as payment in full, *members* can maximize their *coverage* and minimize their out-of-pocket expenses by visiting a *participating provider*.

All *participating providers* must seek payment, other than *cost-sharing amounts*, directly from *Capital*. ***Participating providers* may not seek payment from *members* for services that qualify as *benefits*.** However, a *participating provider* may seek payment from *members* 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 *participating provider* must inform *members* prior to performing the noncovered services that they may be liable to pay for these services, and the *members* must agree to accept this liability.

The status of a *provider* as a *participating provider* may change from time to time. It is the *member's* responsibility to verify the current status of a *provider*. To find a *participating provider* within the *Capital service area, members* can call 1-800-962-2242 or visit capbluecross.com.

Services Provided by Nonparticipating Providers

A *nonparticipating provider* is a *provider* who does not contract with *Capital* or with another *Host Blue* to provide *benefits* to *members*.

Services provided by *nonparticipating providers* may require higher *cost-sharing amounts* or may not be covered *benefits*. If such services are covered, *benefits* will be reimbursed at a percentage of the *allowable amount* applicable to this *coverage* with *Capital*. Information on whether *benefits* are provided when performed by a *nonparticipating provider* and the applicable level of payment for such *benefits* is noted in the **Summary of Cost-Sharing and Benefits** section of this *Certificate of Coverage*.

Because *nonparticipating providers* are not obligated to accept *Capital's* payment as payment in full, *members* may be responsible for the difference between the *provider's* charge for that service and the amount *Capital* paid for that service. This difference between the *provider's* charge for a service and the *allowable amount* is called the balance billing charge. There can be a significant difference between what *Capital* pays to the *member* and what the *provider* charged. In addition, unless otherwise required by law, all payments are made directly to the *subscriber*; and the *member* is responsible for reimbursing the *provider*. Additional information on balance billing charges can be found in the **Cost-Sharing Descriptions** section of this *Certificate of Coverage*.

Emergency Services

An *emergency service* is any health care service provided to a *member* after the sudden onset of a medical condition 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:

- 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; or
- 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 and related *emergency services* provided by a licensed ambulance service are *benefits* if the condition qualifies as an *emergency service*.

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

OUT-OF-AREA SERVICES

OVERVIEW

Capital has 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 *members* access healthcare services outside of *Capital's 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 a *member* receives care outside *Capital's service area*, *members* will receive it from one of two kinds of *providers*. Most *providers* ("*participating providers*") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some providers ("*nonparticipating providers*") do not contract with the *Host Blue*. *Capital* explains below how *Capital* pays 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 *Capital* to provide the specific service or services.

BlueCard® Program

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

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

- The billed covered charges for their covered services; or
- The negotiated price that the *Host Blue* makes available to *Capital*.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the *Host Blue* pays to the *member's* healthcare *provider*. Sometimes, it is an estimated price that takes into account special arrangements with the *member's* 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 *Capital* has used for a *member's* claim because they will not be applied after a claim has already been paid.

Nonparticipating Healthcare Providers Outside Capital's Service Area

Member Liability Calculation – When covered healthcare services are provided outside of *Capital's service area* by *nonparticipating providers,* the amount *members* pay for such services will normally be based on either the *Host Blue's nonparticipating provider* local payment or the pricing arrangements required by applicable state law. In these situations, *members* may be responsible for the difference between the amount that the *nonparticipating provider* bills and the payment *Capital* 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.

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

Emergency Services – When Emergency Services are provided outside of *Capital's* service area by *nonparticipating providers*, *Capital* will cover *members* at the highest level that federal regulations allow. *Members* will have to pay for any charges that exceed any such amount as well as for any *deductibles, coinsurance, copayments, and amounts that exceed any benefit maximums*.

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 *Capital* through average pricing or fee schedule adjustments. Additional information is available upon request.

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

If *Capital* has entered into a *negotiated arrangement* with a *Host Blue* to provide *Value-Based Programs* to *contract holder* on a *member's* behalf, *Capital* 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 a *member* is outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), he/she may be able to take advantage of the Blue Cross Blue Shield Global Core when accessing covered healthcare services. 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 the *member* with accessing a network of inpatient, outpatient and professional *providers*, the network is not served by a *Host Blue*. As such, when a *member* receives care from *providers* outside the BlueCard service area, the *member* will typically have to pay the providers and submit the claims to obtain reimbursement for these services.

If a *member* needs medical assistance services (including locating a doctor or *hospital*) outside the BlueCard service area, he/she should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 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 a *member* contacts the service center for assistance, *hospitals* will not require the *member* to pay for covered inpatient services, except for the cost-share amounts/*deductibles*, *coinsurance*, etc. In such cases, the *hospital* will submit the claims to the service center to begin claims processing. However, if a *member* pays in full at the time of service, he/she must submit a claim to receive reimbursement for covered healthcare services. **A *member* must contact *Capital* 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 a *member* to pay in full at the time of service. A *member* must submit a claim to obtain reimbursement for covered healthcare services.

- Submitting a Blue Cross Blue Shield Global Core Claim

When a *member* pays for covered healthcare services outside the BlueCard service area, he/she must submit a claim to obtain reimbursement. For institutional and professional claims, a *member* 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 *Capital*, the service center or online at www.bcbsglobalcore.com. If a *member* needs assistance with a claim submission, he/she should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

SUMMARY OF COST-SHARING AND BENEFITS

This section of the *Certificate of Coverage* provides a summary of the applicable *cost-sharing amounts* and *benefits* provided under this *coverage* with *Capital*.

The *benefits* listed in the **Summary of Benefits** in this section are covered when *medically necessary* and preauthorized (when required) in accordance with *Capital's clinical management* policies and procedures.

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

It is also important for *members* to remember that *nonparticipating providers* will bill *members* directly and may balance bill them as described in the **Cost-Sharing Descriptions** section of this *Certificate of Coverage*.

The *benefit period* for this *coverage* is the **calendar year**.

SUMMARY OF COST-SHARING		
	Amounts *Members* Are Responsible For:	
	Participating Providers	***Nonparticipating Providers***
Preauthorization Penalty	Not Applicable	
Copayments – ***Additional Copayments may apply. See the Summary of Benefits for details***		
• Office Visits	$20 *copayment* per visit when provided by a Family Practitioner, General Practitioner, Internist, or Pediatrician $30 *copayment* per visit for all other *professional providers*	Not Applicable
• Emergency Room	$100 *copayment* per visit, waived if admitted (Only one ER *copayment* will apply for the administration of the rabies vaccine series at the initial visit/injection.) **Note**: Cost share is the same regardless of whether the emergency services are provided by a *participating provider* or a *nonparticipating provider*. Observation status is not considered *inpatient* admission. Emergency room *copayments* will apply to observational care unless admitted *inpatient*.	
• *Urgent Care*	$45 *copayment* per visit	20% *coinsurance**
• Inpatient (Per Admission)	Not Applicable	50% *coinsurance**

SUMMARY OF COST-SHARING		
	Amounts *Members* Are Responsible For:	
	Participating Providers	***Nonparticipating Providers***
***Deductible* (per *benefit period*)**	$500 per *member* $1,000 per family	$1,000 per *member* $2,000 per family
	The *deductible* does not apply to the following *benefits:* • *Emergency services*; • Emergency ambulance services; • Annual screening mammograms; • Annual screening gynecological examinations; • Annual screening Papanicolaou smears; • Pediatric preventive care (*participating providers* only); • Mandated childhood immunizations; • Adult preventive care (*participating providers* only); • Certain nutritional supplements (see Benefit Descriptions section for more details); and • Home health care visits related to childbirth.	
Coinsurance	Not Applicable	20% *coinsurance**
Out-of-Pocket Maximum	$2,000 per *member* $5,400 per family	$2,000 per *member* $4,000 per family
When the out-of-pocket maximum is reached, payment for all other benefits during the remainder of the benefit period are made at 100% of the allowable amount, except for nonparticipating facility providers, which remain at the percentage of the allowable amount indicated in the Payment Levels for Facility Providers chart in this **Summary of Benefits and Cost-Sharing** section.	The following expenses do not apply to the *out-of-pocket maximum*: • Charges exceeding the *allowable amount;* and • Expenses incurred for payment of a *benefit* after any applicable *benefit period maximum* has been exhausted.	

Nonparticipating providers* may balance bill the *member* as described in the **Cost-Sharing Descriptions section of this *Certificate of Coverage.*

SUMMARY OF PAYMENT LEVELS FOR FACILITY PROVIDERS		
	Amounts *Members* Are Responsible For:	
	Participating Providers	***Nonparticipating Providers***
Ambulance (nonemergency)	Covered in Full after *deductible*	50% *coinsurance* after *deductible*
Ambulatory Surgical Facility	Covered in Full after *deductible*	50% *coinsurance* after *deductible*
Birthing Facility	Covered in Full after *deductible*	50% *coinsurance* after *deductible*
Durable Medical Equipment Supplier	Covered in Full after *deductible*	50% *coinsurance* after *deductible*
Emergency Services	Covered in Full *deductible* waived	Covered in Full *deductible* waived
Freestanding Diagnostic Facility	Covered in Full after *deductible*	50% *coinsurance* after *deductible*
Freestanding Dialysis Facility	Covered in Full after *deductible*	Not covered
Home Health Care Agency	Covered in Full after *deductible*	50% *coinsurance* after *deductible*
Hospice	Covered in Full after *deductible*	50% *coinsurance* after *deductible*
Hospital	Covered in Full after *deductible*	50% *coinsurance* after *deductible*
Hospital Laboratory	Covered in Full after *deductible*	50% *coinsurance* after *deductible*
Infusion Therapy Provider	Covered in Full after *deductible*	50% *coinsurance* after *deductible*
Long Term Acute Care Hospital	Covered in Full after *deductible*	Not covered
Orthotic Supplier	Covered in Full after *deductible*	50% *coinsurance* after *deductible*
Prosthetic Supplier	Covered in Full after *deductible*	50% *coinsurance* after *deductible*
Psychiatric *Hospital*	Covered in Full after *deductible*	50% *coinsurance* after *deductible*
Psychiatric *Partial Hospitalization* Facility	Covered in Full after *deductible*	50% *coinsurance* after *deductible*
Rehabilitation Hospital	Covered in Full after *deductible*	50% *coinsurance* after *deductible*
Skilled Nursing Facility	Covered in Full after *deductible*	50% *coinsurance* after *deductible*
Substance Use Disorder Treatment Facility	Covered in Full after *deductible*	50% *coinsurance* after *deductible*
Urgent Care Services	Covered in Full *deductible* waived	20% *coinsurance* after *deductible*

SUMMARY OF BENEFITS *** It is important for *members* to refer to the Payment Levels for Facility Providers chart to determine the level of payment for *facility providers*. *Members* will be responsible for paying the *coinsurance* percentage reflected in that chart in addition to the *coinsurance* percentage reflected in this Summary of Benefits chart. *Nonparticipating providers* may balance bill *members*. ***			
	Amounts Members Are Responsible For:		**Limits and Maximums(If Applicable)**
	Participating Providers	***Nonparticipating Providers***	
ACUTE CARE *HOSPITAL* ROOM & BOARD AND ASSOCIATED CHARGES			
Acute Care *Hospital*	Covered in Full after *deductible*	50% *coinsurance* after *deductible*	
Long Term Acute Care Hospital	Covered in Full after *deductible*	Not covered	
ACUTE INPATIENT REHABILITATION			
Benefits	Covered in Full after *deductible*	50% *coinsurance* after *deductible*	60 days per *benefit period*
ALLERGY SERVICES			
Benefits	Covered in Full after *deductible*	20% *coinsurance* after *deductible*	
BLOOD AND ADMINISTRATION			
Benefits	Covered in Full	20% *coinsurance*	
DIABETIC SUPPLIES			
Benefits	Covered in Full after *deductible*	20% *coinsurance* after *deductible*	
DIAGNOSTIC SERVICES			
Laboratory Tests	Covered in Full after *deductible* when performed at an independent clinical laboratory (ICL) or drawn at a physician's office and sent to an ICL. Covered in Full after *deductible*, when performed at a Facility/*Hospital* owned laboratory	20% *coinsurance* after *deductible*	
Medical Tests	Covered in Full after *deductible*	20% *coinsurance* after *deductible*	

SUMMARY OF BENEFITS *** It is important for *members* to refer to the Payment Levels for Facility Providers chart to determine the level of payment for *facility providers*. *Members* will be responsible for paying the *coinsurance* percentage reflected in that chart in addition to the *coinsurance* percentage reflected in this Summary of Benefits chart. *Nonparticipating providers* may balance bill *members*. ***			
	Amounts Members Are Responsible For:		**Limits and Maximums(If Applicable)**
	Participating Providers	***Nonparticipating Providers***	
Radiology Tests (Outpatient Facility Only)	Covered in Full after *deductible* for outpatient facility procedures for high tech imaging (MRI, MRA, CT scan, PET scan, SPECT scan and cardiac nuclear medicine procedures.) Covered in Full after *deductible* for outpatient facility procedures for radiology tests other than high-tech radiology tests.	20% *coinsurance* after *deductible*	
DIALYSIS TREATMENT			
Benefits	Covered in Full after *deductible*	20% *coinsurance* after *deductible*	
DURABLE MEDICAL EQUIPMENT (DME) & SUPPLIES			
Benefits	Covered in Full after *deductible*	20% *coinsurance* after *deductible*	
EMERGENCY AND URGENT CARE SERVICES			
Emergency Services **Consultations received in the emergency room are subject to the applicable *outpatient* consultation *cost-share*.** ***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. Any emergency room cost-share will apply to observational care unless admitted inpatient.**	Covered in Full, *deductible* waived. $100 *copayment* per visit, waived if admitted *inpatient* **Note: Cost share is the same regardless of whether the emergency services are provided by a *Participating Provider* or a *Nonparticipating Provider*.**		Limitation within 72 hours and all follow up Services incurred as a result of hazardous hobbies such as parachuting, bungee jumping, etc are not covered Services incurred as a result of occupational illnesses and injuries are excluded Standard, except limitation within 24 hours

SUMMARY OF BENEFITS *** It is important for *members* to refer to the Payment Levels for Facility Providers chart to determine the level of payment for *facility providers*. *Members* will be responsible for paying the *coinsurance* percentage reflected in that chart in addition to the *coinsurance* percentage reflected in this Summary of Benefits chart. *Nonparticipating providers* may balance bill *members*. ***			
	Amounts Members Are Responsible For:		**Limits and Maximums(If Applicable)**
	Participating Providers	***Nonparticipating Providers***	
Urgent Care Services	$45 *copayment* per visit	20% *coinsurance*after *deductible*	Limitation within 72 hours and all follow up Services incurred as a result of hazardous hobbies such as parachuting, bungee jumping, etc are not covered Services incurred as a result of occupational illnesses and injuries are excluded Standard, except limitation within 24 hours
ENTERAL NUTRITION			
Benefits	Covered in Full after *deductible* *Enteral nutrition products for certain therapeutic treatments are not subject to *deductible*. See Benefit Descriptions section for details.	20% *coinsurance* after *deductible*	
GYNECOLOGICAL SERVICES			
Screening Gynecological Exam	Covered in Full, *deductible* waived	20% *coinsurance*, *deductible* waived	
Screening Pap Smear	Covered in Full, *deductible* waived	20% *coinsurance*, *deductible* waived	
HOME HEALTH CARE SERVICES			
Benefits	Covered in Full after *deductible*	20% *coinsurance* after *deductible*	90 visits per *benefit period*
HOSPICE CARE			
Benefits (includes *Residential Hospice Care*)	Covered in Full after *deductible*	20% *coinsurance* after *deductible*	
IMMUNIZATIONS AND INJECTIONS			
Benefits	Covered in Full after *deductible*	20% *coinsurance* after *deductible*	

SUMMARY OF BENEFITS ***** It is important for *members* to refer to the Payment Levels for Facility Providers chart to determine the level of payment for *facility providers*. *Members* will be responsible for paying the *coinsurance* percentage reflected in that chart in addition to the *coinsurance* percentage reflected in this Summary of Benefits chart. *Nonparticipating providers* may balance bill *members*. *****			
	Amounts Members Are Responsible For:		**Limits and Maximums(If Applicable)**
	Participating Providers	***Nonparticipating Providers***	
INFERTILITY SERVICES			
Benefits	Covered in Full after *deductible*	20% *coinsurance* after *deductible*	
INFUSION/IV THERAPY			
Benefits	Covered in Full after *deductible*	20% *coinsurance* after *deductible*	
INTERRUPTION OF PREGNANCY			
Benefits	Not covered	Not covered	
MAMMOGRAMS			
Screening Mammogram	Covered in Full, *deductible* waived	20% *coinsurance*, *deductible* waived	
Diagnostic Mammogram	Covered in Full after *deductible*	20% *coinsurance* after *deductible*	
MATERNITY SERVICES			
Benefits for Prenatal Services, Delivery and Postpartum Services	Covered in Full after *deductible*	20% *coinsurance* after *deductible*	
MEDICAL TRANSPORT			
Emergency Ambulance	Covered in Full, *deductible* waived **Note: Cost share is the same regardless of whether the emergency services are provided by a *Participating Provider* or a *Nonparticipating Provider*.**		
Nonemergency Ambulance	Covered in Full after *deductible*	20% *coinsurance* after *deductible*	
MENTAL HEALTH CARE SERVICES			
Inpatient Services	Covered in Full after *deductible*	20% *coinsurance* after *deductible*	
Partial Hospitalization	Covered in Full after *deductible*	20% *coinsurance* after *deductible*	

SUMMARY OF BENEFITS *** It is important for *members* to refer to the Payment Levels for Facility Providers chart to determine the level of payment for *facility providers*. *Members* will be responsible for paying the *coinsurance* percentage reflected in that chart in addition to the *coinsurance* percentage reflected in this Summary of Benefits chart. *Nonparticipating providers* may balance bill *members*. ***			
	Amounts Members Are Responsible For:		**Limits and Maximums(If Applicable)**
	Participating Providers	***Nonparticipating Providers***	
Outpatient Services	$20 *copayment* per visit when provided by a Family Practitioner, General Practitioner, Internist, or Pediatrician $30 *copayment* per visit for all other *professional providers*	20% *coinsurance* after *deductible*	
NEWBORN CARE			
Benefits	Covered in Full after *deductible*	20% *coinsurance* after *deductible*	
NUTRITION THERAPY (COUNSELING AND EDUCATION)			
Benefits	Covered in Full after *deductible*	20% *coinsurance* after *deductible*	2 visits per *benefit* period for nonpreventive obesity services
ORTHOTIC DEVICES			
Benefits	Covered in Full after *deductible*	20% *coinsurance* after *deductible*	Foot orthotics are covered for all members for any reason.
PREVENTIVE CARE SERVICES			
Pediatric Preventive Care (includes physical examinations, childhood immunizations and tests)	Covered in Full, *deductible* waived	20% *coinsurance*, *deductible* waived for Pennsylvania mandated childhood immunizations	
Adult Preventive Care (includes physical examinations, immunizations and tests as well as specific women's preventive services as required by law)	Covered in Full, *deductible* waived	20% *coinsurance* after *deductible*	
PRIVATE DUTY NURSING SERVICES			
Benefits	Covered in Full after *deductible*	20% *coinsurance* after *deductible*	
PROFESSIONAL PROVIDER EVALUATION & MANAGEMENT (E&M) TELEHEALTH SERVICES AND CONSULTATIONS			
Inpatient E&M	Covered in Full after *deductible*	20% *coinsurance* after *deductible*	

SUMMARY OF BENEFITS *** It is important for *members* to refer to the Payment Levels for Facility Providers chart to determine the level of payment for *facility providers*. *Members* will be responsible for paying the *coinsurance* percentage reflected in that chart in addition to the *coinsurance* percentage reflected in this Summary of Benefits chart. *Nonparticipating providers* may balance bill *members*. ***			
	Amounts Members Are Responsible For:		**Limits and Maximums(If Applicable)**
	Participating Providers	***Nonparticipating Providers***	
Outpatient E&M (Office Visit)	$20 *copayment* per visit when provided by a Family Practitioner, General Practitioner, Internist, or Pediatrician $30 *copayment* per visit for all other *professional providers*	20% *coinsurance* after *deductible*	
Inpatient Consultations	Covered in Full after *deductible*	20% *coinsurance* after *deductible*	
Outpatient Consultations	$20 *copayment* per visit when provided by a Family Practitioner, General Practitioner, Internist, or Pediatrician $30 *copayment* per visit for all other *professional providers*	20% *coinsurance* after *deductible*	
Telehealth Services	$10 *copayment* per visit when provided by a Family Practitioner, General Practitioner, Internist, or Pediatrician $30 *copayment* per visit for all other *professional providers*	Not Covered	
PROSTHETIC APPLIANCES			
Prosthetic Appliances (other than wigs)	Covered in Full after *deductible*	20% *coinsurance* after *deductible*	
Wigs	Covered in Full after *deductible*	Covered in Full after *deductible*	
SKILLED NURSING FACILITY			
Benefits	Covered in Full after *deductible*	50% *coinsurance* after *deductible*	100 days per *benefit period*
SUBSTANCE USE DISORDER SERVICES			
Detoxification - *Inpatient*	Covered in Full after *deductible*	20% *coinsurance* after *deductible*	
Rehabilitation – *Inpatient*	Covered in Full after *deductible*	20% *coinsurance* after *deductible*	

SUMMARY OF BENEFITS *** It is important for *members* to refer to the Payment Levels for Facility Providers chart to determine the level of payment for *facility providers*. *Members* will be responsible for paying the *coinsurance* percentage reflected in that chart in addition to the *coinsurance* percentage reflected in this Summary of Benefits chart. *Nonparticipating providers* may balance bill *members*. ***			
	Amounts Members Are Responsible For:		**Limits and Maximums(If Applicable)**
	Participating Providers	***Nonparticipating Providers***	
Rehabilitation - *Outpatient*	$20 *copayment* per visit when provided by a Family Practitioner, General Practitioner, Internist, or Pediatrician $30 *copayment* per visit for all other *professional providers*	20% *coinsurance* after *deductible*	
SURGERY			
Evaluation & Management	$20 *copayment* per visit when provided by a Family Practitioner, General Practitioner, Internist, or Pediatrician $30 *copayment* per visit for all other *professional providers*	20% *coinsurance* after *deductible*	
Surgical Procedure	Covered in Full after *deductible*	20% *coinsurance* after *deductible*	
Anesthesia	Covered in Full after *deductible*	20% *coinsurance* after *deductible*	
Mastectomy and Related Services	Covered in Full after *deductible*	20% *coinsurance* after *deductible*	
Oral *Surgery*	Covered in Full after *deductible*	20% *coinsurance* after *deductible*	
THERAPY SERVICES (REHABILITATIVE AND HABILITATIVE)			
Cardiac Rehabilitation Therapy	Covered in Full after *deductible*	20% *coinsurance* after *deductible*	
Chemotherapy	Covered in Full after *deductible*	20% *coinsurance* after *deductible*	
Manipulation Therapy	$30 *copayment* per visit	20% *coinsurance* after *deductible*	20 visits per *benefit period*
Occupational Therapy (includes Rehabilitative/*Habilitative*)	$30 *copayment* per visit	20% *coinsurance* after *deductible*	30 visits per *benefit period* (Visit limits not applicable to Mental Health Care and Substance Use Disorder services)

SUMMARY OF BENEFITS *** It is important for *members* to refer to the Payment Levels for Facility Providers chart to determine the level of payment for *facility providers*. *Members* will be responsible for paying the *coinsurance* percentage reflected in that chart in addition to the *coinsurance* percentage reflected in this Summary of Benefits chart. *Nonparticipating providers* may balance bill *members*. ***			
	Amounts Members Are Responsible For:		**Limits and Maximums(If Applicable)**
	Participating Providers	***Nonparticipating Providers***	
Physical Therapy (includes Rehabilitative/*Habilitative*)	$30 *copayment* per visit	20% *coinsurance* after *deductible*	30 visits per *benefit period* (Visit limits not applicable to Mental Health Care and Substance Use Disorder services)
Radiation Therapy	Covered in Full after *deductible*	20% *coinsurance* after *deductible*	
Respiratory/Pulmonary Rehabilitation Therapy	$30 *copayment* per visit	20% *coinsurance* after *deductible*	
Speech Therapy (includes Rehabilitative/*Habilitative*)	$30 *copayment* per visit	20% *coinsurance* after *deductible*	30 visits per *benefit period* (Visit limits not applicable to Mental Health Care and Substance Use Disorder services)
TRANSPLANT SERVICES			
Evaluation, Acquisition and Transplantation	Covered in Full after *deductible*	20% *coinsurance* after *deductible*	
Blue Distinction Centers for Transplant (BDCT) Travel Expenses	Covered in Full, *deductible* waived	Not covered	$10,000 per transplant episode
OTHER SERVICES			
Contraceptives	Covered in Full, *deductible* waived	20% *coinsurance* after *deductible*	Limited to *coverage* for those prescribed contraceptive products 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*	20% *coinsurance* after *deductible*	
Nonroutine Foot Care	Covered in Full after *deductible*	20% *coinsurance* after *deductible*	
Orthodontic Treatment of Congenital Cleft Palates	Covered in Full after *deductible*	20% *coinsurance* after *deductible*	
Routine Costs Associated with Approved Clinical Trials	Covered in Full after *deductible*	20% *coinsurance* after *deductible*	

SUMMARY OF BENEFITS *** It is important for *members* to refer to the Payment Levels for Facility Providers chart to determine the level of payment for *facility providers*. *Members* will be responsible for paying the *coinsurance* percentage reflected in that chart in addition to the *coinsurance* percentage reflected in this Summary of Benefits chart. *Nonparticipating providers* may balance bill *members*. ***			
	Amounts Members Are Responsible For:		**Limits and Maximums(If Applicable)**
	Participating Providers	***Nonparticipating Providers***	
Vision Care for Illness or Accidental Injury	Covered in Full after *deductible*	20% *coinsurance* after *deductible*	

COST-SHARING DESCRIPTIONS

This section of the *Certificate of Coverage* describes the cost-sharing that may be required under this *coverage* with *Capital*.

Since *cost-sharing amounts* vary depending on the *member's* specific *coverage*, it is important that the *member* refers to the **Summary of Cost Sharing and Benefits** section of this *Certificate of Coverage* for information on the specific cost-sharing and the applicable *cost-sharing amounts* that are required under this *coverage*.

APPLICATION OF COST-SHARING

All payments made by *Capital* for *benefits* are based on the *allowable amount*. The *allowable amount* is the maximum amount that *Capital* will pay for *benefits* under this *coverage*. Before *Capital* makes payment, any applicable *cost-sharing amount* is subtracted from the *allowable amount*.

Payment for *benefits* may be subject to any of the following cost-sharing in the following order of application:

1. *Preauthorization Penalty*
2. *Copayments*
3. *Deductibles*
4. *Coinsurance*
5. *Out-of-Pocket Maximums*
6. *Benefit Period Maximums*
7. *Benefit Lifetime Maximums*

In addition, *members* are responsible for payment of any:

- Balance billing charges, which are amounts due to a *nonparticipating provider* that exceed the *allowable amount*.
- Services for which *benefits* are not provided under the *member's coverage*, without regard to the *provider's* participation status.

Under certain circumstances, if *Capital* pays the healthcare provider amounts that are the *member's* responsibility, such as *deductible*, *copayments* or *coinsurance*, *Capital* may collect such amounts directly from the *member*. The *member* agrees that *Capital* has the right to collect such amounts from the *member*.

PREAUTHORIZATION PENALTY

When applicable, if a *member* fails to follow *Capital's preauthorization* requirements, *Capital* may impose a penalty and/or deny or reduce the level of payment for *benefits*, even if the *benefits* are *medically necessary*. This reduction in the amount payable for *benefits* is called a *preauthorization penalty*. This amount, which can be assessed as a fixed dollar amount or percentage, is subtracted from the *allowable amount* paid by *Capital* for *benefits*.

Preauthorization penalties for which *members* may be responsible apply only to services provided by *BlueCard participating providers* and *nonparticipating providers*. Amounts due to *providers* after the application of a *preauthorization penalty* are the *member's* responsibility. Payment should be made directly to the *provider*.

Members should refer to the **Summary of Cost-Sharing and Benefits** section of this *Certificate of Coverage* to determine if a *preauthorization penalty* applies to their *coverage*.

COPAYMENT

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

Members should refer to the **Summary of Cost-Sharing and Benefits** section of this *Certificate of Coverage* to determine if any *copayments* apply to their *coverage*.

Covered Service Location Cost Sharing

Certain *benefits* (as indicated on the **Summary of Cost-Sharing and Benefits section**) are subject to a *copayment* based on the type of facility where the covered service is provided (e.g., laboratory tests for example) because the provider charges *Capital* separately both for the service and the use of the facility. This *copayment* is in addition to any cost-sharing obligation for the covered service being provided to the *member*.

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 *allowable amount* that *Capital* 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 *participating providers* and a separate *deductible* amount applicable only to *benefits* received for services provided by *nonparticipating providers*.

Each *member* must satisfy the individual *deductible* applicable to this *coverage* every *benefit period* before *benefits* are paid. Once the family *deductible* has been met, *benefits* will be paid for a family *member* regardless of whether that family *member* has met his/her individual *deductible*. In calculating the family *deductible*, *Capital* will apply the amounts satisfied by each *member* towards the *member's* individual *deductible*. However, the amounts paid by each *member* that count towards the family *deductible* are limited to the amount of each *member's* individual *deductible*. Generally, satisfaction of *deductible* amounts is determined separately for *participating* and *nonparticipating providers*.

Members should refer to the **Summary of Cost-Sharing and Benefits** section of this *Certificate of Coverage* to determine if any *deductibles* apply to their *coverage*.

COINSURANCE

Coinsurance is the percentage of the *allowable amount* payable for a *benefit* that *members* are obligated to pay. Depending on the *member's coverage*, the *coinsurance* may be calculated as two separate percentages: one for *benefits* received for services provided by *participating providers*; and one for *benefits* for services provided by *nonparticipating providers*.

A claim for a *nonparticipating provider* is calculated differently than a claim for a *participating provider*.

Members should refer to the **Summary of Cost-Sharing and Benefits** section of this *Certificate of Coverage* to determine if *coinsurance* applies to their *coverage*.

OUT-OF-POCKET MAXIMUM

The *out-of-pocket maximum* is the maximum *cost-sharing amount* that an individual *member* or a *subscriber's* entire family must pay during a *benefit period*. Depending on the *member's coverage*, there may be an *out-of-pocket maximum* amount applicable only to *benefits* received for services provided by *participating providers* and

a separate *out-of-pocket maximum* amount applicable only to *benefits* received for services provided by *nonparticipating providers*.

Each *member* must satisfy the individual *out-of-pocket maximum* applicable to this *coverage* every *benefit period*. Once the family *out-of-pocket maximum* has been met, *benefits* will be paid for a family *member* regardless of whether that family *member* has met his/her individual *out-of-pocket maximum*. In calculating the family *out-of-pocket maximum*, *Capital* will apply the amounts satisfied by each *member* toward the *member's* individual *out-of-pocket maximum*. However, the amounts paid by each *member* that count towards the family *out-of-pocket maximum* are limited to the amount of each *member's* individual *out-of-pocket maximum*.

Generally, satisfaction of *out-of-pocket maximum* amounts is determined separately for *participating* and *nonparticipating providers*.

Members should refer to the **Summary of Cost-Sharing and Benefits** section of this *Certificate of Coverage* to determine if any *out-of-pocket maximums* apply to their *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 visit limits, day limits, 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*.

Members should refer to the **Summary of Cost-Sharing and Benefits** section of this *Certificate of Coverage* to determine if any *benefit period maximums* apply to their *coverage*.

BENEFIT LIFETIME MAXIMUM

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

Members should refer to the **Summary of Cost-Sharing and Benefits** section of this *Certificate of Coverage* to determine if any *benefit lifetime maximums* apply to their *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 *allowable amount*.

How the interaction between the *allowable amount* and the *provider's* billed charge affects the payment for *benefits* and the amount the *member* will be responsible to pay a *provider* varies depending on whether the *provider* is a *participating provider* or a *nonparticipating provider*.

- For *participating providers*, the *allowable amount* for a *benefit* is set by the *provider's* contract with *Capital*. These contracts also include language whereby the *provider* agrees to accept the amount paid by *Capital*, minus any *cost-sharing amount* due from the *member*, as payment in full.

- For *nonparticipating providers*, the *allowable amount* for a *benefit* determines the maximum amount *Capital* will pay a *member* for *benefits*. Since the *nonparticipating provider* does not have a contract with *Capital*, the *provider* has not agreed to accept *Capital's* payment, minus any *cost-sharing amount* due from the

member, as payment in full. The *allowable amount* in these situations can be less than the *provider's* charge. Therefore, the *member* is also responsible for paying the difference between the *provider's* billed charge and the *allowable amount* in addition to any applicable *cost-sharing amount*. Unless otherwise agreed to by *Capital*, or required by law, all payment for services performed by a *nonparticipating provider* will be made to the *member*.

BENEFIT DESCRIPTIONS

Subject to the definitions in this *Certificate of Coverage* and in the *group contract*, and the terms, conditions, and exclusions specified in this *Certificate of Coverage* and subject to the payment by *members* of the applicable *cost-sharing amounts*, if any, *members* shall be entitled to receive the *coverage* for the *benefits* listed below. Services will be covered by *Capital*: a) only if they are *medically necessary;* and b) only if they are preauthorized (as applicable) by *Capital* and/or its designee; and c) only if the *member* is actively enrolled at the time of the service.

It is important to refer to the Summary of Cost-Sharing and Benefits section of this *Certificate of Coverage* to determine whether a service described in this section is a covered *benefit,* to determine the amounts *members* are responsible for paying to *providers*, and to determine whether any *benefit* limitations/maximums apply to this *coverage*.

Certain services require *preauthorization* by *Capital* or its designee. Please consult the **Preauthorization Program** attachment to determine which services require *preauthorization.*

ACUTE CARE HOSPITAL ROOM & BOARD AND ASSOCIATED CHARGES

Benefits for room and board in an acute care *hospital* include bed, board and general nursing services when a *member* occupies:

- A semi-private room (two or more beds);
- A bed in a *special accommodations unit*; or
- 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 the comfort and/or convenience of the *member*. When a private room is selected at the *member's* option, the *member* is responsible for paying ten percent (10%) of the *hospital's* private room charge.

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

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

Long-Term Acute Care Hospital

Benefits for *long-term acute care hospitals* include services provided when a member is 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 a *member* requires 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. *Capital* must concur 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) 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 (i.e., pillows, mattress casing, air filter, etc.) 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

Autism spectrum disorders include any of the conditions defined as such in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). *Benefits* include coverage for the diagnostic assessment and treatment of *autism spectrum disorders*.

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 disorder*. The diagnosis is valid for not less than twelve (12) months unless a licensed physician or psychologist determines an assessment is needed sooner.

Treatment

Treatment of *autism spectrum disorders* must be specified in a treatment plan or functional behavioral assessment developed by a licensed physician or licensed psychologist following a comprehensive evaluation or reevaluation, and include short and long-term goals that can be measured objectively. Treatment plans must be submitted to *Capital,* or the *contract holder's* Managed Behavioral Healthcare Organization. Review of the treatment plan will be required by *Capital* prior to authorization of services. Treatment plans will be reviewed every six (6) months unless there is clear evidence of regression necessitating changes in treatment.

Coverage for the treatment of *autism spectrum disorders*, as prescribed in a specific treatment plan, may include to the following services (visit limits may apply when rendered to *members* aged twenty-one (21) and older; refer to the **Summary of Cost-Sharing and Benefits** section of this *Certificate of Coverage* for applicable limits):

- *Medically necessary* medical therapy (e.g. physical therapy, occupational therapy, speech therapy) or psychotherapy specifically for the treatment of pervasive developmental disorders;

- *Medically necessary* behavior therapy and behavior modification including mobile therapy, behavior specialist consultation, therapeutic staff support;
- *Medically necessary* interventions to improve verbal and nonverbal communication skills;
- *Medically necessary* and appropriate treatment for comorbidities, including psychotherapy, behavioral therapy, physical and occupational therapy;
- Continued rehabilitative medical treatment once the therapeutic goals have been achieved to preserve the current level of function and prevent regression (maintenance).

Additionally, *coverage* for the treatment of autism spectrum disorders may include Applied Behavior Analysis for *members* less than twenty-one (21) years of age.

Medical necessity review of behavioral health services will be conducted by the *contract holder's* Managed Behavioral Healthcare Organization.

Benefits are also subject to any applicable *cost-sharing amounts* (i.e. office visit *copayment*, *deductible* and *coinsurance*) as determined by the type of treatment rendered at time of service.

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 SUPPLIES

Drugs and Supplies

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:

- Injectable aids (e.g., syringes);
- Pharmacological agents for controlling blood sugar;
- Standard blood glucose monitors and related supplies;
- Insulin infusion devices; and
- Orthotics.

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, in nature.

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* other than an *independent clinical laboratory* (ICL). For a list of *independent clinical laboratories*, as well as how to access them, *members* should go to capbluecross.com or contact *Capital's* Customer Service Department using the telephone number on the back of their ID card.

Medical Tests

Benefits for diagnostic medical tests include EKG's, EEG's, 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, MRI's (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 Magnetic Resonance Imaging (MRI), 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) & SUPPLIES

Durable medical equipment consists of items that are:

- 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; and
- 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 include reasonable repairs, adjustments and certain supplies that are necessary to utilize 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 upon:

- *Member's* condition at diagnosis;
- *Member's* prognosis;
- Anticipated time frame for utilization; and
- 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 DME is purchased by the *member*, the previous allowances for rental of the DME will be deducted from the amount allowed for the purchase of the DME.

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.

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 durable medical equipment.

EMERGENCY AND URGENT CARE SERVICES

An *emergency service* is any health care service provided to a *member* after the sudden onset of a medical condition 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:

- Placing the health of the *member*, 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; or
- 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*.

Benefits for emergency dental accident services include treatment required only to stabilize the *member* 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.

If *Capital*, upon reviewing the emergency room records, determines 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 nonlife threatening and urgent and 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 offering 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 at standard *member cost sharing amounts* if the enteral nutrition product provides fifty percent (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 and are exempt from *deductibles*; however, all other *member* cost-sharing will apply. 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; however, all standard *member cost-sharing amounts* (including *deductibles*) will apply.

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.

GYNECOLOGICAL SERVICES

Screening Gynecological Exam

A screening gynecological exam is a preventive service performed by a gynecologist, primary care physician, or other qualified health care *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 of this *Certificate of Coverage* and are highlighted on the **Schedule of Preventive Care Services** document attached to this *Certificate of Coverage*.

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 of this *Certificate of Coverage* and are highlighted on the **Schedule of Preventive Care Services** document attached to this *Certificate of Coverage.*

Diagnostic Pap smears are covered under the **Diagnostic Services, Laboratory Tests** section of this *Certificate of Coverage* and may be subject to *cost-sharing amounts.*

HOME HEALTH CARE SERVICES

Home health care 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 health care services provided to a homebound patient include:

- 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; and
- Medical social service consultation.

No home health care *benefits* are provided for:

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

Home Health Care Visits Related to Mastectomies

Benefits for home health care visits related to mastectomies include one (1) home health care visit, as determined by the *member's physician*, received within 48 hours after discharge, if such discharge occurs within 48 hours after an admission for a mastectomy.

Home Health Care Visits Related to Maternity

Benefits for home health care visits related to maternity include one (1) home health care 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 health care visits 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 health care *provider* whose scope of practice includes postpartum care must make such home health care visits. At the mother's sole discretion, the home health care visit may occur at the facility of the *provider*. Home health care 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.)

All eligible *hospice* services must be billed by the *hospice provider*.

Benefits for *hospice* care include the following services provided to a *member* by a *hospice provider* responsible for the *member's* 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; and
- *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.

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 *Capital's* 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; and
- Family counseling services.

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

- Volunteers;
- Pastoral services;
- Homemaker services; and
- 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

Benefits for immunizations and injections include certain immunizations if an individual is determined to be at high risk. *Capital* follows 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 the Patient Protection and Affordable Care Act.

Injectables that are "primarily self-administered" are not covered under the *member's* medical *benefit* under any circumstances, even if the *member* is unable to self-administer. In the event a *member* is 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. *Members* can view the list of medications that *Capital* considers to be primarily self-administered by accessing the Self-Administered Medications Policy on the Capital BlueCross website at capbluecross.com.

INFERTILITY SERVICES

Benefits for infertility services include testing to diagnose the causes of infertility and treatments and procedures for infertility.

However, 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), and artificial insemination are not covered.

INFUSION/IV THERAPY

Infusion/IV therapy involves the administration of pharmaceuticals, fluids, and biologicals intravenously or through a gastrostomy tube or subcutaneously through a pump. Infusion/IV therapy is used for a broad range of therapies such as antibiotic therapy, chemotherapy, pain management, and hydration therapy. A home infusion therapy *provider* typically provides services in the home, but a patient is not required to be homebound.

Benefits for infusion/IV therapy include the drugs and IV solutions, supplies and equipment used to administer the drugs, and nursing visits to administer the therapy.

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 of this *Certificate of Coverage* and are highlighted on the **Schedule of Preventive Care Services** document attached to this *Certificate of Coverage.*

Diagnostic Mammogram

A diagnostic mammogram is intended to provide specific evaluation of patients with a detected breast abnormality. *Benefits* for diagnostic mammograms are covered under the **Diagnostic Services, Radiology Tests** section of this *Certificate of Coverage* and may be subject to *cost-sharing amounts*.

MATERNITY SERVICES

Benefits for maternity services include prenatal, delivery and postpartum services provided to a female *member* for pregnancies.

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 health care *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, *members* may be required to obtain *precertification*. For information on *precertification*, contact the plan administrator.

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 pick-up 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).

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. Also, membership fees are excluded from coverage.

MENTAL HEALTH CARE SERVICES

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

Inpatient Services

Benefits for *inpatient mental health care* services include bed, board and general *inpatient* nursing services when provided for the treatment of *mental illness*. Services provided by a *professional provider* to a *member* who is an *inpatient* for *mental health care* 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 care* 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 *Capital* or its designee. *Partial hospitalization mental health care* is not covered for halfway houses.

Outpatient Services

Benefits for *outpatient mental health care* services include the *outpatient* treatment of *mental illness* by a *hospital*, a *physician* or another eligible *provider*.

Attention deficit/hyperactivity disorder (ADHD) is classified as a mental health condition. Treatments for ADHD are eligible under *mental health care benefits.* However, office visits for medication checks are considered medical visits.

NEWBORN CARE

Benefits for newborn care include routine nursery care, prematurity services, preventive health care 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.

If a *deductible* applies to the *member's coverage,* only one facility provider *deductible* will be applied when the mother and newborn are discharged from the *hospital;* however, *deductibles* for other *professional providers* may also apply. If the newborn remains in the *hospital* after the mother is discharged or if the newborn is transferred to another *hospital*, another individual *deductible* will not need to be met before eligible claims are paid for the newborn.

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* including but not limited to the treatment of diabetes heart disease, obesity and morbid obesity.

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

- Visits upon obtaining a diagnosis of a medical condition in which nutrition therapy is *medically necessary*; and

- Visits when a licensed *physician* identifies or diagnoses a significant change in the patient's symptoms or conditions that necessitates changes in a patient's self-management, or when a new medication or therapeutic process relating to the patient's treatment and/or management of the medical condition has been identified as *medically necessary* by a licensed *physician*.

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 health care professional with expertise in diabetes, and subject to the criteria determined by *Capital*. These criteria are based on certification programs for diabetes education developed by the American Diabetes Association or American Association of Diabetes Educators.

ORTHOTIC DEVICES

An orthotic device is a rigid or semi-rigid supportive device that 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.

PREVENTIVE CARE SERVICES

Benefits for preventive care are highlighted on the **Schedule of Preventive Care Services** document attached to this *Certificate of Coverage*. 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** attached to this *Certificate of Coverage*.

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** document attached to this *Certificate of Coverage*.

Services that need to be performed more frequently than stated in the **Schedule of Preventive Care Services** document attached to this *Certificate of Coverage* due to high-risk situations are covered when the diagnosis and procedure(s) are otherwise covered. *Capital* follows guidelines set by the Center for Disease Control in determining high-risk individuals. These services are subject to all applicable *cost-sharing amounts*.

PRIVATE DUTY NURSING

Benefits for private duty nursing include services provided by an actively practicing registered nurse or a *licensed practical nurse* when ordered by a *physician* provided that such nurse does not ordinarily reside in the *member's* home or is not a member of the *member's* immediate family and that *Capital* concurs with the *physician's* certification that the care is *medically necessary*.

PROFESSIONAL PROVIDER EVALUATION & MANAGEMENT (E&M), TELEHEALTH SERVICES, AND CONSULTATIONS

Evaluation & management and consultation services involve clinical and physical exams required for the prevention, diagnosis and treatment of an illness or injury.

Evaluation and Management

Inpatient – *Benefits* for *inpatient* evaluation and management include medical care services provided by a *physician* or other *professional provider* to a *member* who is a *hospital inpatient*. Medical care includes *inpatient* visits and intensive care. *Inpatient* E&M services for a condition related to *surgery*, maternity, *mental health care*, or *substance use disorder* care are addressed elsewhere in this *Certificate of Coverage*.

Outpatient – *Benefits* for *outpatient* evaluation and management include *outpatient* visits to a *professional provider* for the prevention, diagnosis, and treatment of an injury or illness. *Outpatient* E&M services for a condition related to *surgery*, maternity, *mental health care*, or *substance use disorder* care are addressed elsewhere in this *Certificate of Coverage*.

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 a *member* by another *physician* at the request of the attending *physician*.

Consultations that are not *benefits* include:

- Staff consultations required by *hospital* rules and regulations; and
- 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 and is open to the public for walk-in, unscheduled visits during all open hours offering significant extended hours, which may include evenings, holidays and weekends. *Benefits* for *retail clinic services* are calculated at the same benefit level as professional provider outpatient E&M office visits.

Telehealth Services

Benefits for *telehealth* services are limited to those *medically necessary* services provided by a *Capital telehealth participating provider* and for the:

- Diagnosis and management of acute minor illness that do not typically require direct hand-on *provider* examination.
- Individual Behavioral Health diagnosis, counseling, and treatment. (*Benefits* do not include group counseling.)
- Treatment for nicotine cessation.
- *Remote Patient Monitoring.*

Coverage for *telehealth services* does not include the following:

- E-mail or non-video enabled telephone 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

To find a *telehealth participating provider*, *members* can call 1-800-962-2242 or visit capbluecross.com.

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 a *member* requires *inpatient skilled nursing services* on a daily basis and these *skilled nursing services* are provided in accordance with a *physician*'s order. *Capital* 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 *members* with a diagnosis of *substance use disorder* in overcoming their addiction. *Members* must be detoxified before rehabilitation will be covered. A *substance use disorder* treatment program provides rehabilitation care.

Inpatient — *Benefits* for *inpatient substance use disorder* rehabilitation include: bed, board and general *inpatient* nursing services. *Substance use disorder* care provided by a *professional provider* to a *member* who is an *inpatient* for *substance use disorder* rehabilitation 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* rehabilitation include services that would be covered on an *inpatient* basis but are otherwise provided for *outpatient,* in an intensive outpatient treatment program (IOP) or through *partial hospitalization*.

SURGERY

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

Evaluation & Management (E&M)

Benefits for evaluation and management related to *surgery* include the initial consultation or evaluation of the problem by the surgeon to determine the need for *surgery*.

Surgical Procedure

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

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 *hospital*ization 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 *Capital* has 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. Reconstruction 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 thirty-one (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 determined by *Capital* 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 an eligible dental patient are subject to all applicable *cost-sharing amounts.*

Other Surgeries

Benefits for other specialized surgical procedures include:

- Routine neonatal circumcisions; and
- Sterilization procedures

THERAPY SERVICES (REHABILITATIVE AND HABILITATIVE)

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

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 person's 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, 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 through the use of intermittent positive breathing (IPPB) treatments, chest percussion, and postural drainage.

Pulmonary therapy includes treatment through a multi-disciplinary program which 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 *Capital* has 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 the *member* assumes 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 both the recipient and donor are covered by *Capital*, *benefits* are provided to both, each pursuant to the terms of each person's respective contract.

- If only the transplant recipient is covered by *Capital*, *benefits* are provided 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 the transplant recipient is covered by *Capital* 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 BlueCross BlueShield Association and participating 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, lodging, and meal expenses for the *member* and one support companion. Items that are not covered expenses include, but are not limited to, alcohol, tobacco, car rental, entertainment, expenses for persons other than the *member* and the *member's* companion, telephone calls, and personal care items.

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 Screening

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

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

Nonroutine 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 to *members* with 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 a *member* with 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 either the *member's* referring *provider* is a *participating provider* who has concluded the *member's* participation in the trial would be appropriate, or the *member* furnishes medical and scientific information establishing that his or her participation in the trial would be appropriate, *benefits* shall be payable for *Routine Costs Associated with Approved Clinical Trials*. *Capital* must be notified in advance of the *member's* participation in the *Approved Clinical Trial*.

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 of this *Certificate of Coverage*.

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

SCHEDULE OF EXCLUSIONS

Except as specifically provided in this *Certificate of Coverage*, no *benefits* are provided under this *coverage* with *Capital* for services, supplies, or equipment described or otherwise identified below.

1. Which are not *medically necessary* as determined by *Capital's* Medical Director(s) or his/her designee(s);

2. Which are considered by *Capital* to be *investigational*, except where otherwise required by law;

3. For any illness or injury which occurs in the course of employment if *benefits* or compensation are available or required, in whole or in part, under a workers' compensation policy and/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 the *member* makes a claim for the *benefits* or compensation under the applicable workers' compensation policy/coverage and/or the applicable law;

4. For any illness or injury suffered after the *member's effective date of coverage* which resulted from an act of war, whether declared or undeclared;

5. For services received by veterans and active military personnel at facilities operated by the Veteran's Administration or by the Department of Defense, unless payment is required by law;

6. Which are received 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*;

7. For the cost of *hospital*, medical, or other *benefits* resulting from accidental bodily injury arising out of 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;

8. For items or services paid for by *Medicare* when *Medicare* is primary consistent with the Medicare Secondary Payer Laws. This exclusion shall not apply when the *contract holder* is obligated by law to offer the *member* the *benefits* of this *coverage* as primary and the *member* so elects this *coverage* as primary;

9. For care of conditions that federal, state or local law requires to be treated in a public facility;

10. For court ordered services when not *medically necessary* and/or not a covered *benefit*;

11. For 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;

12. Which are not billed by and either performed by or under the supervision of an eligible *provider*;

13. For services rendered by a *provider* who is a member of the *member's immediate family*;

14. For telephone and electronic consultations, including *telehealth visits*, between a *provider* and a *member*, except as otherwise provided in this *Certificate of Coverage*;

15. For charges for failure to keep a scheduled appointment with a *provider*, for completion of a claim or insurance form, for obtaining copies of medical records, or for a *member's* decision to cancel a *surgery*, or for *hospital* mandated on call service;

16. For 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*;

17. Which exceed the *allowable amount* except as otherwise provided for in this *Certificate of Coverage*;

18. Which are *cost-sharing amounts* required of the *member* under this *coverage*;

19. For the amount of any *preauthorization penalty* applied under the *preauthorization* provision of a *member's coverage*;

20. For which a *member* would have no legal obligation to pay;

21. For services incurred prior to the *member's effective date of coverage*;

22. For services incurred after the date of termination of the *member's coverage* except as provided for in this *Certificate of Coverage*;

23. For services received by a *member* in a country with which United States law prohibits transactions;

24. For prophylactic blood, cord blood or bone marrow storage to be used in the event of an accident or unforeseen *surgery* or transplant;

25. For *custodial care*, domiciliary care, residential care, protective and supportive care including educational services, rest cures, convalescent care, or respite care not related to *hospice* services;

26. For services related to organ donation where the *member* serves as an organ donor to a nonmember;

27. For transplant services where human organs were sold rather than donated and for non-Food and Drug Administration (FDA) approved devices functioning as total artificial organs;

28. For anesthesia when administered by the assistant to the operating *physician* or the attending *physician*;

29. For *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 bodily 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* or accidental injury. For purposes of this exclusion, prior *surgery* is not considered an accidental injury;

30. For oral *surgery*, except as specifically provided in this *Certificate of Coverage*;

31. For maintenance therapy services, except for manipulation therapy for chronic pain management or as required by law;

32. For physical therapy for work hardening, vocational and prevocational assessment and training, functional capacity evaluations, as well as its use towards enhancement of athletic skills or activities;

33. For occupational therapy for work hardening, vocational and prevocational assessment and training, functional capacity evaluations, as well as its use towards enhancement of athletic skills or activities;

34. For all rehabilitative therapy, other than as described in the *Certificate of Coverage*, including but not limited to play, music, equestrian/hippotherapy, and recreational therapy;

35. For cognitive rehabilitation therapy, except when provided integral to other supportive therapies, such as, but not limited to physical, occupational and speech therapies in a multidisciplinary, goal-oriented and integrated treatment program designed to improve management and independence following neurological damage to the central nervous system caused by illness or trauma (For example: stroke, acute brain insult, encephalopathy);

36. For sports medicine treatment or equipment which is intended primarily to enhance athletic performance;

37. For services or supplies that are considered by *Capital* to be *investigational*, except routine costs associated with *Approved Clinical Trials* that have been preauthorized by *Capital*. Routine costs do not include any of the following:

    a. The *investigational* drug, biological product, device, medical treatment or procedure itself.

    b. The services and supplies provided solely to satisfy data collection and analysis needs and that are not used in the direct *clinical management* of the patient.

    c. The services and supplies customarily provided by the research sponsors free of charge for any enrollee in the *Approved Clinical Trial*.

    d. *Member* travel expenses.

38. For all dental services rendered after stabilization of a *member* in an emergency following an accidental injury, including but not limited to, oral *surgery* for replacement teeth, oral prosthetic devices, bridges, or orthodontics;

39. For travel expenses incurred in conjunction with *benefits* unless specifically identified as a covered service elsewhere in this *Certificate of Coverage*;

40. For back-up or secondary durable medical equipment and prosthetic appliances, except ventilators,

41. For durable medical equipment requested specifically for travel purposes, recreational or athletic activities, or when the intended use is primarily outside the home;

42. For replacement of lost or stolen durable medical equipment items, including prosthetic appliances, within the expected useful life of the originally purchased durable medical equipment

43. For continued repair of durable medical equipment after its useful life has exhausted;

44. For replacement of defective or nonfunctional durable medical equipment when the equipment is covered under the manufacturer's warranty;

45. For upgrade or replacement of durable medical equipment when the existing equipment is functional except when there is a change in the health of the *member* such that the current equipment no longer meets the *member's* medical needs

46. For modifications, adjustments, accessories to durable medical equipment, orthotics, prosthetics and diabetic shoes that do not improve the functionality of the equipment;

47. For durable medical equipment intended for use in a facility (*hospital* grade equipment)

48. For home delivery, education and set up charges associated with purchase or rental of durable medical equipment, as such charges are not separately reimbursable and are considered part of the rental or purchase price;

49. For prosthetic appliances dispensed to a patient prior to performance of the procedure that will necessitate the use of the device;

50. For personal hygiene, comfort and/or convenience items such as, but not limited to, air conditioners, humidifiers, air purifiers and filters, physical fitness or exercise equipment, including, but not limited to inversion, tilt, or suspension device or table, radio and television, beauty/barber shop services, guest trays, chairlifts, elevators, incontinence supplies, deodorants, spa or health club memberships, or any other modification to real or personal property, whether or not recommended by a *provider*;

51. For items used as safety devices, and for elastic sleeves (except where otherwise required by law), thermometers, bandages, gauze, dressings, cotton balls, tape, adhesive removers, or alcohol pads;

52. For supportive environmental materials and equipment such as handrails, ramps, telephones, and similar service appliances and devices;

53. For enteral nutrition due to lactose intolerance or other milk allergies;

54. For blenderized baby food, regular shelf food, or special infant formula, except as specified in this *Certificate of Coverage*;

55. For 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 *Certificate of Coverage;*

56. For immunizations required for travel or employment except as required by law;

57. For routine examination, counseling services, testing, immunization, treatment and preparation of specialized reports solely for insurance, licensing, or employment including but not limited to pre-marital examinations, physicals for college, camp, sports or travel;

58. For 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 and as specifically provided in this *Certificate of Coverage*;

59. For treatment of temporomandibular joint syndrome (TMJ) by any and all means including, but not limited to, *surgery*, intra-oral devices, splints, physical therapy, and other therapeutic devices and interventions, except for evaluation to diagnose TMJ and except for treatment of TMJ caused by physical trauma resulting from an accident; Intra-oral reversible prosthetic devices/appliances are excluded regardless of the cause of TMJ;

60. For *hearing aids*, examinations for the prescription or fitting of *hearing aids*, and all related services;

61. For 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;

62. For 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;

63. For 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;

64. For 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;

65. For *infertility* 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;

66. For donor services related to assisted fertilization;

67. For procedures to reverse sterilization;

68. For 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;

69. For treatment, medicines, devices, or drugs in connection with sexual dysfunction, both male and female, not related to organic disease or injury;

70. For elective terminations of pregnancy;

71. For all prescription and over-the-counter drugs dispensed by a pharmacy or *provider* for the *outpatient* use of a *member*, whether or not billed by a *facility provider*, except for allergy serums and mandated pharmacological agents used for controlling blood sugar, FDA approved drugs for the treatment of Substance Use Disorder, and where otherwise required by law;

72. For 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 approved by *Capital*;

73. For *inpatient* stays to bring about nonsurgical weight reduction;

74. For acupuncture;

75. For biofeedback;

76. For autopsies or any other services rendered after a *member's* demise;

77. For wigs and other items intended to replace hair loss due to male/female pattern baldness;

78. For nonneonatal circumcisions, unless *medically necessary*;

79. For all types of skin tag removal, regardless of symptoms or signs that might be present, except when the condition of diabetes is present;

80. For membership dues, subscription fees, charges for service policies, insurance premiums and other payments analogous to premiums which entitle enrollees to services, repairs, or replacement of devices, equipment or parts without charge or at a reduced charge;

81. For services provided at unapproved sites, for a *member's* individualized education program (IEP), or as part of a *member*'s education, except as may be required by statute or explicit legal requirement;

82. For at-home genetic testing, including confirmatory testing for abnormalities detected by at-home genetic testing, and genetic testing of a *member* done primarily for the clinical management of family members who are not *members* and are, therefore, not eligible for *coverage*;

83. For supplying medical testimony;

84. For any services related to or rendered in connection with a noncovered service, including but not limited to anesthesia, diagnostic services, etc.; and

85. For any other service or treatment except as provided in this *Certificate of Coverage*.

CLINICAL MANAGEMENT

A wide range of *Clinical Management* Programs are available under this *coverage* with *Capital*.

These *Clinical Management* Programs are intended to provide a personal touch to the administration of the *benefits* available under this *coverage.* Program goals are focused on providing *members* with the skills necessary to become more involved in the prevention, treatment and recovery processes related to their specific illness or injury.

Clinical Management Programs include:

- Utilization Management;
- Care Management;
- Disease Management;
- Maternity Management;
- Quality Management; and
- Health Education and Wellness.

All of *Capital's* standard products include the full array of *Clinical Management* Programs. Under specific circumstances, groups may choose not to include all or some of the *Clinical Management* Programs described below in this *coverage*. Therefore, it is important for *members* to determine program eligibility before assuming that all of these programs are available to them.

UTILIZATION MANAGEMENT

The Utilization Management Program is a primary resource for the identification of *members* for timely and meaningful referral to other *Clinical Management* Programs and includes *Preauthorization,* Concurrent Review and Medical Claims Review. *Preauthorization,* Concurrent Review, and Medical Claims Review use a *medical necessity* and/or *investigational* review to determine whether services are covered *benefits*.

Medical Necessity Review

This *coverage* with *Capital* provides *benefits* only for services *Capital* or its designee determines to be *medically necessary* as defined in the **Definitions** section of this *Certificate of Coverage*.

When *preauthorization* is required, *medical necessity* of *benefits* is determined by *Capital* or its designee prior to the service being rendered. However, when *preauthorization* is not required, services may still undergo a *medical necessity* review and must still be considered *medically necessary* to be eligible for coverage as a *benefit*.

A *participating provider* will accept *Capital's* determination of *medical necessity*. The *member* will not be billed by a *participating provider* for services that *Capital* determines are not *medically necessary*.

A *nonparticipating provider* is not obligated to accept *Capital's preauthorization* denial or determination of *medical necessity*, and therefore, may bill a *member* for services determined not to be *medically necessary*. A *member* is solely responsible for payment of such services and can avoid this responsibility by choosing a *participating provider*.

Even if a *participating provider* recommends that a *member* receive services from a *nonparticipating provider*, the *member* is responsible for payment of all services determined by *Capital* to be not *medically necessary*.

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

A *member* or the *provider* may contact *Capital's* Clinical Management Department to determine whether a service is *medically necessary*. The criteria for *medical necessity* determinations, including those made with respect to *mental health care* or *substance use disorder benefits*, will be made available to any current or potential *member* or *participating provider* upon request.

Investigational Treatment Review

This *coverage* with *Capital* does not include services *Capital* determines to be *investigational* as defined in the **Definitions** section of this *Certificate of Coverage*.

However, *Capital* recognizes that situations occur when a *member* elects to pursue *investigational* treatment at the *member's* own expense. If the *member* receives a service *Capital* considers to be *investigational*, the *member* is 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.

A *member* or a *provider* may contact *Capital* to determine whether *Capital* considers 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 facilitate the receipt by *members* of:

- Medically appropriate treatment to meet individual needs;
- Care provided by *participating providers* delivered in an efficient and effective manner; and
- Maximum available *benefits*, resources, and coverage.

Participating providers are responsible for obtaining required *preauthorizations*.

However, if a *nonparticipating provider* is used, the *member* is responsible for obtaining the required *preauthorization*. *Members* may be subject to a *preauthorization penalty* or the full charge for the service for failure to comply with *preauthorization* requirements. *Members* should refer to the **Schedule of Cost-Sharing and Benefits** section of this *Certificate of Coverage* to determine whether a *preauthorization penalty* applies to their *coverage*.

Members should refer to the **Preauthorization Program** attachment to this *Certificate of Coverage* for information on this program. *Members* should carefully review this attachment to determine whether services they wish to receive must be preauthorized by *Capital* and for instructions on how to obtain *preauthorization*. This listing may be updated periodically.

A *preauthorization* decision is generally issued within fifteen (15) business 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 experienced *Capital* registered nurses and board-certified physicians to 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, such as Case Management and Disease Management; to identify potential quality of care issues; and to facilitate timely and appropriate discharge planning. A concurrent review decision is generally issued within one (1) day of receiving all necessary information.

Discharge Planning - Discharge planning is performed by concurrent review nurses who communicate with *hospital* staff, either in person or by telephone, 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.

Medical Claims Review

Capital's clinicians conduct Medical Claims Review retrospectively 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 *Capital* receives a claim for payment for services that have already been provided. Claims that require retrospective review include, but are not limited to, claims incurred:

- 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; or
- for services that have not complied with *preauthorization* requirements.

A retrospective review decision is generally issued within thirty (**30)** calendar days of receiving all necessary information.

If a retrospective review finds a procedure to not be *medically necessary*, the *member* may be liable for payment to the *provider* if the *provider* is *nonparticipating*.

CARE MANAGEMENT

The Care Management Program is a proactive *Clinical Management* Program designed for *members* with acute or complex medical needs who could benefit from additional support with coordinating their care. The Care Management Program includes:

- Care Management;
- Specialized Case Management Oncology Program;
- Transplant Case Management Program;
- Case Management Awareness Program;
- Discharge Outreach Call Program;
- Transition of Care Program; and

- Emergency Room Utilization.

Case Management Program

The Case Management Program is a service for *members* with complex medical needs or who may be at risk for future adverse health events due to an existing medical condition or who may require a wide variety of resources, information, and specialized assistance to help them manage their health and improve their quality of life. The program assigns an experienced *Capital* case management nurse or coordinator to a *member* or family caretaker to help make arrangements for needed care or to provide assistance in locating available community resources.

Case management services provided to *members* are numerous and are always tailored to the individual needs of a *member*. Participation in *Capital's* Case Management Program is voluntary and involves no additional cost to our *members*. Services often include, but are not limited to:

- Assistance with coordination of care;
- Discussion of disease processes;
- Facilitating arrangements for complex surgical procedures, including organ and tissue transplants;
- Facilitating arrangements for home services and supplies, such as durable medical equipment and home nursing care; or
- Identification and referral to available community resources, programs; or organizations.

Specialized Case Management Oncology Program

This program is comprised of a dedicated oncology case management team of specially trained staff experienced in cancer care and end-of-life issues who provide assessment and support to *members* at all stages of adjustment to a cancer diagnosis. Core goals of this program include education regarding early symptom identification and pain management, increased *member* understanding of and satisfaction with their treatment plan, improved overall quality of life, and improved coping surrounding end-of-life issues. Care coordination benefits of the program include: management of care and services between the *members*, their family, *providers*, vendors, and the health plan; appropriate utilization of services; and the potential for cost savings through reductions in potentially avoidable admissions and emergency department use.

Transplant Case Management Program

This program is comprised of a dedicated transplant case management team specially trained and experienced in transplant care that provides 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®. Care Coordination benefits of the program include: coordinating the exchange of information between the *hospital*, physicians, and the health plan that is required for evaluation and authorization of required services, consultation with medical/surgical transplant team, and ordering/requesting specialists to implement a member-centric plan of care, facilitating expected rehabilitation and convalescence needs, and identifying available medical, family, and community resources.

Case Management Awareness Program

This program contacts *members* who may benefit from case management services because they have multiple medical conditions, may be at risk for future illness or disease due to an existing medical condition, have undergone an extended *hospital* stay, are having difficulty managing a health condition, or are seeking medical services from several *providers*. Identified *members* will receive an automated outbound call to provide educational information regarding the benefits, value, and purpose of case management. They will be offered the opportunity, either through warm transfer or a return call, to speak with a Capital BlueCross case management nurse regarding their health care needs and to potentially enroll in one of the Capital BlueCross care management programs.

Discharge Outreach Call Program

The Discharge Outreach Call Program assists *members* in understanding their post-discharge treatment plan and thereby helps prevent avoidable complications and readmissions. Within two (2) days of discharge from a *hospital*, a *Capital* nurse may contact a *member* by telephone to discuss any discharge concerns; to assess the *member's* understanding of and adherence to the provider's discharge instructions, including the timing of any follow-up appointments, to determine the *member*'s understandings about any medications prescribed; and to make sure any necessary arrangements for services, such as home health care, are proceeding appropriately.

Transition of Care Program

This program addresses the needs of Capital BlueCross *members* who have been discharged from an acute care facility. Through the use of an automated outbound calling system, an initial screening is completed on all Capital BlueCross *members* with an acute *hospital* stay resulting in discharge to their home. We address changes to medications, follow-up lab and imaging appointments, and physician follow-up appointments to ensure smooth transitions to home and outpatient care and minimize the potential for readmission. Depending on the *member*'s answers to the screening questions, which will identify potential areas of concern, *members* are referred on to the DOC Program for additional assessment and follow up by the DOC nurse.

Emergency Room Utilization Program

This program provides an integrated care management approach for *members* who have had an emergency room (ER) visit and were not subsequently admitted to an acute inpatient facility. *Members* will receive an automated outbound telephone call to provide educational information related to available alternative care options. Alternative care options include Capital BlueCross' Nurse Line, the *member's* primary care *provider* office, and Urgent Care Centers. The educational telephone call is not to discourage utilization of the ER, but to provide education on the use of alternative care options when appropriate. *Members* will be asked if they have a primary care provider. If they do not, assistance in locating either a primary care provider or an Urgent Care Center will be offered. The Capital BlueCross website and Customer Service telephone number also will be offered. Additional follow-up telephone calls along with more intensive assessments will be made to *members* with multiple ER visits. Referrals to a care management program will be made where appropriate.

DISEASE MANAGEMENT

The Disease Management Program is a collaborative program that assesses the health needs of *members* with a chronic condition and provides education, counseling, and information designed to increase the *member's* self-management of this condition.

The goals of *Capital's* Disease Management Program are to maintain and improve the overall health status of *members* with specific diseases through the provision of comprehensive education, monitoring and support for healthy self-management techniques. The Disease Management Program is especially beneficial for *members* who have complex health care needs or who require additional assistance and support. Participation in *Capital's* Disease Management Program is voluntary and involves no additional cost to our *members*.

Members should refer to the **Disease/Condition Management Programs** attachment to this *Certificate of Coverage* for a description of Disease Management Programs available to them.

MATERNITY MANAGEMENT PROGRAM

Precious Baby Prints® is a voluntary Maternity Management Program designed to support expectant mothers who experience both complicated and uncomplicated pregnancies. Program participation extends throughout pregnancy, delivery and postpartum care. The program provides educational information, teaching, and personalized support to pregnant *members.*

The assessment phase of the program includes a questionnaire that helps to identify *members* who may be at risk for pregnancy-related complications or who may be experiencing complications. *Members* identified as being potentially at high risk for complications are assigned a Maternity Case Manager (R.N.) for more intensive personalized services.

Program activities for low risk *members* are designed to supplement the advice and treatment provided by the *member's* Obstetric *provider* and *physicians*. The program is tailored to each *member's* individual health and educational needs and provides credible educational materials related to pregnancy, general health issues, childcare and parenting skills.

QUALITY MANAGEMENT PROGRAM

The Quality Management Program is designed to facilitate the receipt of quality care and services by *Capital members*. The program is multidisciplinary, involving all departments within *Capital* that have a direct impact on quality of care, services and accessibility. The program provides for the monitoring, evaluation, measurement, and reporting of the quality of medical care, the quality of service, and the safety of program services.

Responsibilities of the Quality Management Program include but are not limited to:

- Clinical appeals and grievances;
- Identification, evaluation and corrective action (as necessary) for all potential quality issues;
- Analysis of *member* satisfaction surveys;
- Monitoring of *provider* practice patterns; and
- Compliance with all regulatory and accrediting standards.

HEALTH EDUCATION AND WELLNESS PROGRAMS

Capital's Health Education and Wellness Programs are provided through a special unit within the *Clinical Management* Department. *Capital* believes that motivating individuals to adopt healthier lifestyles results in better outcomes when individuals have access to comprehensive and accurate health and wellness information. In addition, the Health Education and Wellness Programs include a 24-Hour Nurse Line service that is available to all of our *members* free of charge and a Nicotine Cessation Program.

Multiple areas on the Capital BlueCross website are dedicated to providing health and wellness education for our *members*. For more information, visit capbluecross.com and www.healthforums.com.

24-Hour Nurse Line

The *Capital* 24-Hour Nurse Line staff of registered nurses are available to answer questions on health-related issues 24 hours a day, every day of the year. The service is designed to offer health and medical information, education and support. The service also offers assessment and advice, and suggests appropriate levels of care for symptomatic callers in the event *members* are unable to reach their *physician*. *Members* are encouraged to call **1-800-452-BLUE** when they have the need for health information/education, or want assistance in determining how to best handle specific medical symptoms. Nurses are prepared to provide the following services:

- Answers to a *member's* questions on a health-related topic;
- Send information/educational materials as appropriate to the *member's* home; or

- Refer a *member* to an Audio Library for comprehensive information on a specific topic, disease or procedure.

If the call is for symptomatic reasons, the nurses will:

- Conduct an assessment of the *member's* symptoms;
- Direct the *member* to dial 911 in the event the symptoms described warrant it;
- Suggest the appropriate level of care in the event the *member's physician* is not available.

Nicotine Cessation Program

Capital's Nicotine Cessation Program is designed to assist *members* who are interested in breaking their habit of tobacco product use. *Members* may access information via *Capital's* website, including contact information for the PA Quit Line, Pennsylvania's nicotine cessation counseling services. Additional resources available via *Capital's* website include:

- Nurse Line - access 24 hours a day to a live nurse who can assist *members* with questions and resources focused on nicotine cessation;
- Discount Health Network - a network of local and regional community organizations which offer discounts on health-related services;
- Website links to credible organizations and programs focused on nicotine cessation; and
- References to available community programs.

Members also have access to nicotine replacement therapy (e.g. gum, patches) provided by *Capital's* vendor, subject to any applicable *cost-sharing amount* required of the *member*.

HOW WE EVALUATE NEW TECHNOLOGY

Changes in medical procedures, behavioral health procedures, drugs, and devices occur at a rapid rate. *Capital* strives 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 *Capital* concerning our medical policies, with an emphasis on community practice standards. The Committee, along with *Capital's* 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 Food and Drug Administration, the National Institutes of Health, and the Centers for Disease Control and Prevention. The five (5) key criteria used by the Committee to evaluate new technology are listed below:

- 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; and

- 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 Committee provides a recommendation to *Capital's* Corporate Policy Committee regarding the new technology and any necessary changes to medical policy. The Corporate Policy Committee makes final determinations concerning medical policy after assessing *provider* and *member* impacts of recommended policies.

Capital's medical policies are developed to assist us in administering *benefits* and do not constitute medical advice. Although the medical policies may assist *members* and their *provider* in making informed health care decisions, *members* and their 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* 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

Members should refer to the *contract holder's* Summary Plan Description for information and requirements related to eligibility and enrollment.

TERMINATION OF COVERAGE

TERMINATION OF GROUP CONTRACT

Termination of the *group contract* automatically terminates *coverage* with *Capital* for all *members*. 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

A *member* cannot be terminated based on health status, health care 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:

- *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*.
- Child - *Coverage* of a child ends on the date in which the child is no longer eligible as described in the **Enrollment** section of this *Certificate of Coverage*. However, *coverage* of a child may continue as a *dependent* disabled child as described in the **Membership Status** section of this *Certificate of Coverage.*
- *Dependent* Disabled Child - *Coverage* of a *dependent* disabled child ends when the *subscriber* does not submit to *Capital*, through the *contract holder*, the appropriate information as described in the **Membership Status** section of this *Certificate of Coverage*. The *subscriber* must notify *Capital* of a change in status regarding a *dependent* disabled child.

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

- Using an *ID card* to obtain goods or services:
  - ◊ Not prescribed or ordered for the *subscriber* or the *subscriber's dependents* or
  - ◊ 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 *Capital*, on any *enrollment application* form.

The actual termination date is the date specified by the *contract holder* and approved by *Capital*. *Members* should check with the *contract holder* for details regarding specific termination dates. Except as provided for in this *Certificate of Coverage*, 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

COBRA COVERAGE

COBRA (Consolidated Omnibus Budget Reconciliation Act) is a Federal 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* with *Capital*.

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

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

Capital is not liable for the cost of *benefits* provided to *members* after the date of termination.

Enrollment forms are available from *Capital's* Customer Service Department and can be obtained by calling the customer service number located on the *identification 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 BlueCross family of companies.

Enrollment forms are available from *Capital's* Customer Service Department and can be obtained by calling the customer service number located on the *identification card*.

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

CLAIMS REIMBURSEMENT

CLAIMS AND HOW THEY WORK

In order to receive payment for *benefits* under this *coverage,* a claim for *benefits* must be submitted to *Capital*. The claim is based upon the itemized statement of charges for health care services and/or supplies provided by a *provider*. After receiving the claim, *Capital* will process the request and determine if the services and/or supplies provided under this *coverage* with *Capital* are *benefits* provided by the *member's coverage*, and if applicable, make payment on the claim. The method by which *Capital* receives a claim for *benefits* is dependent upon the type of *provider* from which the *member* receives services. *Providers* that are excluded or debarred from governmental plans are not eligible for payment by *Capital*.

Participating Providers

When *members* receive services from a *participating provider*, they should show their *Capital identification card* to the *provider*. The *participating provider* will submit a claim for *benefits* directly to *Capital*. *Members* will not need to submit a claim. Payment for *benefits* – after applicable *cost-sharing amounts*, if any - is made directly to the *participating provider*.

Nonparticipating Providers

If *members* visit a *nonparticipating provider*, they may be required to pay for the service at the time the service is rendered. Although many *nonparticipating providers* file claims on behalf of *Capital's members*, they are not required to do so. Therefore, *members* need to be prepared to submit their claim to *Capital* for reimbursement. Unless otherwise agreed to by *Capital*, payment for services provided by *nonparticipating providers* is made directly to the *subscriber*. It is then the *subscriber's* responsibility to pay the *nonparticipating provider*, if payment has not already been made.

Out-of-Area Providers

If *members* receive services from a *provider* outside of the *Capital service area*, and the *provider* is a member of the local Blue Plan, *members* should show their *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 *Capital* for processing. *Capital* applies the applicable *benefits* and *cost-sharing amounts* to the claim. This information is then sent back to the local Blue Plan that will in turn make payment directly to the *participating provider* – after applicable *cost-sharing amounts*, if any, have been applied.

ALLOWABLE AMOUNT

For *professional providers* and *facility providers*, the *benefit* payment amount is based on the *allowable amount* on the date the service is rendered.

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 the *member's cost-sharing amount* obligations.

FILING A CLAIM

If it is necessary for *members* to submit a claim to *Capital*, they should be sure to request an itemized bill from their health care *provider*. The itemized bill should be submitted to *Capital* with a completed *Capital* Claim Form.

Members can obtain a copy of the *Capital* Claim Form by contacting Customer Service or visiting the Member link on *Capital's* website at capbluecross.com. The *member's* claim will be processed more quickly when the

Capital Claim Form is used. A separate claim form must be completed for each *member* who received medical services.

Members should include **all** of the following information with their claim:

1. Identification Number – *subscriber's* nine-digit identification number, preceded by three-letter alpha prefix.
2. Group Number – number of the sponsoring *group* or employer.
3. Name of *Subscriber* – full name of the person enrolled for *coverage* through the group.
4. Address – full address of the *subscriber* including: number and street, city, state, country, and ZIP code.
5. Patient's Name – last and first name of the patient who received the service.
6. Patient's Gender – indicate male or female.
7. Patient's Date of Birth – patient's date of birth by month, day, and year.
8. Patient's Relationship to *Subscriber* – relationship of the patient to the *subscriber*.
9. *Provider* Name – full name, address, city, state, country, and ZIP code of the facility, *physician*, or supplier rendering the services.
10. Procedure Code – procedure code or description of each service rendered.
11. Type of Admission/*Surgery* – Type of service such as *inpatient* or *outpatient* and what was done, if applicable.
12. Date(s) of Service – dates on which patient received services, including initial admission date and final discharge date if applicable.
13. Diagnosis, Illness, or Injury – complete diagnosis or injury for particular admission.
14. Receipts from *Provider* – receipts from *provider* showing patient name, type of service, date of each service, and amount charged for each service.

Members must also provide the following information, if applicable:

1. Other insurance payment and/or rejection notices including a *Medicare* Summary Notice if applicable.
2. Accident information (i.e., date of accident, type of accident, payment or rejection notice, letter of benefit exhaustion, itemized statement).
3. Workers' compensation payment and/or rejection notice.
4. Student information.
5. Medical records which may include *physician* notes and/or treatment plans (see special note regarding medical records).
6. Ambulance information – point of origin and destination (example: from home to *hospital*).
7. Anesthesia – the length of time patient was under anesthesia and specific *surgery* for which anesthesia was given.

8. Blood – number of units received, charge for each unit, and number of units replaced by donor(s).

9. Chemotherapy – name of drug, dosage of drug, charge for each drug, and the method of administration (oral, intra-muscular injections, intravenous, etc.)

10. Durable medical equipment certification from the doctor concerning the *medical necessity* and expected length of time equipment will be needed. If renting equipment, *members* should have the durable medical supplier provide the equipment purchase price.

A Special Note About Medical Records

In order to determine if the services are *benefits* covered under this *coverage*, the *member* (or the *provider* on behalf of the *member*) may need to submit medical records, *physician* notes, or treatment plans. *Capital* will contact the *member* and/or the *provider* if additional information is needed to determine if the services and/or supplies received are *medically necessary*.

Where to Submit Medical Claims

Members can submit their claims, which include a completed *Capital* Claim Form, an itemized bill, and all required information listed above, to the following address:

Capital BlueCross
PO Box 211457
Eagan, MN 55121

Members who need help submitting a medical claim can contact Customer Service at **1-800-962-2242** (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 *members* to pay only the usual *cost-sharing amounts*. The *hospital* files the claim for the *member*. *Members* who receive *inpatient hospital* care from a *nonparticipating hospital* or services that were not coordinated through the service center 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, the *member* pays the *provider* and then submits 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 capbluecross.com.

CLAIM FILING AND PROCESSING TIME FRAMES

Time Frames for Submitting Claims

All claims must be submitted within twelve (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 the *member's* claim involves a medical service or supply that has not yet been received (pre-service claim), *Capital* will process the claim within fifteen (15) days of receiving the claim. If the *member's* claim involves a medical service or supply that was already received (post-service claim), *Capital* will process the claim within thirty (30) days of receiving the claim. *Capital* may extend the fifteen (15) day or thirty (30) day time period one (1) time for up to fifteen (15) days for circumstances beyond *Capital's* control. *Capital* will notify the *member* prior to the expiration of the original time period if an extension is needed. The member and *Capital* may also agree to an extension if the member or *Capital* 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 the life or health of the *member*, their ability to regain maximum function or in the opinion of a *physician* with knowledge of the *member's* medical condition, would subject the *member* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Capital will notify the *member* of the decision on an *urgent care* claim as soon as possible but not later than seventy-two (72) hours after receipt of the claim, unless information is insufficient to make a determination of *coverage*. If such is the case, *Capital* will notify the *member* of the additional information needed within twenty-four (24) hours of receipt of the claim. The *member* will be given a reasonable amount of time but no less than forty-eight (48) hours to submit the additional necessary information. *Capital* will notify the *member* 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 the *member* to provide the information, whichever is earlier.

Special Time Frames Applicable to "Concurrent Care" Claims

Medical circumstances may arise under which *Capital* approves an ongoing course of treatment to be provided to the *member* over a period of time or number of treatments. If the *member* or the *member's provider* believe that the period of time or number of treatments should be extended, the *member* should follow the steps described below.

If it is believed that any delay in extending the period of time or number of treatments would jeopardize the *member's* life, health, or ability to regain maximum function, the *member* must request an extension at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments. The *member* must make a request for an extension by calling *Capital's* Customer Service Department, toll-free, at **1-800-962-2242**. *Capital* will review the *member's* request and will notify the *member* of *Capital's* decision within twenty-four (24) hours after receipt of the request.

Members who are dissatisfied with the outcome of their request may submit an appeal. The **Appeal Procedures** section of this *Certificate of Coverage* contains instructions for submission of an appeal. For all other requests to extend the period of time or number of treatments for a prescribed course of treatment, *members* should contact *Capital's* Customer Service Department.

COORDINATION OF BENEFITS (COB)

The coordination of *benefits* provision of this *Certificate of Coverage* applies when a person has health care 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 of this *Certificate of Coverage*, 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 health care benefits or services through:

1. individual, group, blanket or franchise insurance coverage except that it shall not mean any blanket student accident coverage or *hospital* indemnity plan of one hundred ($100) dollars or less;
2. Blue Cross, Blue Shield, group practice, individual practice, and other prepayment coverage;
3. coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans; and
4. 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 health care 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 health care 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 the *member* has health care 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 a *member* does 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.

Capital 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 *Capital* is furnished with information regarding Other Plans by the *contract holder* or *subscriber* or any other organization or person.

Allowable Expense: Allowable expense is a health care 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 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 (2) 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 (2) 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 health care 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 (2) 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 of this *Certificate of Coverage*.

    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 health care 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 health care 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 health care 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 health care 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 <u>not</u> 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. <u>Active Employee or Retired or Laid-off Employee.</u>

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 "Nondependent or Dependent "rule can determine the order of benefits.

d. <u>*COBRA* or State Continuation Coverage.</u>

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 "Nondependent or Dependent" rule can determine the order of benefits.

e. <u>Longer or Shorter Length of Coverage.</u>

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 health care 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 health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Coverage and other Plans. *Capital* 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. *Capital* 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 *Capital* any facts needed to apply those rules and determine *benefits* payable.

Failure to complete any forms required by *Capital* 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, *Capital* 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. *Capital* 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 *Capital* is more than the amount that should have been paid under this COB provision, *Capital* 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 his/her spouse), age sixty-five (65) or older, is entitled to benefits under *Medicare* and the *subscriber* works for an employer that did not employ twenty (20) or more employees for each working day in each of twenty (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 his/her spouse), age sixty-five (65) or older, is entitled to benefits under *Medicare* and the *subscriber* works for an employer that employed twenty (20) or more employees for each working day in each of twenty (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 sixty-five (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 *Capital*, 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 sixty-five (65), and the *subscriber* has current employment status with an employer with fewer than one hundred (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 sixty-five (65), and the *subscriber* has current employment status with an employer with at least one hundred (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 ESRD 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 remain primary for the first thirty (30) months of a *member's* eligibility or entitlement to *Medicare* due to End Stage Renal Disease (as defined under applicable *Medicare* statutes). 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 of this *Certificate of Coverage*.

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

Capital reserves the right to recoup from the *member* or *provider*, any payments made in error, whether for a *benefit* or otherwise.

APPEAL PROCEDURES

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 *coverage* with *Capital* for a service:

- Based on a determination of a *member*'s eligibility to enroll under the *group contract*;
- Resulting from the application of any utilization review; or
- Not provided because it is determined to be *investigational* or not *medically necessary*.

Members who disagree with an *adverse benefit determination* with respect to *benefits* available under this *coverage* 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 including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a *benefit* resulting from the application of any utilization review, as well as a failure to cover an item or service for which *benefits* are otherwise provided because it is determined to be *experimental or investigational* or not *medically necessary*. A rescission of coverage also constitutes an adverse benefit determination.

INTERNAL APPEAL PROCESS

Whenever a *member* disagrees with *Capital's* adverse benefit determination, the *member* may seek internal review of that determination by submitting a written appeal. At any time during either the internal or external appeal process, the m*ember* may appoint a representative to act on his or her behalf as more fully discussed below. The appeal should include the reason(s) the *member* disagrees with the adverse benefit determination. The appeal must be received by *Capital* within one hundred eighty (180) days after the *member* received notice of the adverse benefit determination. The *member*'s appeal must be sent to:

Capital BlueCross
PO Box 779518
Harrisburg, PA 17177-9518

The *member* 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, *Capital* will provide the *member* with a full and fair internal review. *Capital* will provide the *member,* 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 the *member* to have a reasonable opportunity to respond prior to the issuance of the final internal appeal determination.

In reviewing the appeal, *Capital* will utilize health care 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.* The *member* may contact *Capital* at 1-800-962-2242 (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 *Capital* relied

upon in making the adverse benefit determination. *Para obtener asistencia en Español, llame al 1-800-962-2242. Capital* will provide the *member* with a determination within thirty (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 sixty (60) days for an appeal of an adverse benefit determination for a post-service claim (where services or supplies have already been received). If Capital's determination is still adverse to the *member* in whole or in part, the *member* will receive a Final Internal Adverse Benefit Determination.

EXTERNAL APPEAL PROCESS

A *member* 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 the Capital's 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.

In order to request an external appeal pertaining to *medical necessity*, the *member* must write to *Capital* at the address set forth above within four (4) months from receipt of the Final Internal Adverse Benefit Determination. *Capital* will forward the appeal along with all materials and documentation to an IRO. The member will be able to submit additional information to the IRO for consideration in the external appeal.

The IRO must notify the *member* of its decision on the appeal in writing within forty-five (45) days from receipt of the request for external review.

*Member*s of a group health plan subject to ERISA 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. The *member* may seek expedited internal review of the determination of a claim involving urgent care by contacting *Capital* at the telephone number above. *Capital* will respond with a determination within seventy-two (72) hours. The *member* may also request an expedited external appeal simultaneously with the request for an expedited internal appeal. If Capital's determination is still adverse to the *member* in whole or in part, the *member* will receive a Final Internal Adverse Benefit Determination.

Expedited External Appeal Process For Claims Involving Urgent Care. The *member* 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 health care service for which the *member* received emergency services but has not been discharged from a facility. To request an expedited external appeal review of such a Final Internal Adverse Benefit Determination, the *member* or their physician must contact *Capital* at the telephone number above and may provide *Capital* with a physician's certification that the *member's* claim is urgent in accordance with the definition above. Upon receipt of a request for an expedited external review, Capital BlueCross will assign an IRO and will transmit the file to the assigned IRO to review the appeal. The IRO will issue a determination within seventy-two (72) hours of receipt of the request.

Simultaneous Internal and External Appeal Process for Claims Involving Urgent and Concurrent Care. The *member* 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 *Capital* approved an ongoing course of treatment to be provided over a period of time or number of treatments, the *member* has the right to an expedited appeal of any reduction or termination of that course of treatment by *Capital* before the end of such previously approved period of time or number of treatments. *Capital* will notify the *member* of its decision to reduce or terminate the *member's* course of treatment at a time sufficiently in advance of the reduction or termination to allow the *member* to appeal and obtain an appeal decision before the m*ember's benefits* are reduced or terminated.

Members who wish to appeal must call *Capital's* Customer Service Department at 1-800-962-2242 (TTY: 711). *Capital* will notify the *member* of the outcome of the appeal via telephone or facsimile not later than seventy-two (72) hours after *Capital* receives the appeal. *Capital* will defer any reduction or termination of the *member's* ongoing course of treatment until a decision has been reached on the appeal.

Simultaneous Internal and External Appeal Process for Claims Involving Urgent and Concurrent Care. The *member* 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

Members may designate another individual to act on their behalf in pursuing a benefit claim or appeal of an unfavorable benefit decision.

To designate an individual to serve as their "authorized representative" or "designee" *members* must complete, sign, date, and return a *Capital's* Member Authorization Form. *Members* may request this form from our Customer Service Department at 1-800-962-2242 (TTY: 711).

Capital communicates with the *member's* authorized representative only after *Capital* receives the completed, signed, and dated authorization form. The *member's* authorization form will remain in effect until the *member* notifies *Capital* in writing that the representative is no longer authorized to act on the m*ember's* behalf, or until the *member* designates a different individual to act as his/her authorized representative.

For purposes of reviewing *member* appeals, if *benefits* are provided under:

- An insured arrangement, *Capital* is the named fiduciary.
- A self-funded or "self-insured" arrangement, either *Capital* 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.

MEMBER RIGHTS AND RESPONSIBILITIES

Members of *Capital's* Preferred Provider Organization (PPO), have certain rights and responsibilities. The success of treatment and *member* satisfaction depends, in part, on *members* taking responsibility as patients. Acquainting *members* with their rights and responsibilities will help *members to* take a more active role in their health care.

MEMBER RIGHTS

Members have a right:

- To be treated with respect and recognition of their dignity and right to privacy at all times, to receive considerate and respectful care regardless of religion, race, color, national origin, age, sex, gender identity or sexual orientation, health status, or financial status.
- To receive information about *Capital*, its services, its contracted practitioners and *providers* (including information regarding a *provider's* qualifications, such as medical school attended, residency completed, or board certification status), and *member* rights and responsibilities. *Members* can call Customer Service to obtain this information.
- To make recommendations to the list of *member* rights and responsibilities.
- To have *Capital member* literature and material for the *member's* use, written in a manner which truthfully and accurately provides relevant information that is easily understood.
- To know the name, professional status, and function of those involved in their care.
- To obtain from their *physician* complete current information concerning their diagnosis, treatment, and prognosis in terms they can reasonably understand, unless it is not medically advisable to provide such information.
- To candid discussion of appropriate or *medically necessary* treatment options for their condition, regardless of cost or *benefit* coverage.
- To participate with practitioners in decision making regarding their health care.
- To know what procedure and treatment will be used so that when they give consent to treatment, it is truly informed consent. *Members* should be informed of any side effects or complications that may arise from proposed procedures and treatment in addition to possible alternative procedures. Their physician is responsible for providing them with information they can understand.
- To be advised if any experimentation or research program is proposed in their case and of their right to refuse participation.
- To refuse any drugs, treatment, or other procedure offered to them to the extent permitted by law and to be informed by their *physician* of the medical consequences of such refusal.
- To all information contained in their medical record unless access is specifically restricted by the attending *physician* for medical reasons.
- To expect that all records pertaining to their medical care are treated as confidential unless disclosure is necessary for treatment, payment and operations.

- To be afforded the opportunity to approve or refuse release of identifiable personal information except when such release is allowed or required by law.
- The right to file dissatisfaction about *Capital* or the care rendered by their *provider* and to file an appeal from an adverse benefit determination or final internal adverse *benefit* determination.

MEMBER RESPONSIBILITIES

Members have a responsibility:

- To follow the rules of membership and to read all materials carefully.
- To carry their *Capital ID card* with them and present it when seeking health care services.
- To provide *Capital* with relevant information concerning any additional health insurance coverage which they or any of their *dependents* may have.
- To timely notify *Capital* and their employer of any changes in their membership, such as change of address, marital status, etc.
- To seek and obtain services from the primary care physician they have chosen as well as direct access to obstetrical/gynecological care and in emergencies or when their chosen *physician* has referred them to other *participating providers* and/or *Capital* has preauthorized them to do so.
- To communicate openly with the *physician* they choose by developing a physician-patient relationship based on trust and cooperation.
- To follow the plans and instructions for care that they have agreed upon with their practitioner.
- To ask questions to make certain they understand the explanations and instructions they are given.
- To understand their health problems and participate, to the degree possible, in developing mutually agreed-upon treatment goals.
- To understand the potential consequences if they refuse to comply with treatment plans or recommendations.
- To keep scheduled appointments or give adequate notice of delay or cancellation.
- To pay appropriate *copayments* and *coinsurance* to *providers* when services are received.
- To keep *Capital* informed of any concerns regarding the medical care they receive.
- To provide information, to the extent possible, that *Capital* needs to administer coverage and that practitioners need to provide care.
- To treat others with respect and recognition of dignity, and to provide considerate and respectful interaction with others regardless of their religion, race, color, national origin, age, sex, gender identity or sexual orientation, health status, or financial status.

GENERAL PROVISIONS

ADDITIONAL SERVICES

From time to time, *Capital*, in conjunction with contracted companies, may offer other programs under this *coverage* with *Capital* to assist *members* in obtaining appropriate care and services. Such services may include a 24-hour nurse line, *case management*, maternity management, and Disease Management Programs.

DISCOUNTS AND INCENTIVES

Capital may also make available to its *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 *Capital* 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 *Certificate of Coverage*, the *contract holder* makes *Capital coverage* available to eligible *members*. However, this *Certificate of Coverage* 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 sixty (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 sixty (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 sixty (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 STATE 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 participating or nonparticipating 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 health care *provider*. If the *member's participating provider* ceases participation, *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 *group policy* and the *Certificate of Coverage*, the terms of the *group policy* shall control and be enforceable over the terms of the *Certificate of Coverage*.

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.

FAILURE TO ENFORCE

The failure of either *Capital*, the *contract holder*, or a *member* to enforce any provision of the *group contract* shall not be deemed or construed to be a waiver of the enforceability of such provision. Similarly, the 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 default.

FAILURE TO PERFORM DUE TO ACTS BEYOND CAPITAL'S CONTROL

The obligations of *Capital* under the *group contract*, including this *Certificate of Coverage*, 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).

IDENTIFICATION CARDS

Capital provides *identification cards* to all *subscribers* and other *members* as appropriate. For purposes of identification and specific coverage information, a *member's ID card* must be presented when service is requested.

Identification cards are the property of *Capital* and should be destroyed when a *member* no longer has *coverage*. Upon request, *identification cards* must be returned to *Capital* within thirty-one (31) days of the *member's* termination. *Identification 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 sixty (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 (3) 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 twelve (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 Schedule of Cost Sharing in this *Certificate of Coverage*. 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 BlueCross
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 twelve (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 *participating 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 *Certificate of Coverage*, with which *members* shall comply.

RELATIONSHIP OF PARTIES

Health care *providers* maintain the physician-patient relationship with *members* and are solely responsible to *members* for all medical services. The relationship between *Capital* and health care *providers* (including *PCPs* and other *physicians*) is an independent contractor relationship. Health care *providers* are not agents or employees of *Capital*, nor is any employee of *Capital* an employee or agent of a health care *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 health care *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 BlueCross, 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 a *participating provider* or *nonparticipating 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 a pandemic, *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 a *participating 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 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

Capital members may submit a written request for any of the following written information:

1. A list of the names, business addresses and official positions of the membership of the board of directors or officers of *Capital*.

2. The procedures adopted by *Capital* to protect the confidentiality of medical records and other *member* information.

3. A description of the credentialing process for *participating providers*.

4. A list of the *participating providers* affiliated with participating *hospitals*.

5. If prescription drugs are provided as a *benefit* under this *coverage*, whether a specifically identified drug is included or excluded from this *coverage*.

6. A description of the process by which a *participating 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*.

7. A description of the procedures followed by *Capital* to make decisions about the nature of individual drugs, medical devices or treatments.

8. 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 a *participating provider*.

9. 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 BlueCross
PO Box 779519
Harrisburg, PA 17177-9519

Members may also fax their requests to 717-541-6915 or by accessing capbluecross.com, an email can be sent to the Customer Service Department.

Members may inform *Capital* of their dissatisfaction with the quality of care or service they may have received by writing to the address above or by faxing *Capital* at the number above. *Members* can also call Customer Service to register the dissatisfaction (please refer to the HOW TO CONTACT US section of this *Certificate of Coverage* for contact information).

DEFINITIONS

For the purpose of the *group contract*, the terms below have the following meanings whenever italicized in the *group contract*:

Accountable Care Organization (ACO): A group of healthcare providers who agree to deliver coordinated care and meet performance benchmarks for quality and affordability in order to manage the total cost of care for their member populations.

Adverse Benefit Determination: 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, or failure to provide or make payment that is based on a determination of a *member's* eligibility to participate in a plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a *benefit* resulting from the application of any utilization review, as well as a failure to cover an item or service for which *benefits* are otherwise provided because it is determined to be *investigational* or not *medically necessary*. Adverse Benefit Determinations also include a rescission of coverage (whether or not in connection with the rescission, there is an adverse effect on any particular benefit at the time.)

Allowable Amount: The payment level that *Capital* reimburses for *benefits* provided to a *member* under the *member's coverage*.

- for *participating providers*, the allowable amount is the amount provided for in the contract between the *provider* and *Capital*, unless otherwise specified in this *Certificate of Coverage*.
- for *nonparticipating providers*, the allowable amount is the lesser of the *provider's* billed charge or the amount reflected in the *fee schedule*, unless otherwise specified in this *Certificate of Coverage*.

Ambulatory Surgical Facility: A *facility provider* licensed and approved by the state in which it provides covered health care services or as otherwise approved by *Capital* and which:

- 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* whenever the patient is in the facility;
- does not provide *inpatient* accommodations; and
- is not, other than incidentally, a facility used as an office or clinic for the private practice of a *physician*.

Annual Enrollment: A specific time period during each calendar year when the *contract holder* permits its employees or members to make enrollment changes.

Approved Clinical Trial: 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 is described below:

- 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 National Institutes of Health for center support grants.

7. The Department of Veterans Affairs, the Department of Defense 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 National Institute of Health, 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.

In the absence of meeting the criteria listed in above, the Clinical Trial must be approved by *Capital* as a qualifying Clinical Trial.

Autism Spectrum Disorders: A subclass of *pervasive developmental disorders* which is characterized by impaired verbal and nonverbal communication skills, poor social interaction, limited imaginative activity and repetitive patterns of activities and behavior.

Benefit Lifetime Maximum: The limit of *coverage* for a *benefit* payable by *Capital* under the *group contract* during the duration of a *member's coverage* under the *group contract*. Such limits may be in the form of visits, days, or dollars. Benefit lifetime maximums are described in the **Summary of Cost-Sharing and Benefits** section of this *Certificate of Coverage*.

Benefit Period: The specified period of time during which charges for *benefits* must be incurred to be eligible for payment by *Capital*. A charge for *benefits* is incurred on the date the service or supply was provided to a *member*. However, the benefit period does not include any part of a calendar year during which a person has no *coverage* under the *group contract*, or any part of a year before the date of this *Certificate of Coverage* or similar provision(s) takes effect. **The benefit period for this *coverage* is the calendar year.**

Benefit Period Maximum: The limit of coverage for a *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 of this *Certificate of Coverage*.

Benefits: Those *medically necessary* health care services, supplies, equipment and facilities charges covered under, and in accordance with, this *coverage*.

Birth Defect: Also known as congenital anomalies, congenital disorders or congenital malformation, 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 *facility provider* licensed and approved by the appropriate governmental agency, which is primarily organized and staffed to provide maternity care by a licensed certified nurse midwife.

BlueCard Program: A program that allows a *member* to access covered health care services from *Host Blue participating providers* of a Blue Cross and/or Blue Shield Licensee located outside the *service area*. The local Blue Cross and/or Blue Shield Licensee servicing the geographic area where the covered health care service is provided is referred to as the "Host Blue."

Capital: Capital BlueCross and Capital Advantage Assurance Company, the entities administering this *coverage*, as indicated on the cover page of this *Certificate of Coverage*.

Care Coordination: Organized, information-driven patient care activities intended to facilitate the appropriate responses to a *member's* healthcare needs across the continuum of care.

Care Coordinator: An individual within a provider organization who facilitates *care coordination* for patients.

Care Coordinator Fee: A fixed amount paid by a BlueCross and/or BlueShield Licensee to providers periodically for *care coordination* under a *Value-Based Program*.

Case Management: A *Clinical Management* Program that coordinates and manages complicated medical care.

Certificate of Coverage: This document that is issued to *subscribers* as part of the *group contract* entered into between the *contract holder* and *Capital*. It explains the terms of this *coverage*, including the *benefits* available to *members* and information on how this *coverage* is administered.

Clinical Management: Programs used to approve, review, and facilitate health care services.

COBRA: Collectively, the Consolidated Omnibus Budget Reconciliation Act of 1985 and its related regulations, each as amended.

Coinsurance: The percentage of the *allowable amount* that will be paid by the *member*. Coinsurance percentages, if any, are identified in the **Summary of Cost-Sharing and Benefits** section of this *Certificate of Coverage* or in the applicable rider to this *Certificate of Coverage*.

Contract Holder: The organization or firm, usually an employer, union, or association, that contracts with *Capital* to provide coverage for *benefits* to *members*. The contract holder is identified in the *group policy*.

Copayment: The fixed dollar amount that a *member* must pay for certain *benefits*. The *member* must pay copayments directly to the *provider* at the time services are rendered. Copayments, if any, are identified in the **Summary of Cost-Sharing and Benefits** section of this *Certificate of Coverage* or in the applicable rider to this *Certificate of Coverage*.

Cosmetic Surgery or 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 considered unpleasant or unsightly.

Cost-Sharing Amount: The amount subtracted from the *allowable amount* which the *member* is obligated to pay before *Capital* makes payment for *benefits*. Cost-sharing amounts include: *preauthorization penalties*, *copayments*, *deductibles*, *coinsurance*, and *out-of-pocket maximums*.

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

Custodial Care: Care provided primarily for maintenance of the *member* or which is designed essentially to assist the *member* 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 in order to be performed safely and effectively.

Deductible: The amount of the *allowable amount* that must be incurred by a *member* each *benefit period* before *benefits* are covered under the *group contract*. Deductibles are described in the **Summary of Cost-Sharing and Benefits** section of this *Certificate of Coverage*.

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

Effective Date of Coverage: The date the *member's coverage* under the *group contract* begins as shown on the records of *Capital*.

Emergency Service: Any health care services provided to a *member* after the sudden onset of a medical condition 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:

- 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 (with respect to a pregnant woman having contractions, an emergency service would include when there is inadequate time to safely transfer the woman to another *hospital* for delivery or when a transfer may pose a threat to the health or safety of the woman or the unborn child);
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part; or
- other serious medical consequences.

Transportation and related *emergency services* provided by a licensed ambulance service are *benefits* if the condition is as described in this definition.

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

ERISA: Collectively, the Employee Retirement Income Security Act of 1974 and its related regulations, each as amended.

Facility Provider: Facility *providers* include:

- Ambulance Service *Provider*
- *Ambulatory Surgical Facility*
- *Birthing Facility*
- Durable Medical Equipment Supplier
- Freestanding Outpatient/Diagnostic Facility
- *Freestanding Dialysis Treatment Facility*
- *Home Health Care Agency*
- *Hospice*
- *Hospital*
- *Hospital* Laboratories

- Infusion Therapy *Provider*
- *Long-Term Acute Care Hospital*
- Orthotics Supplier
- Prosthetics Supplier
- *Psychiatric Hospital*
- *Rehabilitation Hospital*
- *Residential Treatment Facility*
- *Skilled Nursing Facility*
- *Substance Use Disorder Treatment Facility*
- Urgent Care Center

Information on whether these facility *providers* are covered under the *group contract* can be found in the **Summary of Cost-Sharing and Benefits** section of this *Certificate of Coverage*.

Fee Schedule: The predetermined fee maximums that will be paid by *Capital* for services performed by *nonparticipating 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.

Freestanding Dialysis Facility: A *facility provider* licensed and approved by the state in which it provides health care services, or as otherwise approved by *Capital*, and which is primarily engaged in providing dialysis treatment, maintenance or training to *members* on an *outpatient* or home care basis.

Freestanding Outpatient Facility: A *facility provider*, licensed and approved by the state in which it provides health care services, or as otherwise approved by *Capital*, and which is 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 where an individual is physically limited in the performance of basic daily activities.

Global Payment/Total Cost of Care: A payment methodology that is defined at the patient level and accounts for either all patient care or for a specific group of services delivered to the patient such as outpatient, physician, ancillary, *hospital* services and prescription drugs.

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 *Capital*, together with any amendments or modifications thereto.

Group Contract: The contract for Administrative Services Only and any attachments or amendments thereto, including but not limited to, the *group application*, the *enrollment applications* and this *Certificate of Coverage*, between the *contract holder* and *Capital* for the administration of *benefits*.

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

Group Enrollment Period: A period of time established by the *contract holder* and *Capital* from time to time, but no less frequently than once in any twelve (12) consecutive months, during which eligible persons who have not previously enrolled with *Capital* may do so; or those who have previously enrolled in a *Capital* program may switch to another program.

Habilitative Services: Health care 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).

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, devices that produce sound by mechanically vibrating bone, 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.

HIPAA: The Health Insurance Portability and Accountability Act of 1996, and its related regulations, each as amended.

Home Health Care Agency: A *facility provider*, licensed and approved by the state in which it provides health care services, or as otherwise approved by *Capital*, which 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 *facility provider* licensed and approved by the state in which it provides health care services, or as otherwise approved by *Capital*, and which is 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:

- is licensed by the state in which it is located,
- provides twenty-four (24) hour nursing services by certified registered nurses on duty or call,
- provides services under the supervision of a staff of one or more *physicians* to diagnose and treat ill or injured bed patients *hospital*ized for surgical, medical or psychiatric conditions, and
- is certified by the Joint Commission on the Accreditation of Healthcare Organizations, an equivalent body, or as accepted by *Capital*.

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 Capital's 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 health care services rendered to *Capital's members* who utilize services of such *providers* when traveling outside of *Capital's* service area.

Identification Card (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, 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 Clinical Laboratory (ICL) - A laboratory that performs clinical pathology procedure and that is not affiliated or associated with a *hospital*, *physician* or *facility provider*.

Infertility: The medically documented diminished ability to conceive, or to conceive and carry to live birth. A couple is considered infertile if conception does not occur after a one-year period of unprotected coital activity without contraceptives, or there is the inability on more than one occasion to carry to live birth.

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

Inpatient: A *member* who is admitted as a patient and spends greater than 23 hours in a *hospital*, a *rehabilitation hospital*, a *skilled nursing facility*, a *residential treatment facility* or a *substance use disorder treatment facility* and for whom a room and board charge is made. This term may also describe the services rendered to such a *member*.

Intensive Outpatient Treatment (also known as 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 (2) hours per day, three (3) days per week.

Investigational: For the purposes of the *group contract*, a drug, treatment, device, or procedure is investigational if:

- it cannot be lawfully marketed without the approval of the Food and Drug Administration ("FDA") and final approval has not been granted at the time of its use or proposed use;
- 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 in order to define safety, toxicity, effectiveness or effectiveness compared with other approved alternatives; or
- 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:

- the *member's* medical records;
- the protocol(s) pursuant to which the treatment or procedure is to be delivered;
- any consent document the patient has 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; and
- the opinion of a third party medical expert in the field, obtained by *Capital*, with respect to whether a treatment or procedure is investigational.

Level of Coverage: The level of payment made by *Capital* to a *participating provider* or a *nonparticipating provider* described in the **Summary of Cost-Sharing and Benefits** section of this *Certificate of Coverage*.

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

Long-Term Acute Care *Hospital* (LTACH): An acute care *hospital* designed to provide specialized acute care for medically stable, but complex, patients who require long periods of *hospital*ization (average 25 days) and who would require high-intensity services. LTACHs are often described as a "*hospital* within a *hospital*" because they generally are located within a short-term acute care *hospital*. In Pennsylvania, LTACHs are licensed by the Pennsylvania Department of Health as an acute care facility.

Marketplace: Shall mean a Marketplace established and operated within Pennsylvania by the United States Secretary of Health and Human Services under section 1321(c)(1) of *PPACA* or operated by the Commonwealth of Pennsylvania in accordance with *PPACA's* provisions. Also called an "Exchange."

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): Shall mean:

- 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 health care *provider*; and
- not more costly than alternative services or supplies at least as likely to produce equivalent results for the *member's* condition, disease, illness or injury.

For purposes of this definition, "generally accepted standards of good medical practice" means standards that are 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 of itself determine *medical necessity* or make such a service or supply a covered *benefit*.

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

Member: A *subscriber*, *dependent* or "Qualified Beneficiary" (as defined under *COBRA*) who enrolled for *coverage* with *Capital* and is entitled to receive covered services under the *group contract* in accordance with its terms and conditions. For purposes of the Complaint and Grievance 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.

Member Effective Date: The date when a *member's coverage* under the *group contract* begins. This date is agreed to by *Capital* and the *contract holder* and entered on the records of *Capital* in accordance with the terms of the *group contract* as described in this *Certificate of Coverage*. *Coverage* begins at 12:00:00 AM, local Harrisburg, Pennsylvania time, on the member effective date.

Mental Health Care: Care received in connection with the treatment of a *mental illness* or a *serious mental illness*.

Mental Illness/Disorder: A health condition that is 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 that is not delivered through the *BlueCard Program*.

Nonparticipating Provider: A *provider* who is not under contract with *Capital* or a *provider* who is not a *BlueCard participating provider*.

Official Notice of Change: The documents issued by *Capital* to communicate changes to the *group contract* and which are identified within the document as an "Official Notice of Change". Such documents may be communicated to the *contract holder* or *subscriber* (as applicable) in various formats including, but not limited to:

- Letters;
- Official *Capital* publications such as group or *member* newsletters; or
- Contract riders or amendments.

Delivery may be made via U.S. Mail or electronic mail to the address on record with *Capital*, and shall be deemed delivered upon mailing.

Out-of-Pocket Maximum: The amount of the *allowable amount* that a *member* is required to pay during a *benefit period*. After this amount has been paid, the *member* is no longer required to pay any portion of the *allowable amount* for *benefits* during the remainder of that *benefit period*. The amount of the out-of-pocket maximum is described in the **Summary of Cost-Sharing and Benefits** section of this *Certificate of Coverage*.

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

Partial Hospitalization: The provision of medical, nursing, counseling, or therapeutic services on a planned and regularly scheduled basis in a *hospital* or non-*hospital* facility licensed as a *mental health care* 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 *hospital*ization services must be provided for a minimum of four (4) hours, with a maximum of twelve (12) hours per day without incurring a charge for an overnight stay.

Participating Provider(s): A *professional provider*, *facility provider*, or any other eligible health care *provider* or practitioner that is approved by *Capital* 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 *Capital* to provide *benefits* to *members* and who satisfies *Capital's* credentialing and privileging criteria. The status of a *provider* as a participating *provider* may change from time to time. It is the *member's* responsibility to verify the current status of a *provider*.

Participating Provider Level of Coverage: The level of payment made by *Capital* when a *member* receives benefits from a *participating provider* in accordance with *Capital's* policies and procedures.

Patient-Centered Medical Home (PCMH): A model of care in which each patient has an ongoing relationship with a primary care physician who coordinates a team to take collective responsibility for patient care and, when appropriate, arranges for care with other qualified physicians.

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, each as amended.

Preauthorization: An authorization (or approval) from *Capital* or its designee which results from a process utilized to determine *member* eligibility at the time of request, *benefit* coverage and *medical necessity* of proposed medical services prior to delivery of services. Preauthorization is required for the procedures identified in the **Preauthorization Program** attachment to this *Certificate of Coverage*.

Preauthorization Penalty: An amount deducted from the *allowable amount* when a *member* did not comply with *Capital's clinical management* policies and procedures. Preauthorization penalties are described in the **Summary of Cost-Sharing and Benefits** section of this *Certificate of Coverage*.

Professional Provider: Professional *providers* include:

- Audiologist
- Certified Registered Nurse Anesthetist
- Certified Registered Nurse Midwife
- Certified Registered Nurse Practitioner
- Chiropractor
- Clinical or Physician Laboratory
- Doctor of Medicine (M.D.)
- Doctor of Osteopathy (D.O.)
- Licensed Dietitian-Nutritionist
- Licensed Social Worker
- Occupational Therapist
- Oral Surgeon
- Physical Therapist
- Physician's Assistant
- Podiatrist
- Psychologist
- Respiratory Therapist
- Retail Clinic
- Speech Language Pathologist

Provider: A *hospital*, *physician*, person or practitioner licensed (where required) and performing services within the scope of such licensure and as identified in this *Certificate of Coverage*. Providers include *participating providers* and *nonparticipating providers.*

Provider Incentive: An additional amount of compensation paid to a healthcare provider by a BlueCross and/or BlueShield 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 *provider* licensed and approved by the state in which it provides health care services, or as otherwise approved by *Capital*, and which is primarily engaged in providing diagnostic and therapeutic services for the *mental health care*. Such services are provided by or under the supervision of an organized staff of *physicians*.

Qualified Medical Child Support Order: An order determined by *Capital* to satisfy the requirements of state or federal law.

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

Rehabilitation Hospital: A *provider* licensed and approved by the state in which it provides health care services, or as otherwise approved by *Capital*, and which is 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*.

Rehabilitative Services: Health care 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.

Remote Monitoring: a type of *telehealth service* in which mobile medical technology for remote patient 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 Hospice Care: Care provided in a *hospice* facility. *Residential hospice care* is 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 (ADL's) as well as specialized *hospice* care on a twenty-four hour per day basis.

Residential Treatment Facility (RTF): -A non-hospital *facility provider*, licensed and approved by the state in which it provides health care services or as otherwise approved by *Capital*, which provides 24-hour level of care that offers treatment for patients that require close monitoring of their behavioral and clinical activities related to their psychiatric treatment, eating disorder, chemical dependency, or addiction to drugs or alcohol. This level of care offers an organized set of services, including diagnostic, medical management and monitoring, and therapeutic services, as well as daily living skill development. These comprehensive programs provide an individually planned regime of care through a multidisciplinary team approach, including 24-hour RN supervision, individual therapy, group therapy and family counseling. The primary focus is on short-term stabilization or rehabilitation, but may also include residential level of care crisis services.

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 *Capital* 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 *Certificate of Coverage* that would typically 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.

Serious Mental Illness: Any of the following *mental illnesses* as defined by the American Psychiatric Association in the most recent edition of the Diagnostic and Statistical Manual or as otherwise approved by *Capital*: schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder, and delusional disorder.

Service Area: The following Pennsylvania Counties: Adams, Berks, Centre, Columbia, Cumberland, Dauphin, Franklin, Fulton, Juniata, Lancaster, Lebanon, Lehigh, Mifflin, Montour, Northampton, Northumberland, Perry, Schuylkill, Snyder, Union, and York.

Shared Savings: A payment mechanism in which the provider and payer share cost savings achieved against a target cost budget based upon agreed upon terms and may include downside risk.

Skilled Nursing Facility: A *provider*, licensed and approved by the state in which it provides health care services, or as otherwise approved by *Capital*, and which is primarily engaged in providing daily *skilled nursing services* and related skilled services to *members* requiring twenty-four (24) hour skilled nursing services but not requiring confinement in an acute care general *hospital*. Such care is rendered by or under the supervision of *physicians*. A skilled nursing facility is not, other than incidentally, a place that provides:

- minimal care, *custodial care*, ambulatory care, or part-time care services; or
- 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.

Special Accommodations Unit: A designated unit within an acute care *hospital* which 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.

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 *Capital* and for whom such *enrollment application* has been accepted by *Capital*. 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 *provider* licensed and approved by the state in which it provides health care services, or as otherwise approved by *Capital* and 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 health care 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 Participating Provider: *Participating providers* who are *physicians*, nurse practitioners (NPs), physician assistants (PAs), within the specialties of family medicine, pediatrics, internal medicine, and psychiatrists and *participating providers* who are licensed psychologists, social workers, behavioral specialists,

marriage counselors, certified psychiatric nurses and family therapists who are identified as telehealth providers in the provider directory.

Telehealth Services: *Medically necessary* services provided to a *member* by a *telehealth participating provider* in which the method of care delivery involves interaction between a *member* and *telehealth participating provider* utilizing a secure, interactive real time, audio and 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.

Ward: A child for whom the *subscriber,* or the *subscriber's* spouse has been granted legal custody by a court of competent jurisdiction.

Capital BLUE

2019 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, 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+

GENERAL HEALTH CARE*		
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) • Calcium/vitamin D intake • Drug use • Family Planning • Fall Prevention (age 65 and older)	• Physical Activity • 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	Testing every 2 years for women age 19-64 at high risk for Osteoporosis. Once every 2 years for women over age 65 and older.
BRCA screening/genetic counseling/testing	Beginning at age 19 for high risk women, including those not previously diagnosed with BRCA-related cancer but who have a history of breast cancer, ovarian cancer or other cancer; reassess screening every 5-10 years or as determined by your health care provider.
Chlamydia and Gonorrhea test	Test all sexually active women from age 19-24 years; women at increased risk at age 25 years and older, as recommended by your health care provider. Suggested testing is every 1-3 years.
Domestic/Interpersonal/Partner Violence screening/counseling	Intervention services available at least annually for women age 19 and older.
HIV Screening/Counseling	Age 19 and older: Preventive education and risk-assessment for infection at least annually. More frequently for high risk women.
Mammogram (2D or 3D)	Beginning at age 40, every 1-2 years.
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 Duplex Ultrasound	One-time screening for abdominal aortic aneurysm in men age 65-75 who have ever smoked.
Prostate Cancer screening	Beginning at age 19 for high risk males. Beginning at age 50, annually.
Prostate Specific Antigen	Beginning at age 50, annually.
Men and Women	
Alcohol misuse screening/counseling	Behavioral counseling interventions for adults age 19 and older who are engaged in risky or hazardous drinking.
CT Colonography[2]	Beginning at age 50, every 5 years
Colonoscopy[3]	Beginning at age 50, every 10 years.
Depression screening	Age 19 and older: annually or as determined by your health care provider.
Diabetes (type 2)/Abnormal Blood Glucose Screening	Test all adults age 40-70 who are overweight or obese; if normal, rescreen every 3 years. If abnormal, offer Intensive Behavioral Therapy (IBT) counseling to promote a healthful diet and physical activity.
Fasting Lipid Profile	Beginning at age 20, every 5 years.
Fecal Occult Blood test (gFOBT/FIT)[4]	Beginning at age 50, annually.
FIT-DNA/Cologuard Test	Beginning at age 50, every 3 years.
Flexible Sigmoidoscopy[3]	Beginning at age 50, every 5 years.
Hepatitis B test	For adults age 19 and older who have not been vaccinated for hepatitis B virus (HBV) infection and other high risk adults; Periodic repeat testing of adults with continued high risk for HBV infection.
Hepatitis C test	Offer one-time testing of adults born between 1945 and 1965. Periodic repeat testing of adults with continued high risk for HCV infection.

High Blood Pressure (HBP)	Every 3-5 years for adults age 19-39 with BP<130/85 who have no other risk factors. Annually for adults age 40 and older, and annually for all adults at increased risk for HBP.
HIV test	Routine one-time testing of adults age 19-65 at unknown risk for HIV infection. Periodic repeat testing (at least annually) of all high risk adults age 19 and older.
Latent Tuberculosis (TB) Infection Test	At least one-time testing of adults age 19 and older at high risk. Periodic repeat testing of adults with continued high risk for TB infection.
Low-dose CT Scan for Lung Cancer	Annual testing until smoke-free for 15 years for high risk adults 55-80 years of age.
Obesity	Age 19 and older for high risk adults: every visit (BMI of 30 or greater: Intensive Multicomponent Behavioral Therapy (IBT) counseling available).
Obesity/Overweight + Cardiovascular Risk Factor combination	Age 19 and older: (BMI of 25 or greater: Intensive Behavioral Therapy (IBT) counseling available to promote a healthful diet and physical activity).
STI counseling	Age 19 and older for high risk adults: Moderate and Intensive Behavioral Therapy (IBT) counseling available.
Sun/UV (ultraviolet) Radiation Skin Exposure; Skin Cancer counseling	Counseling to minimize exposure to UV radiation for adults age 19-24 with fair skin.
Syphilis test	Test all high risk adults age 19 and older; suggested testing is every 1-3 years.
Tobacco use assessment/counseling and cessation interventions	Age 19 and older: 2 cessation attempts per year (each attempt includes a maximum of 4 counseling visits of at least 10 minutes per session); FDA-approved tobacco cessation medications[5]; individualize risk in pregnant women.
IMMUNIZATIONS**	
Hemophilus Influenza type b (Hib)	Age 19 and older Based on individual risk or health care provider recommendation: one or three doses
Hepatitis A (HepA)	Age 19 and older Based on individual risk or health care provider recommendation: two or three doses
Hepatitis B (HepB)	Age 19 and older Based on individual risk or health care provider recommendation: two or three doses
Human Papillomavirus (/9vHPV - women)	Age 19-26: Two or three doses, depending on age at series initiation.
Human papillomavirus (/9vHPV - men)	Age 19-21: Two or three doses depending on age at series initiation. Age 22+, as determined by your health care provider.
Influenza[6]	Age 19 and older One dose annually during influenza season.
Measles/Mumps/Rubella (MMR)	Age 19 and older: Based on indication (born 1957 or later) or health care provider recommendation, one or two doses.
Meningococcal (conjugate) (MenACWY)	Age 19 and older Based on individual risk or health care provider recommendation: One or two doses depending on indication, then booster every 5 years if risk remains
Meningococcal B (MenB)	Age 19 and older Based on individual risk or health care provider recommendation: Two or three doses
Pneumococcal (conjugate) (PCV13)	Age 19-64: One dose (high risk; serial administration with PPSV23 may be indicated). Beginning at 65: One dose (only if PCV13-naive; serial administration with PPSV23 may be indicated)
Pneumococcal (polysaccharide) (PPSV23)	Age 19-64: One or two doses (high risk; serial administration with PCV13 may be indicated). Beginning at 65: One dose at least 1 year after PCV13 (regardless of previous PCV13/PPSV23 immunization; serial administration with PCV13 may be indicated).
Tetanus/diphtheria/pertussis (Td or Tdap)	Age 19 and older One dose of Tdap, then for Td booster every 10 years.
Varicella (Chickenpox)	Beginning at age 19; two doses, as necessary based upon past immunization or medical history.
Zoster (Shingles)	Beginning at age 50; two doses, regardless of prior zoster episodes.

[1] Coverage is provided without cost-share for all FDA-approved generic contraceptive methods and all FDA-approved contraceptives without a generic equivalent. See the Rx Preventive Coverage List at capbluecross.com for details. Coverage includes clinical services, including patient education and counseling, needed for provision of the contraceptive method. If an individual's provider recommends a particular service or FDA-approved item based on a determination of medical necessity with respect to that individual, the service or item is covered without cost-sharing.

[2] CT Colonography is listed as an alternative to a flexible sigmoidoscopy and colonoscopy, with the same schedule overlap prohibition as found in footnote #3.

[3] Only one endoscopic procedure is covered at a time, without overlap of the recommended schedules.

[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 that is listed on the Capital BlueCross web site at [capbluecross.com].

[6] Capital BlueCross has extended coverage of influenza immunization to all individuals with the preventive benefit regardless of risk.

Schedule for Maternity

SCREENINGS/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:

- Anemia screening (CBC)
- Breastfeeding support/counseling/supplies
- Gestational Diabetes screening (prenatal/postpartum)
- Hepatitis B screening at the first prenatal visit
- HIV screening
- Low-dose aspirin after 12 weeks of gestation for preeclampsia in high risk women
- Maternal depression screening (at well-child visits)
- Preeclampsia screening
- Rh blood typing
- Rh antibody testing for Rh-negative women
- Rubella Titer
- Syphilis Test
- Tobacco Use Assessment, Counseling and Cessation Interventions
- Urine culture and sensitivity
- Other preventive services may be available as determined by your health care provider

* Services that need to be performed more frequently than stated due to specific health needs of the member and that 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

GENERAL HEALTH CARE

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 2½ years)
- Body mass index (BMI; beginning at 2 years of age)
- Developmental milestones surveillance (except at time of developmental screening)
- Head circumference (up to 24 months)
- Height/length and weight
- Newborn evaluation (including gonorrhea prophylactic topical eye medication)
- Weight for length (up to 18 months)
- Anticipatory guidance for age-appropriate issues including:
  - Growth and development, breastfeeding/nutrition/support/counseling/supplies, obesity prevention, physical activity and psychosocial/behavioral health
  - Safety, unintentional injuries, firearms, poisoning, media access
  - Contraceptive methods/counseling (females)
  - Tobacco products
  - Oral health risk assessment/dental care/fluoride supplementation (> 6 months)[1]
  - Fluoride varnish painting of primary teeth (to age 5 years)
  - Folic Acid (childbearing age)

	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*																					
Alcohol, tobacco and drug use assessment (CRAFFT)													✔	✔	✔	✔	✔	✔	✔	✔	✔
Alcohol misuse screening/ counseling																				✔	✔
Anemia			✔	Assess risk at all other well child visits																	
Autism spectrum disorder screening	At 18 months			✔																	
Chlamydia test	For sexually active females: suggested testing interval is 1-3 years.																				
Depression screening (PHQ-2)														✔	✔	✔	✔	✔	✔	✔	✔
Developmental screening		✔	✔	✔	At 9 months, 18 months and 2½ years																
Domestic/Interpersonal/Intimate Partner Violence	Intervention services available at least annually for adolescents of childbearing age 11 years of age and older.																				
Gonorrhea test	For sexually active females: suggested testing interval is 1-3 years.																				
Hearing screening/risk assessment	Between 3-5 days through 3 years; repeat at 7and 9																				
Hearing test (objective method)	✔					✔	✔	✔		✔		✔	Once between ages 11-14, 15-17 and 18+								
Hemoglobin and Hematocrit			✔	Assess risk at all other well child visits																	
Hepatitis B test	Beginning at 11 years (children who have not been vaccinated for hepatitis B virus (HBV) infection/other high risk); Periodic repeat testing of children with continued high risk for HBV infection.																				
High blood pressure (HBP)					✔	Beginning at 3 years: at every well-child visit. Confirm HBP by measuring outside office setting utilizing Ambulatory Blood Pressure Monitoring (ABPM) before treating.															
HIV screening/risk assessment	Annually beginning at 11 years																				
HIV test	Routine one-time testing between ages 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: 9-12 months (at risk)[2]; Risk Assessment at 6, 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.																				

	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
Maternal Depression Screening	By 1 month, 2 month, 4 month and 6 month																				
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.												
STI counseling	Beginning at 11 years (at risk, sexually active): offer Intensive Behavioral Therapy (IBT) counseling												✔								
STI screening													✔	✔	✔	✔	✔	✔	✔	✔	✔
Sun/UV (ultraviolet) radiation skin exposure; skin cancer counseling	Beginning at 6 months, counseling to minimize exposure to 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 (each attempt includes a maximum of 4 counseling visits); FDA-approved tobacco cessation medications[3]																			✔	✔
Tuberculin test	Assess risk at every well child visit.																				
Vision risk assessment	Up to 2½ 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**	
Diphtheria/Tetanus/Pertussis (DTaP)	2 months, 4 months, 6 months, 15–18 months, 4–6 years
Hemophilus influenza type b (Hib)	2 months, 4 months, 6 months, 12–15 months (catch-up through age 5) for specific vaccines and 5–18 years for those at high risk
Hepatitis A (HepA)	12–23 months (2 doses) (catch-up through age 18) and 2–18 years for those at high risk
Hepatitis B (HepB)	Birth, 1–2 months, 6–18 months (catch-up through age 18)
Human papillomavirus	11–12 years (2 doses) (catch-up through age 18: 2 or 3 doses) and 9–10 years for individuals at high risk or individualization for non-high risk
Influenza[4]	6 months–18 years; annually during flu season
Measles/Mumps/Rubella (MMR)	12–15 months, 4-6 years (catch-up through age 18)
Meningococcal (MenACWY-D/MenACWY-CRM)	11–12 years, 16 years (catch-up through age 18); 2 months–18 years for those at high risk
Meningococcal B (MenB)	10–18 years for those at high risk; 16–18 years for individuals not at high risk
Pneumococcal conjugate (PCV13)	2 months, 4 months, 6 months, 12–15 months (catch up through age 5) and 5–18 years for those at high risk
Pneumococcal polysaccharide (PPSV23)	2–18 years (1 or 2 doses)
Polio (IPV)	2 months, 4 months, 6–18 months, 4–6 years (catch-up through age 17)
Rotavirus (RV)	2 months, 4 months or 6 months for specific vaccines
Tetanus/reduced Diphtheria/Pertussis (Tdap)	11–12 years (catch-up through age 18)
Varicella/Chickenpox (VAR)	12–15 months, 4–6 years (catch-up through age 18)

[1] Fluoride supplementation pertains only to children who reside in communities with inadequate water fluoride.
[2] Encourage all PA-CHIP Members to undergo blood lead level testing before age 2 years.
[3] Capital BlueCross providers should refer to the most recent Formulary that is listed on the Capital BlueCross web site at capbluecross.com.
[4] Children aged 6 months to 8 years who are receiving influenza vaccines for the first time should receive 2 separate doses (> 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 that 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.
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)

SERVICES REQUIRING PREAUTHORIZATION

Members should present their *identification card* to their health care *provider* when medical services or items are requested. When *members* use a *participating provider* (including a BlueCard facility *participating provider* providing ***inpatient*** **services**), the *participating provider* will be responsible for obtaining the *preauthorization*. If *members* use a *non-participating provider* or a BlueCard *participating provider* providing ***non-inpatient*** **services**, the *non-participating provider* or BlueCard *participating provider* may call for *preauthorization* on the *member's* behalf; however, it is ultimately the *member's* responsibility to obtain *preauthorization*. *Providers* and *members* should call *Capital's Utilization* Management Department toll-free at **1-800-471-2242** to obtain the necessary *preauthorization*.

Providers/Members should request Preauthorization of non-urgent admissions and services well in advance of the scheduled date of service (15 days). *Investigational* or experimental procedures are not usually covered benefits. *Members* should consult their *Certificate of Coverage or Contract, Capital BlueCross' Medical Policies,* or contact Customer Service at the number listed on the back of their health plan identification card to confirm *coverage*. *Participating providers* and *members* have full access to *Capital's* medical policies and may request *preauthorization* for experimental or *investigational* services/items if there are unique *member* circumstances.

Capital only pays for services and items that are considered *medically necessary*. *Providers* and *members* can reference *Capital's* medical policies for questions regarding *medical necessity*.

PREAUTHORIZATION OF MEDICAL SERVICES INVOLVING URGENT CARE

If the *member's* request for *preauthorization* involves *urgent care*, the *member* or the *member's provider* should advise *Capital* of the urgent medical circumstances when the *member* or the *member's provider* submits the request to *Capital's* Clinical Management Department. *Capital* will respond to the *member* and the *member's provider* no later than seventy-two (72) hours after *Capital's* Utilization Management Department receives the *preauthorization* request.

PREAUTHORIZATION PENALTY APPLICABILITY

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* Certificate of Coverage or Contract. Services or items provided without *preauthorization* may also be subject to retrospective *medical necessity* review.

If the *member* presents his/her *ID card* to a *participating provider* in the 21-county area and the *participating provider* fails to obtain or follow *preauthorization* requirements, payment for services will be denied and the provider may not bill the *member*.

When *members* undergo a procedure requiring *preauthorization* and fail to obtain *preauthorization* (when responsible to do so as stated above), *benefits* will be provided for *medically necessary* covered services. However, in this instance, the *allowable amount* may be reduced by the dollar amount or the percentage established in the *Certificate of Coverage* or Contract.

The table that follows is a partial listing of the *preauthorization* requirements for services and procedures.

The attached list provides categories of services for which *preauthorization* is required, as well as specific examples of such services. This list is not all inclusive. For a listing of services currently requiring *preauthorization*, members and providers may consult capbluecross.com.

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 (mental health care/ substance abuse)	*Preauthorization* requirements do not apply to services provided by a *hospital* emergency room *provider*. If an *inpatient* admission results from an emergency room visit, notification must occur within two (2) 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 *Capital* of an admission may result in an administrative denial. Non-routine maternity admissions, including preterm labor and maternity complications, require notification within two (2) business days of the date of admission.
Observation Care Admissions	• Notification is required for all observation stays expected to exceed 48 hours. • All observation care must meet medical necessity criteria from the first hour of admission.	Admissions to observation status require notification within two (2) business days. Failure to notify *Capital* of an admission may result in an administrative denial.
Diagnostic Services	• Genetic disorder testing **except**: standard chromosomal tests, such as Down Syndrome, Trisomy, and Fragile X, and state mandated newborn 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.	Diagnostic services do not require *preauthorization* when emergently performed during an emergency room visit, observation stay, or *inpatient* admission.
Durable Medical Equipment (DME), Prosthetic, Appliances, Orthotic Devices, Implants		*Members* and *providers* may view a listing of services currently requiring *preauthorization* at capbluecross.com.

Category	Details	Comments
Office Surgical Procedures When Performed in a Facility*	• Aspiration and/or injection of a joint • Colposcopy • Treatment of warts • Excision of a cyst of the eyelid (chalazion) • Excision of a nail (partial or complete) • Excision of external thrombosed hemorrhoids; • Injection of a ligament or tendon; • Eye injections (intraocular) • Oral Surgery • Pain management (including trigger point injections, stellate ganglion blocks, peripheral nerve blocks, and intercostal nerve blocks) • Proctosigmoidoscopy/flexible Sigmoidoscopy; • Removal of partial or complete bony impacted teeth (if a benefit); • Repair of lacerations, including suturing (2.5 cm or less); • Vasectomy • Wound care and dressings (including outpatient burn care)	The items listed are examples of services considered safe to perform in a professional *provider's* office. *Medical necessity* review is required when office procedures are performed in a facility setting. *Members* and *providers* may view a listing of services currently requiring *preauthorization* when performed in a facility at capbluecross.com.
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	The items listed are examples of outpatient procedures that may be reviewed for *medical necessity* and or place of service. *Members* and *providers* may view a listing of services currently requiring *preauthorization* at capbluecross.com.
Therapy Services	• Hyperbaric oxygen therapy (non-emergency) • Manipulation therapy (chiropractic and osteopathic) • Occupational therapy • Physical therapy • Pulmonary rehabilitation programs	*Preauthorization* requirements for manipulation therapy may vary based upon the *provider* of the services. The specific requirements for *preauthorization* of manipulation therapy may be found in the Preauthorization Policy at capbluecross.com.
Transplant Surgeries	Evaluation and services related to transplants	*Preauthorization* will include referral assistance to the Blue Distinction Centers for Transplant network if appropriate.

Category	Details	Comments

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
	  ◆ 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
	• Treatment of Varicose Veins and Venous Insufficiency	

Medical Injectables		*Members* and *providers* may view a listing of services currently requiring *preauthorization* at capbluecross.com
Investigational and Experimental procedures, devices, therapies, and pharmaceuticals		*Investigational* or experimental procedures are not usually covered benefits. *Members* and *providers* may request *preauthorization* for experimental or *investigational* services/items if there are unique *member* circumstances.
New to market procedures, devices, therapies, and pharmaceuticals		*Preauthorization* is required during the first two (2) years after a procedure, device, therapy or pharmaceutical enters the market. *Members* and *providers* may view a listing of services currently requiring *preauthorization* at capbluecross.com.
Select Outpatient Behavioral Health Services	• Transcranial Magnetic Stimulation (TMS) • Partial Hospitalization • Substance Use Disorder Intensive Outpatient Programs	The items listed are examples of outpatient procedures that may be reviewed for *medical necessity* and or place of service. *Members* and *providers* may view a listing of services currently requiring *preauthorization* at capbluecross.com

Category	Details	Comments
Other Services	• Bio-engineered skin or biological wound care products • Category IDE trials (Investigational Device Exemption) • Clinical trials (including cancer related trials) • Enhanced external counterpulsation (EECP) • Home health care • Eye injections (Intravitreal angiogenesis inhibitors) • Laser treatment of skin lesions • Non-emergency air and ground ambulance transports • Radiofrequency ablation for pain management • Facility based sleep studies for diagnosis and medical Management of obstructive sleep apnea • Enteral feeding supplies and services	
Pain Management	Interventional Pain Management • Joint injections	Members and providers may view a listing of services currently requiring preauthorization at capbluecross.com
Oncology Services	Radiation therapy and related treatment planning and procedures performed for planning (such as but not limited to IMRT, proton beam, neutron beam, brachytherapy, 3D conform, SRS, SBRT, gamma knife, EBRT, IORT, IGRT, and hyperthermia treatments.)	*Members* and *providers* may view a listing of services currently requiring *preauthorization* at capbluecross.com.
Select Cardiac Services		*Members* and *providers* may view a listing of services currently requiring *preauthorization* at capbluecross.com.

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 *Capital* at 1-800-962-2242 (TTY: 711) with questions regarding the *preauthorization* of a particular service.

For HMO and Gatekeeper PPO *members*, all care rendered by *nonparticipating providers* requires *preauthorization*. This includes care that falls under the Continuity of Care provision of the Certificate of Coverage or Contract.

This information highlights the standard Preauthorization Program. *Members* should refer to their *Certificate of Coverage* or Contract for the specific terms, conditions, exclusions and limitations relating to their *coverage*.

Disease/Condition Management Programs

Capital BlueCross offers its Disease/Condition Management programs for individuals with chronic conditions. These programs are designed to improve an individual's quality of care when dealing with a chronic condition and foster healthy partnerships between the individual and their physician.

Capital BlueCross provides the following Condition Management Programs to our adult *members*:

- Asthma
- Diabetes
- Congestive Heart Failure
- Coronary Artery Disease
- Depression

Capital BlueCross also provides the following Condition Management programs to our pediatric *members*:

- Pediatric Asthma
- Pediatric Diabetes

Capital BlueCross disease management programs are designed to support an individual-centered, best-in-practice approach to care delivery with front-end intervention activities based on individual condition, co-morbidities, risk level, and assessed individual need. Capital's programs are based on nationally-recognized clinical guidelines, which promote adherence to the guidelines and reinforces adherence to the *member's* Primary Care Physician's plan of care.

This program stresses the *member's* use of a disease specific action plan, symptom management, medication adherence, and dietary / lifestyle modification. The program components are used to reduce emergency room and hospital utilization and enable *members'* to self-manage their chronic condition. *Member's* knowledge related to the main program components is assessed at the start of the program and when the *member* graduates from the program. Disease Managers review utilization prior to each contact with the *member* so that adherence to program components can be reviewed and addressed. Our programs combine licensed professional expertise with key industry tools and resources to support screening, assessment and ongoing education and monitoring of the individual throughout program delivery.

Please note that the Depression Management program is offered to *members* in association with pregnancy-related depression and to *members* who screen positive for depression and are currently enrolled in one of our disease or case management programs.

Applicable Group Numbers

PPO Plan 271

July, 2019

PA TRUST EASTERN BENEFIT TRUST (EBT)	
Member Group	**Group #**
Career Institute of Technology	00521914

Appendix C

Career Institute of Technology

Prescription Drug Benefits

IMPORTANT

The benefit explanations contained herein are subject to all provisions of the Group Prescription Drug Contract with Express-Scripts, Inc., and do not modify such contract in any way nor shall you or your eligible dependents accrue any rights because of any statement in or omission from this Plan Document.

Administrative Services provided by:

Express-Scripts, Inc.

One Express Way

St. Louis, MO 63121

1-844-536-9189

www.express-scripts.com

Plan Sponsor:

Career Institute of Technology

5335 Kesslersville Road

Easton, PA 18040

Table of Contents

Introduction

This document is a description of the Career Institute of Technology Employee Benefit Plan's Prescription Drug coverage. No oral interpretations shall change this Plan.

Your prescription drug coverage is included as a part of your medical coverage under the Health Plan. Certain information and guidelines that are not included in this prescription drug plan are provided elsewhere in your medical coverage plan.

Express-Scripts, Inc., (ESI) is the administrator of your prescription drug plan. You may also contact the ESI Prescription Drug Member Services line at 1-844-536-9189 for additional information. If you're a registered member with ESI, visit the ESI website at www.express-scripts.com to learn more.

Important Notices

- The **Summary of Benefits and Coverage** (SBC) required by the Patient Protection and Affordability Act (PPACA) will be distributed to members by the Plan Sponsor. The SBC contains only a partial description of the benefits, limitations and exclusions of this coverage. It is not intended to be a complete list or complete description of available benefits. In the event there are discrepancies between the SBC and this Plan, the terms and conditions of this coverage shall be governed solely by the Plan.
- The protected health information rules as defined under the Health Insurance Portability and Accountability Act of 1996 (**HIPAA**), and its related regulations, each as amended, are enforced under this plan.
- Other companies under contract with Express-Scripts may provide certain services, including administrative services, relating to this coverage.
- To receive certain benefits or to have benefits paid at the highest allowable level, the member's coverage may require services to be performed by ***participating*** pharmacies.
- The benefit period for this coverage is the **calendar year**.
- The rules regarding continuation of coverage after termination are as defined under the Federal law called **COBRA** (Consolidated Omnibus Budget Reconciliation Act). COBRA requires that, under certain circumstances, the Plan Sponsor gives you and your dependents the option to continue under this coverage with Express-Scripts. Members should contact the Plan Sponsor if they have any questions about eligibility for COBRA coverage. The Plan Sponsor is responsible for the administration of the COBRA coverage.
- A member whose coverage is about to terminate may be eligible to convert to an individual contract available from your medical carrier, **Capital BlueCross**. To learn more about available plans, contact **Capital's** Customer Services at 1-866-787-9872. (Express-Scripts does not provide individual prescription drug plans.) Separate and apart from this **conversion** right, a member whose coverage terminates may be eligible for enrollment in individual health plans on or off of the Marketplace. Whether you consider a **Capital** plan or a Marketplace plan, your prescription drug coverage shall be as provided by the plans available at the time of conversion. Applying for conversion coverage is the member's responsibility.

Eligibility

The provisions of eligibility and effective date of coverage are the same as those described in the eligibility section of the Career Institute of Technology Employee Benefit Plan. Please refer to that document for more details.

Schedule of Benefits

The amount you pay for prescription drug coverage depends on whether you:

- Purchase generic, formulary (preferred) brand, or non-formulary (non-preferred) brand-name drugs. Your copayments apply to each prescription and subsequent refill that you and your eligible dependents purchase;
- Purchase drugs at Retail Pharmacy or Mail-Order Pharmacy (Home Delivery);
- Purchase drugs in certain quantities.
- Some covered medications may have federal or state regulations regarding certain days supply limits and/or for certain uses and can only be dispensed at Retail. Where applicable, the Retail Member Copayment applies.
- **Other important information concerning out-of-pocket member cost when purchasing drugs is described in the section entitled "Clinical Programs Related to Your Benefits" on page 8 of this document.**

Deductible:

Retail: Neither you nor your eligible dependents are responsible for an annual deductible for Retail drug purchases.

Mail Order: Neither you nor your eligible dependents are responsible for an annual deductible for Mail Order drug purchases.

Member Copayment: (for each prescription and each refill)

Retail: (up to a 30-day supply)

Generic	$10 copayment
Formulary – Brand (Preferred)	$20 copayment
Non-Formulary – Brand (Non-preferred)	$20 copayment

Mail Order (up to a 90-day supply)

Generic	$15 copayment
Formulary – Brand (Preferred)	$30 copayment
Non-Formulary – Brand (Non-preferred)	$30 copayment

Out-of-Pocket Maximum:

Your annual out-of-pocket expenses (includes copayment and deductible amounts) for prescription drugs which qualify as essential health benefits may also be limited under federal law when purchasing medications from a ***participating*** pharmacy. For 2020, your maximum cost when using ***participating*** pharmacies is $6,150 per member and $10,900 per family, for covered medications. In future years, maximum values shall be indexed according to the rules of the Affordable Care Act. If you or your eligible dependents satisfy the annual maximum amount(s), there are no further out-of-pocket costs to you for services that are provided by ***participating*** pharmacies for copayment and deductible amounts. Under the mandatory generic provision, amounts that you pay for a brand drug when a generic drug is available (ancillary charge) do not apply to the out-of-pocket maximum. The accumulation of your prescription drug expenses is managed electronically by Express-Scripts. Contact Express-Scripts Member Services or visit the web site at www.express-scripts.com to learn more.

Limitations to this Benefit:

- Your benefit excludes any medications stated as not covered under the Express-Scripts prescription drug program. To determine if your prescribed medication is covered or excluded, please call the Member Services telephone number on the back of your prescription ID card, 844-536-9189. If you're a registered member with Express Scripts, you may also access the information through www.express-scripts.com.
- Refills of all medications are limited up to the number of times as specified by a physician or federal or state laws.

Generic, Formulary Brand (Preferred), and Non-Formulary Brand (Non-Preferred) Drugs:

A generic drug includes the same ingredients as its brand name equivalent, but at a lower cost.

A formulary brand drug is a brand name drug that has been selected for its clinical appropriateness (i.e. safety and efficacy) and cost effectiveness.

Non-formulary brand drugs are those which generally have generic equivalents and/or have one or more formulary brand name drugs within the same therapeutic category. These medications are typically covered at the highest copayment.

Preferred Drugs Formulary Management

The Plan includes a list of preferred drugs that are either more effective at treating a particular condition than other drugs in the same class of drugs, or as effective as and less costly than similar medications. Non-preferred drugs may also be covered under the prescription drug program, but at a higher cost-sharing tier. Collectively, these lists of drugs make up the Plan's Formulary. The Plan's Formulary is updated periodically and subject to change, so to get the most up-to-date list go online to www.express-scripts.com. Drugs that are excluded from the Plan's Formulary are not covered under the Plan unless approved in advance by a Formulary exception process managed by Express-Scripts. To determine if

the drug you're taking is considered a formulary medication or to inquire about the formulary exception review process, please call the member services telephone number on the back of your card or go online to www.express-scripts.com. If you are currently taking a medication that will be excluded from the Plan's Formulary, you will receive advanced notification on the status change. The formulary co-payment would apply for the approved drug based on the Plan's cost share structure. Absent such approval, members selecting drugs excluded from the Formulary will be required to pay the full cost of the drug without any reimbursement under the Plan. The Formulary will continue to change from time to time. For example:

- A drug may be moved to a higher or lower cost-sharing Formulary tier.
- Additional drugs may be excluded from the Formulary.
- A restriction may be added on coverage for a Formulary-covered drug (e.g. prior authorization).
- A Formulary-covered brand name drug may be replaced with a Formulary-covered generic drug.

Mail Order Service:

The Express-Scripts mail order service can save you money if you have a condition(s) that requires maintenance medication, or if you take regular medication, or you have a long-term illness. Through this service, you may purchase up to a 90-day supply of most long-term prescribed medications (for example, drugs used to treat high blood pressure or high cholesterol). The amount of your copayment depends on whether you purchase generic, formulary brand, or non-formulary brand drugs. Your copayments apply to each prescription and each refill that you and your eligible dependents purchase.

Plus, you'll receive:

- Free home delivery of your medication(s);
- Up to a three-month supply of each medication; and
- 24-hour access to a pharmacist to answer your questions.

Every prescription is filled and delivered using a safe, reliable process. For example:

- Registered pharmacists check every new prescription.
- Your medication is delivered in a plain, weather-resistant package. This protects the medication and ensures your privacy.
- You receive information about safety issues, side effects and drug interactions.

The ***first time*** you are prescribed a long-term medication, ask your physician for two prescriptions, one for a long-term supply (up to 90 days) and another for immediate use (up to 30 days). You can fill the short-term prescription at a participating retail pharmacy and send in the long-term prescription to the mail order service.

Get started using the ESI Mail Order Service:

Online

Visit www.express-scripts.com/getstarted and follow the instructions to get prescription home delivery. You will need to register yourself as a member. There are no forms to mail, no physician visits to schedule. Just submit your request online and the Express Scripts Pharmacy will do the rest.

By Mail

1. Ask your physician to write a prescription for up to a 90-day supply of your medication (plus refills for up to one year, if appropriate).
2. Complete a Home Delivery Order Form. If you don't have an order form, you can print one at www.express-scripts.com. Or simply request one by calling the toll-free number on your member ID card.
3. Mail your order form and your prescription to the address on the form.

You only have to mail your maintenance medication prescription to the Express Scripts Pharmacy one time. After that, it's easy:

- Your prescription drugs are delivered to your home.
- Your order refills just four times per year instead of every month.
- And you renew your prescription only once per year (if appropriate).

Fill your prescription in one of two ways

To get a prescription filled at a Retail pharmacy, you can find a participating retail pharmacy by going to www.express-scripts.com, or by calling Express-Scripts Member Services at 1-844-536-9189. At the network pharmacy, you should present your ID card and prescription. The pharmacist will look up your benefit information online, verify coverage, and dispense the prescription to you. Your copayment or deductible is payable to the retail pharmacy at the time of purchase. No claim needs to be filed.

To get a prescription filled through Express-Scripts Mail Order, you can complete an Express-Scripts Mail Order Form (also available through the web site or by calling Member Services at 1-844-536-9189 and mail it along with your prescription for a 90-day supply to Express-Scripts. You can provide payment information when you place the order (either by check, money order, or credit card) and expect to receive the medication in approximately 10 to 14 days. Refills can be submitted online, by mail, or by calling the automated telephone line at 1- 844-536-9189 as it appears on your prescription container.

Direct Claim Reimbursement from a Non-Participating Pharmacy

A Direct Reimbursement Claim Form is required when you purchase a prescription from a non-participating pharmacy. Simply request a Direct Reimbursement Claim Form from Express-Scripts. You may obtain the form by downloading it from the Express-Scripts website at www.express-scripts.com. Use one (1) claim form for each prescription. Complete the form and mail it to the address printed on the form.

Specialty Drug Pharmacy Services:

Accredo Pharmacy (a subsidiary of Express-Scripts) is your provider for specialty drugs.

Accredo is Express Scripts' specialty program designed to offer superior patient care for chronic or complex medical conditions and are typically medications produced through DNA technology or biological processes. Under this option, patients obtain specialty medications through the Accredo pharmacy when available (exceptions are limited distribution products). The Accredo program ensures that patients receive consistent, best in-class care to manage their conditions with the help of proven clinical-care modules and specialized clinical staff.

They are injectable and non-injectable drugs defined as having one or more of several key characteristics, including:

- Requirements for frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity and increase the probability for beneficial treatment outcomes;
- Need for intensive patient training and compliance assistance to facilitate therapeutic goals;
- Limited or exclusive product availability and distribution;
- Specialized product handling and/or administration requirements; and
- Cost in excess of $500 for a 30-day supply.

Call Express-Scripts Member Services at 1-844-536-9189 for questions related to Specialty therapies and services. Or visit the Express-Scripts website to view a list of frequently asked questions regarding Specialty Drugs at www.express-scripts.com.

Clinical Programs Related to Your Benefits

Generic Incentive Plan – applies to Retail and Mail Order

If you purchase the Brand medication when a Generic is available, you are responsible for the Copayment *plus* the Difference in cost of the Brand vs Generic Equivalent. You are responsible for this payment unless your physician indicates "Dispense As Written".

Other ESI Clinical Programs

Certain ESI clinical programs and prescription drug management programs ***may be added from time to time*** as accepted by the Plan Sponsor. These programs include, but may not be limited to the following:

- Prior Authorization – Certain drugs or drug classifications may require preauthorization from ESI before it will be covered under the plan.
- Step Therapy – In some cases, where two or more medications are available to treat the same medical condition, ESI may require a doctor to first prescribe an ESI preferred medication (or "first line" medication), and only if that medication does not work would the member be covered for the alternative medication.
- Quantity Limits – Certain prescription drugs may be limited in the quantity of units supplied to ensure consistency with the clinical dosing guidelines, and to minimize waste by ensuring certain medications can be tolerated by the patient.

To determine if your prescribed medication is subject to any ESI Clinical Program limitations, please call the Member Services telephone number on the back of your prescription ID card. If you're a registered member with Express Scripts, you may also access the information through www.express-scripts.com.

Request a Clinical or Administrative Appeal for medications that are not covered

When you or your representative is notified that a claim is wholly or partially denied, you have the right to appeal.

Coverage review description

A member has the right to request that a medication be covered or be covered at a higher benefit (e.g. lower copay, higher quantity, etc). The first request for coverage is called an initial coverage review. Express Scripts reviews both clinical and administrative coverage review requests:

Clinical coverage review request: A request for coverage of a medication that is based on clinical conditions of coverage that are set by the Plan. For example, medications that require a prior authorization.

Administrative coverage review request: A request for coverage of a medication that is based on the Plan's benefit design.

How to request an initial coverage review

The preferred method to request an initial clinical coverage review is for the prescriber or dispensing Pharmacist to call the Express Scripts Coverage Review Department at 1 800-753-2851. Alternatively, the prescriber may submit a completed coverage review form to **Fax** 1 877- 329-3760. Forms may be obtained online at www.express-scripts.com/services/physicians/. Requests may also be mailed to Express Scripts Attn: Prior Authorization Dept., PO Box 66571, St. Louis, MO 63166-6571. Home Delivery coverage review requests are automatically initiated by the Express Scripts Home Delivery pharmacy as part of filling the Prescription.

To request an initial administrative coverage review, the member or his or her representative must submit the request in writing to: Express Scripts, Attn: Benefit Coverage Review Department, PO Box 66587, St Louis, MO 63166-6587.

If the patient's situation meets the definition of urgent under the law, an urgent review may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the patient's provider, the patient's health may be in serious jeopardy or the patient may experience severe pain that cannot be adequately managed without the medication while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by the provider by **phone** at 1 800-753-2851.

How a coverage review is processed

In order to make an initial determination for a clinical coverage review request, the prescriber must submit specific information to Express Scripts for review. For an administrative coverage review request, the member must submit information to Express Scripts to support their request. The initial

determination and notification to patient and prescriber will be made within the specified timeframes as follows:

Type of claim	Decision Timeframe Decisions are completed as soon as possible from receipt of request but no later than:	Notification of Decision	
		Approval	Denial
Standard Pre-Service*	15 days (Retail) 5 days (home delivery)	Patient: automated call (letter if call not successful) Prescriber: Fax (letter if fax not successful)	Patient: letter Prescriber: Fax (letter if fax not successful)
Standard Post-Service*	30 days		
Urgent	72 hours	Patient: automated call and letter Prescriber: Fax (letter if fax not successful)	Patient: live call and letter Prescriber: Fax (letter if fax not successful)

*If the necessary information needed to make a determination is not received from the prescriber within the decision timeframe, a letter will be sent to the patient and prescriber informing them that the information must be received within 45 days or the claim will be denied.

How to request a level 1 appeal or urgent appeal after an initial coverage review has been denied

When an initial coverage review has been denied (adverse benefit determination), a request for appeal may be submitted by the member or authorized representative within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the initial adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

Clinical appeal requests: Express Scripts Attn: Clinical Appeals Department, PO Box 66588, St Louis, MO 63166-6588. **Fax** 1 877- 852-4070

Administrative appeal requests: Express Scripts Attn: Administrative Appeals Department, PO Box 66587 St Louis, MO 63166-6587. **Fax** 1 877- 328-9660

If the patient's situation meets the definition of urgent under the law, an urgent appeal may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the patient's provider, the patient's health may be in serious jeopardy or the patient may experience severe pain that cannot be adequately managed without the medication while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by phone or fax:

Clinical appeal requests: **phone** 1 800-935-6103 **fax** 1 877- 852-4070

Administrative appeal requests: **phone** 1 800-946-3979 **fax** 1 877- 328-9660

Urgent claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

How a level 1 appeal or urgent appeal is processed

Express Scripts completes appeals per business policies that are aligned with state and federal regulations. Depending on the type of appeal, appeal decisions are made by an Express Scripts Pharmacist, Physician, panel of clinicians, or trained prior authorization staff member.

Appeal decisions and notifications are made as follows:

Type of Appeal	Decision Timeframe Decisions are completed as soon as possible from receipt of request but no later than:	Notification of Decision	
		Approval	Denial
Standard Pre-Service	15 days	Patient: automated call (letter if call not successful) Prescriber: Fax (letter if fax not successful)	Patient: letter Prescriber: Fax (letter if fax not successful)
Standard Post-Service	30 days		

Urgent*	72 hours	Patient: automated call and letter Prescriber: Fax (letter if fax not successful)	Patient: live call and letter Prescriber: Fax (letter if fax not successful)

*If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination.

The decision made on an urgent appeal is final and binding. In the urgent care situation, there is only one level of appeal prior to an external review.

How to request a level 2 appeal after a level 1 appeal has been denied

When a level 1 appeal has been denied (adverse benefit determination), a request for a level 2 appeal may be submitted by the member or authorized representative within 90 days from receipt of notice of the level 1 appeal adverse benefit determination. To initiate a level 2 appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient
- Member ID
- Phone number
- The drug name for which benefit coverage has been denied
- Brief description of why the claimant disagrees with the adverse benefit determination
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents

Clinical appeal requests: Express Scripts Attn: Clinical Appeals Department, PO Box 66588,

St Louis, MO 63166-6588. **Fax** 1 877- 852-4070

Administrative appeal requests: Express Scripts Attn: Administrative Appeals Department,

PO Box 66587, St Louis, MO 63166-6587 **Fax** 1 877-328-9660

If the patient's situation meets the definition of urgent under the law, an urgent appeal may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the patient's provider, the patient's health may be in serious jeopardy or the patient may experience severe pain that cannot be adequately managed without the medication while the patient waits for a decision on the review. If the patient or provider believes the patient's situation is urgent, the expedited review must be requested by phone or fax:

Clinical appeal requests: **phone** 1 800-935-6103 **fax** 1 877- 852-4070

Administrative appeal requests: **phone** 1 800-946-3979 **fax** 1 877- 328-9660

Urgent claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.

How a level 2 appeal is processed

Express Scripts completes appeals per business policies that are aligned with state and federal regulations. Appeal decisions are made by an Express Scripts Pharmacist, Physician, or panel of clinicians.

Appeal decisions and notifications are made as follows:

Type of Appeal	Decision Timeframe Decisions are completed as soon as possible from receipt of request but no later than:	Notification of Decision	
		Approval	Denial
Standard Pre-Service	15 days	Patient: automated call (letter if call not successful) Prescriber: Fax (letter if fax not successful)	Patient: letter Prescriber: Fax (letter if fax not successful)
Standard Post-Service	30 days		
Urgent*	72 hours	Patient: automated call and letter Prescriber: Fax (letter if fax not successful)	Patient: live call and letter Prescriber: Fax (letter if fax not successful)

*If new information is received and considered or relied upon in the review of the appeal, such information will be provided to the patient and prescriber together with an opportunity to respond prior to issuance of any final adverse determination.

When and How to request an External Review

The right to request an independent external review may be available for an adverse benefit determination involving medical judgment, rescission, or a decision based on medical information, including determinations involving treatment that is considered experimental or investigational.

Generally, all internal appeal rights must be exhausted prior to requesting an external review. The external review will be conducted by an independent review organization with medical experts that were not involved in the prior determination of the claim. The request must be received within 4 months of the date of the final Internal adverse benefit determination (If the date that is 4 months from that date is a Saturday, Sunday or holiday, the deadline will be the next business day).

To submit an external review, the request must be mailed or faxed to:

Express Scripts

Attn: External Review Requests

PO Box 66587

St. Louis, MO 63166-6587

Phone: 1 800- 946- 3979

Fax: 1 877- 328- 9660

How an External Review is processed

Standard External Review: Express Scripts will review the external review request within 5 business days to determine if it is eligible to be forwarded to an Independent Review Organization (IRO) and the patient will be notified within 1 business day of the decision.

If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO within 5 business days of assigning the IRO. The IRO will notify the claimant in writing that it has received the request for an external review and if the IRO has determined that the claim involves medical judgment or rescission, the letter will describe the claimant's right to submit additional information within 10 business days for consideration to the IRO. Any additional information the claimant submits to the IRO will also be sent back to the claims administrator for reconsideration. The IRO will review the claim within 45 calendar days from receipt of the request and will send the claimant, the plan and Express Scripts written notice of its decision. If the IRO has determined that the claim does not involve medical judgment or rescission, the IRO will notify the claimant in writing that the claim is ineligible for a full external review.

Urgent External Review: Once an urgent external review request is submitted, the claim will immediately be reviewed to determine if it is eligible for an urgent external review. An urgent situation is one where in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health or the ability for the patient to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the claim is eligible for urgent processing, the claim will immediately be reviewed to determine if the request is eligible to be forwarded to an IRO, and the claimant will be notified of the decision. If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO. The IRO will review the claim within 72 hours from receipt of the request and will send the claimant written notice of its decision.